ATTRIBUTES OF PATIENT-PHYSICIAN RELATIONSHIPS IN A TEACHING HOSPITAL: AN EMERGENT MODEL OF INTERACTIONS

By

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A DISSERTATION PRESENTED TO THE GRADUATE SCHOOL OF THE UNIVERSITY OF FLORIDA IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

UNIVERSITY OF FLORIDA

2004
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by

Kay Tasso
This dissertation is dedicated in honor of my family and in memory of my mother, Judie Perkins Houck who died of colon cancer at the age of 56. She remains in my heart and I think of her often. I miss her friendship but know that she is filled with pride and joy at my accomplishments.
ACKNOWLEDGMENTS

The research findings contained in this dissertation could not have been possible without the support of the physicians and patients who so selflessly volunteered their time. I thank each and every one of them.

I could not have completed my dissertation without the assistance of the members of my doctoral committee: Dr. Sevan Terzian, Dr. James Doud, Dr. Terri Dolan, and Dr. Art Sandeen. A special thank you goes to my committee chair, Dr. Linda Behar-Horenstein, who provided invaluable guidance and assistance in helping me design, complete, and write my dissertation. Dr. Behar-Horenstein serves as a role model of what a woman in academia can accomplish while still enjoying a family.

I would be remiss if I did not also thank and acknowledge the support and encouragement I received from my colleagues and administrators from the University of North Florida. Rusty Smith, PT, OCS, provided much needed moral support and friendship. Mary Thigpen, PhD, PT, has been a comrade-in-arms, baby-sitter extraordinaire, and a great friend. Her advice regarding how to obtain approval from the institutional review board was absolutely critical. I also want to acknowledge and thank my administrators who offered flexible scheduling so that I could pursue my doctorate in Gainesville while working in Jacksonville.

I was also very fortunate to have my Gainesville friends, Donna and Mitch Wolcott, who allowed me to live with them periodically while I attended courses. They always made me feel welcome in their home. Both Mitch Wolcott and Gwen Creel
provided invaluable assistance helping me meet deadlines in Gainesville while I continued to work in Jacksonville.

Most importantly, I would like to thank my family:

- To my father and his wife, Tom and Joyce Houck, for their moral and financial support. Our annual trips to the beach provided much needed respite and rejuvenated me for yet another year of doctoral studies.

- To my brother and his wife, Jimmy and Martha Houck, for expressing their pride in me and acknowledging how proud our mother, Judie Houck, would be.

- To my sister, Bunny, and my grandmother, Mama Dot, for support and encouragement.

- But most of all, to my husband, Eric Tasso, and my daughter, Christi Tasso, for their encouragement, patience, and sacrifices that allowed me to complete my dissertation and doctorate. I look forward to playing with my daughter and hope to never again say: “I can’t honey. I have to do my homework.”
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The relationship between a patient and physician has received greater attention since the onset of managed healthcare in the late 1980s. Physicians report feeling pressured to see more patients per day. Consequently, they have less time to devote to establishing and maintaining good relations with patients. Research indicates that the patient-physician relationship affects patient satisfaction, adherence to treatment, and the risk of malpractice lawsuits. The purposes of this qualitative study were to describe the attributes that characterize patient-physician communications, the effect of the patient-physician relationship on patient satisfaction, and the correspondence between physicians’ education and training with their relationship with patients. The study examined whether gender or medical subspecialty affected patient-physician interactions.

This study was conducted in an acute care hospital in the southeastern United States. Eight physicians from three medical services participated in and were interviewed for the study. The medical services involved were internal medicine, pediatrics, and
surgery. Twenty-three patients were interviewed regarding their satisfaction with their relationship with their physician and with their hospital stay. A total of 293 interactions between patients and physicians were observed and recorded over a six-month period.

Responses of physicians on how managed care affected their ability to relate to patients varied. In general, physicians practicing more than 10 years reported experiencing more negative effects of managed care than physicians practicing fewer than 10 years. The majority of patients interviewed were satisfied with their relationship with their physician and with their hospital stay. Analysis of written records of the observations revealed three primary ways physicians interacted with patients: physician-dominant, patient-physician reciprocity, and process-dominant. Physicians were observed dominating the interaction when patients were unable to speak and participate in the decision-making process. Patients and physicians worked together to make decisions about the treatment plan when patients were able to actively participate in discussions. At times, such as during team patient care rounds, the interactions were dominated by a process with little interaction between the patient and the physician.

A theoretical model that emerged from the observations was presented and explained.
CHAPTER 1
INTRODUCTION

The relationship between a patient and physician has received increasingly more attention since the onset of managed healthcare in the late 1980s. Prior to that time, patients and physicians enjoyed more long-term, one-on-one interactions (Korsch, Gozzi & Francis, 1968). Researchers have suggested that the priorities of managed care such as cost containment (Beckman, Markakis, Suchman & Frankel, 1994) and bureaucracy (Meldrum & Hardy, 2001) have interfered with this relationship (Degnin, 1999). As a result, physicians feel pressured to see more patients a day (Meldrum & Hardy, 2001). In addition, “many physicians no longer attach high importance to personal rapport with the patient; to some, the ‘bedside manner’ seems a concession to salesmanship not befitting a medical scientist” (Korsch & Negrete, 1972, p. 66).

In 1968, Korsch, Gozzi, and Francis published the first research study that addressed the relationship between patients and physicians. Their study utilized videotapes and audiotapes to examine interactions between pediatricians and parents during office visits and the impact of their relationship on patient satisfaction. Interest in research on patient-physician relations continued through the 1970s and then declined until the onset of managed healthcare in 1990s. Pressure to see more patients per day, bureaucratic changes (Meldrum & Hardy, 2001), and an emphasis on cost containment (Beckman et al., 1994) due to managed care fostered a renewed interest in research regarding patient-physician relationships.
The nature of the patient-physician relationship affects patient satisfaction (Blanck, Buck & Rosenthal, 1986; Buckman, 1992; Comstock, Hooper, Goodwin & Goodwin, 1982; Evans, Kiellerup, Stanley, Burrows & Sweet, 1987; Hall & Dornan, 1988; Hall, Roter & Katz, 1988; Irwin, McClelland & Love, 1989; Korsch, Gozzi & Francis, 1968; Korsch & Negrete, 1972; Levinson & Roter, 1995; Ley, 1988; Rosenberg, Lussier & Beaudoin, 1997; Servellen, 1997), patient adherence to the treatment program (Buckman, 1992; Cole & Bird, 2000; Hinz, 2000; Korsch et al., 1968; Platt & Gordon, 1999; Rosenberg et al., 1997; Roter & Hall, 1992; Servellen, 1997), and the risk of a malpractice lawsuit (Beckman et al., 1994; Lefevre, Waters & Budetti, 2000; Pichert, Hickson & Trotter, 1998; Servellen, 1997). The single factor that is characteristic among these spheres of influence is the physician’s ability to communicate with patients and their families. For example, the patient-physician relationship may impact patient satisfaction based on the information that physicians communicate to patients. Researchers have shown that patients tend to rate their level of satisfaction higher when the physician provides them with the desired amount of information regarding their medical problem (Blanck et al., 1986; Comstock et al., 1982; Hall et al., 1988).

Similarly, patients tend to adhere to their treatment programs better when they are satisfied with their medical care (Cole & Bird, 2000; Roter & Hall, 1992; Servellen, 1997). In contrast, the second most common cause of medical malpractice lawsuits results from poor patient-physician communications and rapport (Pichert et al., 1998; Lefevre et al., 2000).

The training and education of physicians may also impact the quality and dynamics of the patient-physician relationship. Only 43.2% of medical schools include formal
education regarding the development and maintenance of patient-physician relations (Lefevre et al., 2000). Characteristics of patients and physicians also affect the patient-physician relationship. In particular, the role gender plays in the patient-physician relationship has received increased examination (Comstock et al., 1982; Hall & Roter, 1998; Roter & Hall, 1992; Rosenberg et al., 1997; Wasserman, Inui, Barriatua, Carter & Lippincott, 1984; Weisman & Teitelbaum, 1989; West, 1984). There is evidence to suggest that the nature of the patient-physician relationship is influential. However, almost all the research has taken place in an outpatient setting. What is the nature of the patient-physician relationship in acute care? Typically patients experience more anxiety and physicians have greater demands on their time in the acute care setting than in outpatient settings (Korsch & Harding, 1997). Few studies have examined the nature of the inpatient-physician relationships. Only one published study examined any aspect of patient-physician relationships in a hospital setting (Shiminski-Maher, 1993). All other studies were conducted in outpatient offices, clinics, or ambulatory care centers. Yet researchers have reported that the patient-physician relationship influences patients’ perceptions of satisfaction and care and the potential for medical malpractice litigation. Describing the characteristics that typify patient-physician interactions may be instrumental to understanding how interaction styles impact patients’ perceptions of satisfaction and care.

**Purpose of the Study**

The purpose of this study was to identify attributes of the patient-physician relationship that characterize patient-physician communications in the acute care setting and to assess if these attributes impact patient satisfaction. Utilizing participant observation, this study focused on the patient-physician relationship in acute care.
Methods of data collection included unobtrusive observations of interactions between patients and physicians, patient interviews, and physician interviews.

Using a constructivist framework, the researcher considered people’s perceptions, communications, and the context of the setting as essential for developing insight about the observable relationship.

The purpose of this qualitative study was to describe:

1. Attributes that characterize patient-physician communications.
3. How patients’ relationships with their physician influence their level of satisfaction.
5. Whether the medical subspecialty of the physician influences patient satisfaction.
6. How the medical subspecialty of the physician influences the types of interactions between the patient and the physician.
7. If there is a correspondence between the physicians’ education and training and their relationship with their patients.

**Definition of Terms**

The following terms are used in this study as defined below.

**Acute care** – relates to the type of treatment that is provided to patients who are hospitalized for brief periods.

**Adherence** – refers to the behavior of a patient who voluntarily follows through with recommendations from the physician (Sharf, 1984).

**Amenities of care** – refers to Donabedian’s (1980) classification of non-medical services provided in a hospital such as parking, food, and admission procedures.

**Attending physicians** – refers to medical doctors who hold state license and board credentials and work as house staff at a specific hospital.

**Communications** – refers to verbal exchange of information between the sender and the receiver(s).
Compliance – refers to patients’ following through with physician directive for medical treatment.

Fellow – refers to a medical doctor who is in his/her final years of supervision in designated medical subspecialty.

Intern – refers to an individual who has graduated from medical school and is in the first year of clinical training under the supervision of a physician.

Interpersonal care – refers to Donabedian’s classification of verbal and non-verbal communications between a patient and healthcare professional, and the quality of interactions between the patient and healthcare providers that is nurturing, supportive, and comforting.

Medical student – refers to a student who is currently enrolled in a professional program of study that upon matriculation will ultimately result in receipt of the degree of medical doctor.

Non-verbal communication – refers to information that is transmitted between sender and receiver via eye contact, body language, and distance between the parties.

Outpatient – refers to a person who comes to a physician’s office or hospital to receive healthcare services.

Patient care assistants (PCAs) – refers to the unlicensed nursing support personnel whose primary responsibilities include assisting patients with hygienic needs, changing bed linens, and taking vital signs.

Patient-centered approach – refers to the manner in which a physician relates to a patient as a partner.

Patient satisfaction – refers to the degree to which an individual under the treatment of a medical doctor thinks the hospitalization and medical care has met his or her needs.

Patient-physician relationship – refers to the interpersonal dynamics that occur between a patient and his or her physician.

Physicians-in-training – refers to medical students, interns, or residents.

Quality care – refers to characteristics of medical services that represent the caliber of treatment provided or received.

Resident – refers to a physician who has completed medical school and is engaged in the second year (or more) of clinical training under the supervision of a licensed medical doctor.

Rounds – refers to a process where physicians, residents, interns, and medical students conduct visits to see each patient at bedside and to discuss his or her case.
**Technical care** – refers to Donabedian’s classification of medical services provided by healthcare personnel to the patient that are procedural such as the removal of sutures.

**Significance of Study**

The quality of interactions between patient and physician can be manifested within a broad spectrum of influence beyond just the patient’s perception of his/her experience. The caliber of these interactions also impacts the potential for medical malpractice, fiscal solvency of hospitals, public perceptions of physicians, patient adherence to treatment, and the marketability of the hospital. Previous studies have shown that both physicians and patients have expressed frustration and dissatisfaction about the quality of their interactions. Since the inception of managed healthcare, many physicians have expressed dissatisfaction and dislike for the demands placed upon them to show greater productivity. For example, patients have reported that physicians seem less available (Meldrum & Hardy, 2001). Understanding the nature of real time physician communication and interactions is likely to provide important information regarding what changes can be taken to ensure high caliber patient physician interactions. The findings of this study may also offer insight into ways that patient compliance, outcomes, and satisfaction can be increased.

**Limitations**

This study was designed to investigate patient-physician relationships in an acute care teaching hospital located in the southeastern portion of the United States. Because of the location of this study, the generalizability of the results are limited to teaching or not-for-profit hospitals located in the United States. In addition, the results of this study may differ from previous research findings involving outpatient physician’s offices.
The number of participants in this study was limited by the availability of parents who could speak on behalf of their child or by patients who were unable to communicate. At times, patients were discharged before the researcher completed patient care rounds and returned for an interview. The duration of the patient-physician relationship may have influenced the patient-physician interview. For example, in some cases, patients did not know the attending well enough to provide feedback.

The sample of physicians was purposeful. Physicians were recruited based on their willingness to participate and may not be representative of physicians in general. This may represent a source of bias. In addition, physician participants were recruited from only three medical services: medicine, pediatrics, and surgery. Therefore, the findings from this study may not be generalizable to other medical services within an acute care setting. The results of this study may have been influenced by the location of the study. Physicians who work in teaching hospitals are often expected to model skills in patient relations for physicians-in-training.
CHAPTER 2
LITERATURE REVIEW

Introduction

The purpose of this chapter is to provide an overview of related research studies about a) patient-physician relationships, b) theoretical models of patient-physician relationships and c) patient-physician communication.

Patient-Physician Relationship

The nature of the patient-physician relationship has changed over time in response to the changes in healthcare delivery. Servellen (1997) describes four factors that affect how healthcare changes occur: societal influences, public health programs, existing health problems, and levels of technology. An emphasis on providing healthcare for all Americans is one of the factors that has impacted healthcare delivery. One example of a mandated healthcare program is Florida’s Healthy Start program that was designed to improve prenatal care. In response to concerns about the widespread incidence of AIDS and a potential for an epidemic, local health departments offered free HIV testing and screening for HIV in all blood products. The discovery of sulfa drugs and penicillin in the 1930s and 1940s signifies how advances in science and technology have affected healthcare. New vaccinations and pharmacological treatments have prompted a shift in medical practice from patient-centered to a biomedical model. The impact of the biomedical model has resulted in the depersonalization and objectification of patients (Roter & Hall, 1992).
The fee-for-service model in the 1980s and the emergence of the HMOs in the 1990s typifies how societal influences, public health programs, existing health problems, and levels of technology have promoted greater oversight in patients’ access to healthcare (Servellen, 1997). Before managed care and HMOs, patients and physicians sustained long-term relationships that allowed for warm and meaningful connections (Korsch et al., 1968). According to Degnin (1999), managed care “undercut this relationship” (p. 15). Pressure to treat more patients per year has also impacted the quality of the patient-physician relationship. For example, HMOs reprimand physicians through salary penalties when they fail to increase their productivity (Meldrum & Hardy, 2001). This model has prompted “a decisive shift away from the physician-patient relationship and the individual needs of patients . . . by emphasizing cost containment and appropriate care for the average patient, but not necessarily for individual patients” (Beckman et al., 1994, p. 18). Before the introduction of managed care, patients did not question the recommendations (Teutsch, 2003; West, 1984); they were viewed as “God” (West, 1984). Now patients are seen as “customers” who must actively participate in their care (Meldrum & Hardy, 2001). “Many physicians no longer attach high importance to personal rapport with the patient; to some, the ‘bedside manner’ seems a concession to salesmanship not befitting a medical scientist” (Korsch & Negrete, 1972, p. 66).

Korsch, Gozzi, and Francis (1968) conducted the first study of the patient-physician relationship when they examined the relationships between pediatricians and their patients’ parents and how that relationship impacted patient satisfaction and adherence to the treatment plan. Using audiotaped interactions, reviews of the medical records, and follow-up interviews of the family, the researchers found 76% of the 800
mothers were highly to moderately satisfied with the interaction. This seminal study still serves as a foundation for many studies today. For example, during the 1970s, 46 papers on the topic of patient-physician communications were published (Sanson-Fisher, Fairbairn, & Maguire, 1981). The number of research studies on the patient-physician relationship doubled between 1968 and 1988 (Roter, Hall, & Katz, 1988). Interest in research on this topic then declined until the onset of managed care in the late 1990s. As a result, researchers became concerned about how changes in healthcare affected the patient-physician relationship.

**Education and the Patient-Physician Relationship**

Given the importance of the patient-physician relationship, one might surmise medical students, interns, residents, and fellows receive a significant educational experience on building a relationship with patients and their families. Yet, as Gordon and Edwards (1995) have pointed out, physicians and other health care professionals do not receive adequate education regarding interpersonal communications. The medical school curriculum is comprised mostly by the life sciences rather than developing the “physician’s attitudes and actions that demonstrate interest in and respect for the patient and that address the patient’s concerns and values” (Branch, Kern, Haidet, Weissemann, Gracey, Mitchell & Inui, 2001, p. 1067).

Medical students typically receive training in interviewing patients but not how to establish patient rapport (Boulton, Griffiths, Hall, McIntyre, Oliver & Woodard, 1984). For example, in a survey of medical schools, Lefevre, Waters, and Budetti (2000) reported that 43.2% of the 4275 medical programs that responded addressed patient-physician issues by using conferences, lectures, and teaching during clinical rounds rather than more interactive and formal activities that contribute to deep learning. In medical
schools where communication skills were taught, the physician retained the same level of skills when assessed five years later (Roter et al., 1988). This latter finding suggests that formal coursework might be more effective than training in informal settings.

The amount of education regarding interpersonal skills varies regionally, by level of education, and by type of medical service. For example, 62.6% of residencies and 38.8% of fellowships in Middle Atlantic states provide education on patient-provider communication compared to 43.8% of residencies and 23.9% of fellowships in South Atlantic states. Of the 52.5% of residency programs across the United States that do provide education regarding interpersonal skills, 76.1% of the residencies are in primary care and 30.1% of the residencies are in surgery (Lefevre et al., 2000).

Researchers have observed that medical students’ interpersonal skills decline as they progress through their medical training. As students move closer to practicing independently, their interpersonal skills decrease (Gordon & Edwards, 1995). In particular, they become more distant and scientific with their patients (Roter & Hall, 1992). Perhaps this phenomenon is seen because residents are generally more overwhelmed and sleep deprived than medical students, and have many more tasks and demands made on their time (Korsch & Harding, 1997). Interestingly, studies of medical school graduates demonstrate that they believe they had sufficient instruction in communication skills while in medical school despite the fact that few had formal instruction (Pichert et al., 1998; Lefevre et al., 2000).

Researchers have examined the effectiveness of various educational approaches on improving physicians’ interpersonal skills. One medical program examined the effects of videotaping physicians while they participated in patient simulations. Subsequently,
instructors viewed the tape with the physician and provided feedback about his/her interpersonal skills. Whitehouse, Morris, & Marks (1984) pointed out that regardless of the educational approach used, physicians and residents displayed improved levels of empathy. This finding suggests that some form of education is better than no educational experiences. During a 12-week continuing education program participants were videotaped during role-play and real time interactions with patients while tutors provided them with feedback regarding their communication skills. This type of approach was more effective than the apprenticeship model that is used during resident training (Irwin et al., 1989).

**Patient Satisfaction**

The patient-physician relationship is significant to patient satisfaction (Blanck et al., 1986). A good patient-physician relationship increases patient satisfaction (Servellen, 1997). However, assessing patient satisfaction is difficult. “Patient satisfaction is often considered an abstract multidimensional phenomenon” that can only be measured indirectly (Beattie, Pinto, Nelson & Nelson, 2002, p. 558). Typically, patient satisfaction is assessed using surveys (Beattie et al., 2002). Validation of these ratings through multiple methods is extremely difficult.

Other factors also impact the accuracy of patient satisfaction ratings. For example, patient satisfaction appears to fluctuate depending on the amount of time that has passed since the patient was discharged from the hospital. For example, Ley (1988) found that patient satisfaction increased one week after discharge only to decline two to four weeks following discharge. Eight weeks after discharge, patient satisfaction again increased.

The information provided to the patient from the physician also impacts patients’ perceptions of satisfaction. Researchers have reported that the more information patients
receive, the higher the ratings of patient satisfaction (Blanck et al., 1986; Comstock et al., 1982; Hall et al., 1988). Ley (1988) pointed out that patient satisfaction with communication could be defined as “the quality and quantity of information they receive in the clinical encounter” (p.4). Patients are often dissatisfied if the physician fails to provide sufficient information regarding the origin of the medical problem, the prognosis, or the treatment plan (Evans et al., 1987; Irwin et al., 1989).

Patient satisfaction is directly related to the physician’s ability to communicate. Patients tend to be more often dissatisfied with physicians’ communication skills than with their technical skills (Buckman, 1992; Servellen, 1997). In contrast, patient satisfaction increases when physicians who actively listen and allow patients to express themselves. Patients perceive physicians who communicate in this manner as more competent (Buckman, 1992). Physicians who are willing to discuss psychosocial issues and relate to their patients as partners are seen as “patient-centered.” They receive higher ratings on patient satisfaction than physicians who interact with patients in a more traditional fashion (Levinson & Roter, 1995). Patients also rate physicians higher when she or he exhibits courtesy, listens, and demonstrates empathy.

Results about the relationship between the amounts of time physicians spend with patients and patient satisfaction is inconsistent. Comstock et al. (1982) found that there was a low correlation between the amounts of time physicians spent with patients and their ratings of satisfaction. Hall and Dornan (1988) reported that patients were more satisfied with longer physician visits. Yet, other researchers found that neither the length of time a physician spends with a patient nor the patient’s diagnosis correlates with patient satisfaction (Ley, 1988; Korsch et al., 1968; Korsch & Negrete, 1972).
Whether patient expectations were satisfied also impacts patient satisfaction. Patient satisfaction ratings decrease when patient expectations are not met, when the cause of the patients’ problems cannot be determined, when test dates and times are not specified, or when the treatment ordered is not communicated (Ley, 1988). Often patients report that they expect their physicians to answer their questions (Korsch et al., 1968). Even in those instances when a patient has no questions, satisfaction increases if a physician asks the patient if he or she has any questions (Rosenberg et al., 1997). Conversely, patients are dissatisfied when their doctor does not meet their social-emotional needs (Evans et al., 1987; Irwin et al., 1989).

Related to pediatricians, mothers expect physicians to interact with them in a friendly and business-like fashion. They also expect their physician to interact with their children in a friendly and sympathetic manner (Korsch et al., 1968). Mothers report high levels of satisfaction when the pediatrician provides supportive encouragement to her regarding her parenting skills (Wasserman et al., 1984). These findings were upheld by subsequent studies in the pediatric setting (Bernzweig, Takayama, Phibbs, Lewis, & Pantell, 1997; Simonian, Tarnowski, Park, & Bekeny, 1993).

**Patient Adherence**

Factors that impact patient satisfaction also affect patient compliance and outcomes (Servellen, 1997). For example, satisfied patients demonstrated greater adherence to treatment than dissatisfied patients (Cole & Bird, 2000; Roter & Hall, 1992; Servellen, 1997). The more information the physician provides, the more compliant the patient is (Rosenberg et al., 1997). Patients whose expectations are met tend to comply better with their treatment programs (Korsch et al., 1968). Physicians can improve patient satisfaction, compliance, and outcomes by providing information in writing and by
educating patients rather than primarily serving as a diagnostician (Ley, 1988; Roter & Hall, 1992).

Physician communication also impacts patient compliance and outcomes. Patients’ compliance increases when physicians offer suggestions rather than commands. Patients comply better when physicians provide positive, supportive comments, and when patients are asked to participate in decision-making about their treatment (Rosenberg et al., 1997). Physicians who actively listen to patients without interruption exert a positive impact on patient compliance (Buckman, 1992; Hinz, 2000). “The best predictor of patient compliance is the patient’s sense of having been heard fully…” (Platt & Gordon, 1999, p.8).

The physician’s style of interaction also affects patient compliance. Physicians who utilize a patient-centered approach (i.e. willingly discuss psychosocial issues and relate to patients as partners) with patients who have diabetes, arthritis, and hypertension demonstrate better outcomes than patients of physicians who interact in a traditional fashion. Improved outcomes correlate positively with the patient-centered approach among patients with chronic health problems become more active in their care (Cole & Bird, 2000; Levinson & Roter, 1995).

**Litigation**

“The breakdown in the patient-physician relationship may indeed be the major provocation for these malpractice lawsuits” (Servellen, 1997, p. xxxii). In medical malpractice lawsuits that were not related to treatment, the primary reason for the litigation was related to poor patient-physician rapport and communication (Pichert et al., 1998; Lefevre et al., 2000). Patients typically file lawsuits when they perceive that the physician has demonstrated a lack of interpersonal or professional caring or has not
collaborated with the patient and family. Physician unavailability or “desertion”
accounted for 31.5% of litigation (Beckman et al., 1994). Disinterest in patient or family
concerns accounted for another 28.9% of lawsuits. Insufficient information or a lack of
understanding of issues by the patient or family following a significant event accounted
for 26.4% of lawsuits (Beckman et al., 1994).

In a study of 127 parents of children with perinatal injuries Lefevre, Waters, and
Budetti (2000) found that 70% of the lawsuits were from parents who felt the physician
had not informed them about the long term, developmental issues of their child. In the
same study, 48% of the parents complained the physician misled them. Almost one-third
(32%) of the lawsuits resulted from the physician’s failure to speak frankly with the
parents. Parents who felt that the physician would not listen to them initiated 13% of the
lawsuits. Lefevre, Waters, and Budetti (2000) found that physicians who were not sued
spent more time with their patients, provided information to the patient regarding the plan
for the visit, and used humor more often than physicians who were sued.

Theoretical Models of Patient-Physician Relationships

There are few theoretical models regarding the patient-physician relationship. The
most well established framework is Szasz and Hollender’s 1956 model. They identified
three different types of relationships: activity-passivity, guidance-cooperation, and
mutual-participation. In the activity-passivity model, the physician is in complete control
of the decision-making process because the patient is incoherent or unconscious. This
relationship requires little or no interpersonal communication between the two parties. In
the guidance-cooperation model, the patient actively participates in the decisions
regarding healthcare but defers to the medical expertise of the physician for the final
determination. This type of relationship might be appropriate for a patient who has a
fracture and depends on the physician’s expertise in determining the most appropriate
treatment. The third type of relationship is the mutual-participation model. Using this
approach the patient and the physician make decisions together. For example, in
situations where the patient has a chronic illness both the physician’s expertise and the
patient’s personal experience with the illness must be considered so that the most
appropriate decision can be made (Meldrum & Hardy, 1995; Szasz & Hollender, 1987).

Emanuel and Emanuel’s (1992) theoretical framework regarding the patient-
physician relationship posits four different styles of interaction: paternalistic, informative,
interpretative, and deliberative model. The paternalistic interaction is similar to Szasz
and Hollender’s activity-passivity model in which only the physician makes the decisions
regarding treatment. This is an example of authoritative relationship. The informative
interaction style, also known as the scientific or consumer model, places the physician in
the role of provider of technical information regarding the disease and the treatment
options. However, patients have the prerogative to decide what is the most appropriate
approach based on his/her personal values. In the interpretive interaction style, the
physician provides information to the patient regarding the risks and benefits of treatment
options that are unique to the patient’s needs. The physician acts as an advisor to the
patient and helps the patient interpret the medical information. Then the patient makes
the decision regarding the course of treatment. During the deliberative interaction style,
the physician acts as a teacher and friend and empowers the patient to decide is the most
appropriate course of treatment. The physician may try and persuade the patient
regarding the most desirable course of treatment. Some researchers suggest that this is
the most ideal type of patient-physician relationship because it is collaborative yet the
patient is actively involved in decision-making (Emanuel and Emanuel, 1992; Gordon and Edwards, 1995).

**Patient-Physician Communication**

Communication is a large and important component of the patient-physician relationship. In healthcare, communication is defined as “the transmission of messages between provider and patient during face-to-face encounters; both messages from providers to patient and from patients to providers are included in this definition” (Weisman & Teitelbaum, 1989, p. 183). Researchers agree that communication between patients and physicians is fundamental to the patient-physician relationship and essential for the development of the treatment plan (Roter & Hall, 1992, p.3). Since the “rules” of communication include eye contact as an indicator of active listening, patients often perceive that physicians are not listening when writing while the patient is talking. In addition, the use of medical jargon “confuses and alienates the patients often leading to misunderstanding and misinterpretation” (Buckman, 1992, p. 41). Other times, patients are discouraged from participating in two-way communication when physicians use a paternalistic or authoritarian style of interaction (Gordon & Edwards, 1995).

Patients need to feel that physicians are interested in them. One way that physicians can demonstrate interest in their patients is by actively listening to the patient’s story (Roter & Hall, 1992). Research indicates that physicians often interrupt patients within the first 18-23 seconds of patients telling their story (Buckman, 1992; Rosenberg et al., 1997). In one research study, once the patient was interrupted, only 1 of 52 patients finished their statements. Physicians often interrupt for fear that the patient will talk too long (Rosenberg et al., 1997), however, research indicates that when patients are not interrupted, they will only talk 60-150 seconds out of a 12-minute physician visit
Patients who are allowed to speak without interruption are generally more satisfied with their relationship with the physician and report not feeling rushed during their visit (Hinz, 2000). Conversely, patients who were interrupted and could not discuss their primary concern tended to be dissatisfied. Korsch and Negrete (1972) found 68% of parents who did not have the opportunity to discuss their primary concern were dissatisfied. In contrast, 83% of parents who were able to discuss their primary concern were satisfied.

Physicians’ communication skills are critical to an accurate diagnosis (Sanson-Fisher et al., 1981). Physicians who interrupt patients run the risk of missing important information and run the risk of misdiagnosis (Beckman & Frankel, 1984). If patients are interrupted when expressing their medical concerns to their physician, they may not express all of their health concerns. Multiple research studies indicate, “very few patients come to the doctor with just one problem” (Platt & Gordon, 1999, p. 4; Rosenberg et al., 1997). Most patients have at least three concerns they wish to address with the physician. Patients are most reluctant to discuss psychosocial problems as their first presenting problem. Rosenberg, Lussier, and Beaudoin (1997) found that only 6% of patients would disclose a psychosocial issue as their first presenting health concern. Physicians who fail to encourage the patient’s disclosure of all presenting problems risk “hidden agendas” that the patient will address towards the end of the visit (Beckman & Frankel, 1984).

Non-verbal communication is an integral component of patient-physician communication. Ley (1988) categorized non-verbal communication based on three factors: immediacy or closeness, relaxation, and responsiveness. Immediacy or closeness relates to whether the people who are communicating touch, and maintain eye contact.
The posture of the physician and the distance between the parties who are communicating also contribute to the sense of immediacy and closeness. Relaxation refers to the symmetry or asymmetry of the physician’s arms and legs, whether the physician leans forward while delivering the message, and how relaxed the physician’s hands and neck are. Responsiveness includes the tone of voice, facial expression, and the rate and volume of speech of the physician.

Eye contact, facial expression, posture, and tone of voice communicate empathy to the patient. For example, a physician who maintains a close distance with the patient, and who leans forward and maintains eye contact with the patient is perceived as empathetic by the patient (Blanck et al., 1986). Patients respond best when the physicians sit facing them with their legs uncrossed while maintaining eye contact and nodding their head in response to the patients speaking. Whether the physician’s arms are crossed or uncrossed has no impact on the patient’s perception of empathy by the physician (Blanck et al., 1986).

**Patient Characteristics**

According to Roter and Hall (1992), several characteristics affect patients’ communications with their physician such as age, social class, ethnicity, appearance, and gender. In general, older patients tend to receive more information from their physician than younger patients. Patients in a higher socioeconomic class tend to receive more information from physicians than patients in a lower socioeconomic class. Patients from low socioeconomic status also received less information from the physician regarding side effects of medication (Rosenberg et al., 1997). Ethnicity appears to affect patient-physician communications as well. For example, physicians tend to view Italians as having more psychological problems than patients from other ethnic backgrounds. The
appearance of patients also affects the frequency of interruption by physicians. Patients who were cleaner and better dressed tended to be interrupted less frequently. In regards to gender, female patients tended to provide more information to physicians and receive more information from physicians when compared to males. Weisman and Teitelbaum (1989) found that women asked more questions during healthcare interactions than males. Gender differences might be due to the fact that women utilize healthcare more often than men, even when the statistics are adjusted to account for pregnancy (Weisman & Teitelbaum, 1989). Researchers also reported that female patients tend to prefer a physician who is attentive to their feelings (Hall & Roter, 1998).

Differences between men and women in their preference for physician communication have also been reported. For example, male patients dislike discussing psychosocial issues or would prefer to discuss them with a female physician. In contrast, women prefer physicians who discuss psychosocial issues, regardless of the physician’s gender, who provide emotional support, and who build partnerships with their patients (Rosenberg et al., 1997). When examining perceptions of patient-physician communication, differences in variance due to age, social class, ethnicity, appearance, and gender must be measured.

**Physician Characteristics**

How physician characteristics impact patient-physician relationships is less clear and more complex than the effect of patient characteristics on the relationship (Roter & Hall, 1992). Socioeconomic status and gender are the only physician characteristics that have been researched. Historically, the majority of physicians came from upper middle class families. Research indicates that people in the upper middle class tend to be more articulate linguistically (Roter & Hall, 1992). However, as the demographics of medical
students change, so does the diversity of communication styles and abilities. For example, in the 1960s, only 5% of medical students were females. In the 1970s, physicians continued to traditionally consist of white, upper-middle-class males. However, in the 1980s, the demographics began to change. Females accounted for 37% of medical students, African-Americans accounted for 5%, and other minorities accounted for 5% in the 1980s (Roter & Hall, 1992).

Both gender of the patient and physician can impact the patient-physician relationship (Rosenberg et al., 1997). In one of the few studies that addressed this component, Hall and Roter (1998) found that physicians tend to interrupt female patients less frequently than male patients. As a whole, physicians prefer healthy, male patients compared to female or sick patients. Sicker patients tend to be more dissatisfied with their relationship with the physician than healthy patients (Hall & Roter, 1998). Researchers have reported that medical school does not change the pre-existing differences in communication styles between men and women (Rosenberg et al., 1997).

Gender also correlates to the amount of time the physician spends with patients. Female physicians tend to spend more time with patients and encourage more partnership building than male physicians (Hall & Roter, 1998; Rosenberg et al., 1997; Roter & Hall, 1992; Weisman & Teitelbaum, 1989). Female obstetrics/gynecology and pediatric residents demonstrate more empathy with female patients and with mothers than male residents. In addition, patients found female physicians to be more empathic, more sensitive and supportive, more skilled socially, more attentive, and warmer than male physicians (Hall & Roter, 1998; Roter & Hall, 1992; Rosenberg et al., 1997). Female physicians tend to smile more, touch, make eye contact, and position themselves
physically closer to patients than male physicians (Hall & Roter, 1998; Roter & Hall, 1992). Female physicians are better listeners than male physicians. Female physicians reported liking their patients more than male physicians and are more comfortable dealing with their patients’ emotions and psychosocial issues (Hall & Roter, 1998; Roter & Hall, 1992; Rosenberg et al., 1997). Female pediatricians and nurse practitioners provided significantly more supportive comments to parents than male physicians (Wasserman et al., 1984).

Male physicians tend to issue commands more than female physicians while female physicians tend to offer proposals (Rosenberg et al., 1997). However, there is no evidence that patients are more satisfied with female or male physicians (Comstock et al., 1982; Hall & Roter, 1998;). It has been reported that patients are less satisfied with young, female physicians and prefer older, male physicians (Rosenberg et al., 1997).

Clearly the gender of the patient and the gender of the physician impact their relationship. Female patients tend to be more responsive to female physicians. They also tend to ask more questions of female physicians and are more willing to discuss psychosocial issues with them (Roter & Hall, 1992). In a study by West (1984), male family physicians interrupted discussions with patients 67% of the time compared to female family physicians who interrupted patients 32% of the time. West (1984) theorized that male physicians utilized this practice as a method of controlling the discussion. When the patient and physician were of the same sex, the frequency of interruptions remained the same. When the patient and physician were of the opposite sex, males interrupted females more than females interrupted males (Weisman & Teitelbaum, 1989).
Barriers to Communication

Gordon and Edwards (1995) have identified several barriers to successful communication between physicians and patients. For example, the use of medical jargon can confuse patients and contribute to miscommunication and misunderstanding. Physicians who watch the clock while interviewing patients communicate disinterest. Physicians who frown, mumble to themselves, interrupt patients, or ignore patients’ questions risk appearing disinterested to patients. Physicians who leave the room at the conclusion of the patient visit without indicating completion of the office visit hamper communication. In addition, according to Gordon and Edwards (1995) the following behaviors block communication:

- Ordering or warning
- Moralizing or preaching
- Name-calling or labeling
- Judging, blaming, or admonishing
- Contradicting or disagreeing
- Ignoring, diverting, or interrupting

Gordon, and Edwards (1995) recommended that physicians demonstrate positive behaviors such as attending, passive listening, active listening behaviors, non-verbal communication, and maintain eye contact.

Summary

The relationship between patients and their physicians has become increasingly more important due to the onset of health care reform, managed care, and health maintenance organizations (HMO). The patient-physician relationship impacts patient satisfaction, patient compliance and outcome, and the frequency of malpractice lawsuits. One of the most significant factors other than physician training that affect the patient-physician relationship is the physician’s interpersonal communication skill. Even though
“much of medicine’s curative power is recognized as residing in the patient-physician relationship” (Roter et al., 1987, p. 437), communication between patients and physicians is frequently poor or ineffective (Boulton et al., 1984). Poor patient-physician relationships contribute to the frequency of medical malpractice lawsuits (Beckman et al., 1994; Hinz, 2000). Researchers have reported that a poor patient-physician relationship was a component of up to 71% of medical malpractice lawsuits (Beckman & Frankel, 1984; Beckman et al., 1994). Previously, most quality of care case studies only examined the technical care provided by physicians (Roter & Hall, 1992). Other studies about quality of care were conducted only in the outpatient settings (Comstock et al., 1982; Hall et al., 1988; Korsch et al., 1968; Korsch & Negrete, 1972; Wasserman et al., 1984).

There is a dearth of studies about this relationship in acute care settings. Only Shiminski-Maher examined patient-physician relationships in her 1993 study. This article primarily discussed common errors in patient-physician communications and techniques for preventing miscommunication. No experimental design was utilized. In Roter, Hall, and Katz’s (1988) literature review of over 700 published and unpublished studies, only two involved inpatients. However, the two inpatient studies could not be located, possibly since they were unpublished. Identifying characteristics that describe the nature of patient-physician relationships may be helpful in establishing guidelines aimed at promoting patient adherence to treatment plans, ensuring patient satisfaction, and training physicians in interpersonal communications.
CHAPTER 3
METHODS

In this chapter, the theoretical framework, methodology, researcher qualifications and bias, the methods used to gain access into the research setting, the participants, and the instrumentation will be described. This chapter will conclude with a discussion of the data collection and data analysis processes as they relate to the present study.

**Theoretical Framework for This Study**

The theoretical framework for this study is interpretivism. According to Schwandt (2001), proponents of interpretivism seek to “understand human action” by understanding the meaning of that action (p. 191). “The interpreter objectifies (i.e. stands over and against) that which is to be objectified. And, in that sense, the interpreter remains unaffected by and external to the interpretive process (p. 194).” In other words, one can objectively understand what people intend through their actions. The method of participant observation allows the researcher to objectively understand someone’s intent by studying his or her actions in the context of the situation.

The epistemological framework for interpretivism is understanding.  Schwandt (2000) states that understanding is “an intellectual process whereby a knower (the inquirer as subject) gains knowledge about an object (the meaning of human action) (p. 193-194).” For this study, the researcher will analyze interaction between a physician and his or her patient to interpret the physician’s intent in regards to the patient-physician relationship.
Methodology

The methodology used in this research was a case study. Stake (2000) describes a case study as “bounded” and focused on behavioral patterns. In this particular study, bounded refers to limiting the focus of the study to two particular cases: (1) patients, and (2) physicians. Examination of these case groups is also considered bounded since other components of the setting will not be examined. For example, if ethnography of the same participant groups were conducted it would include examination of the cultural norms, lived experience of participants from day to day, noise level, environment, and nursing staff. In this study, these components will not be described. This study will focus on providing a thick and rich description of the observations and interviews.

Consistent with case study methodology, observations between patients and physicians will be used to acquire insight about interactions that are characteristic of each group as well as the relationship between the two groups. As a result, an understanding of the attributes that are common to the patient-physician relationships will be developed.

Researcher Qualifications and Bias

In studies where extensive qualitative fieldwork is conducted, the researcher is the “primary research instrument” because all data is collected through observations and interviews are filtered through the lived experiences, past and present of the researcher. The level of contact that occurs during the observation and interview places the research under the microscope and requires persistent self-monitoring to ensure that data is documented and reported objectively. To fully describe the limitations of the researcher as instrument, relevant aspects of her personal biography and degree of sophistication in data collection are described (Locke, Spirduso, & Silverman, 1993).
As a physical therapist, I have worked in several acute care hospitals during the past 20 years. Consequently, I have insight into the daily operations and medical culture of an acute care hospital. From 1991-1996, I was a physical therapist at the hospital where this study was conducted. As a result, I have had to acknowledge any biases I had from this experience to prevent them from coloring my analysis and discussion of the data. Similarly, I have had to be aware of my biases regarding attributes of physicians as they relate to the medical subspecialty i.e. which physician groups display stronger communication skills.

As a qualitative researcher, I received formal training in participant observation as a program evaluator and experience in using qualitative research methods. Subsequently, I co-authored and published a research article delineating the findings of this study (Tasso, Behar-Horenstein, Aumiller, Gamble, Grimaudo, Guin, Mandell & Ramey, 2002). This article resulted from a study that involved participant observation of health care providers, and patient interviews about their satisfaction. From this experience, I developed a deep understanding of the factors that influence patient satisfaction in acute care. Consequently, from experience as a researcher and patient care provider, I feel I am qualified to conduct this study. While bias cannot be ignored, it can be kept on the side. My role as researcher has been to listen and allow the participants to speak openly about his/her experiences, not to confirm preconceived ideas about their experiences. My hope is that the findings in this study will contribute to developing a better understanding of patient-physician interactions.

**Gaining Access**

In April 2002, the Quality and Regulatory Coordinator of a not-for-profit teaching hospital in north central Florida met with Doctor Linda Behar-Horenstein to discuss the
feasibility of conducting doctoral research at this particular facility. They developed a list of potential research initiatives. Following this meeting, the researcher and Behar-Horenstein met and discussed the possibility of conducting one of the identified studies. After expressing an interest in conducting a qualitative study focused on the nature of patient-physician relationships and their connection to patient satisfaction, the researcher and Behar-Horenstein met with the Quality and Regulatory Coordinator to discuss the possibility of conducting this study at the hospital. Upon approval from the facility’s Institutional Review Board, it was agreed that the Quality and Regulatory Coordinator would facilitate the researcher’s access to the nursing units and patients by informing the nurses and administrative staff about the study.

**Participants**

A letter of inquiry that described the researcher’s interest in studying patient-physician relationships and patient satisfaction was mailed to the department chairs of medicine, surgery, pediatrics, and obstetrics and gynecology. Obstetrics and gynecology declined participation due to their concern about the sensitive nature of patient examinations and communications. Subsequent electronic mail requests for physician volunteers resulted in eleven individuals: four physicians from both internal medicine and pediatrics, and three physicians from surgery who expressed an interest in participating in the study. One of the surgeons who volunteered did not meet the criterion of practicing at the teaching hospital. During the data collection phase, a pediatric and a surgical physician terminated their participation in the study due to schedule complications that arose from emergency surgeries and high clinical loads.

Eight physicians participated in this study, six females and two males (Appendix A.) By subspecialty, four physicians were from the internal medicine service, three
physicians were pediatricians, and one was a surgeon. Seven out of eight of the physicians were Caucasian; one was Chinese. The physicians ranged in age from 33 to 58 years old. The length of their time in practice ranged from three to 28 years.

In regards to education, six of the eight physicians attended a public medical school; two physicians attended a private medical school. All of the physicians who participated attended medical school in the eastern half of the United States although no two physicians attended the same medical school.

Medical school class sizes varied from small (less than 100 students per class) to large (150-400 per class.) Five physicians graduated from large classes, two from medium sized classes, and one from a small class.

A total of 23 patients or parents were interviewed regarding their satisfaction with their physician and overall hospitalization. Five of those interviewed were parents of minors. The adult patients ranged in age from 34 to 76 years old. Fifteen (52%) of the patients interviewed were female and 11 (48%) were male. The majority of patients (n=19, 83%) were Caucasian with only four (17%) African-American patients. Of the patients or parents interviewed, five (21.7%) were cared for by the pediatric service, 15 (65.3%) by internal medicine, and three (13%) by surgery.

Instrumentation

Interview protocols were developed based on protocols used in other studies that were described in the literature review. Questions in the interview protocol were selected on the basis of their relevance to the focus of this particular study. The majority of questions in the interview protocol were derived from published research studies (Comstock et al., 1982; Korsch et al., 1968; Ley, 1988; Roter et al., 1988; Tasso, et al., 2002). As a result, many questions already have a history of eliciting significant
information related to this proposed research study (Comstock et al., 1982; Korsch et al., 1968; Ley, 1988; Roter et al., 1988; Tasso, et al., 2002). The protocol used in this study was comprised mostly by open-ended questions. The use of this semi-structured interview allowed participants to provide more complex responses and allowed the interviewer to invite participants to elaborate further about their views.

Appendix B lists the questions for the patient’s semi-structured interview. The questions focused on the patient’s satisfaction with the hospitalization and the patient’s relationship with the attending physician. For the purposes of this study, patient satisfaction referred to whether the patient’s expectations were met (Taylor, 1994) in areas such as responsiveness to patient needs, competence of health care providers, and communication between health care providers and the patient (Donabedian, 1980). The interview lasted approximately 15-20 minutes.

Appendix C lists the questions used during the physician’s semi-structured interview. These questions focused on the education and training each physician had regarding how to establish and maintain relationships with patients. The interview lasted approximately 20-30 minutes.

**Data Collection**

Data was collected from three primary sources: physician interview, patient interview, and participant observation of patient-physician interactions. Triangulation of data also contributed to the credibility of the results (Creswell, 2002). Physicians who volunteered to participate signed a written informed consent. A schedule was prepared to permit the researcher to observe patient-physician interactions during rounds. The researcher observed the physician interacting with each patient on six separate days. An interaction consisted of a complete conversation between a patient and the attending
physician. Verbatim written notes of these interactions were recorded using the log in Appendix D. During the observations, emphasis was placed on documenting the verbal interaction. However, attention to the physician’s non-verbal behaviors such as sitting, standing, making eye contact, and the proximity of the physician to the patient were recorded. All written notes were transcribed using a word processor. Upon completion of the six separate observations, each physician was interviewed about his or her education and was asked to explain how he or she learned to establish and maintain relationships with patients (Appendix C).

Each day after conducting observations of patient-physician interactions, the researcher returned to the respective patient’s room and requested permission to conduct an interview. Only consenting adult patients or parents of minors were asked to participate. The researcher obtained written informed consent from the participant and reviewed the general purpose of the interview. Patients and parents who agreed to participate and who signed the informed consent were then interviewed (Appendix B). Patients who were unwilling to participate were thanked and the researcher left the patient’s room. If at any time a patient was unable to complete an interview, the researcher excused herself and left the patient’s room. No incomplete interviews were utilized during the analysis of the data.

**Data Analysis**

Analysis of qualitative data serves two primary purposes – interpretation of the data and translation of the data into concepts that explain the relationship between the data. To achieve these purposes, data gathered from physician interviews was compiled and analyzed to see if there were common patterns among the physician regarding what they learned and how they learned to relate to patients. The data gathered during patient
interviews was compiled and analyzed to see if there were common trends and patterns among the patients in their ratings of satisfaction with their hospitalization and in their relationship with the physician.

The constant-comparative method was utilized to analyze and determine attributes that were common among all the physicians across all of observations. In addition, comparisons between physicians within each medical specialty and between medical specialties were made to illuminate the similarities and differences in physician interaction style (Charmaz, 2000). Patient interview responses were compared to assess common themes and patterns in their rating of satisfaction with the hospitalization and regarding their relationship with their physician.

Data from observations of patient-physician interactions was coded. The data were classified and categorized into major codes and subcodes that allowed for the development of common concepts, themes, and patterns that occurred. Memo writing was used during coding. This technique offered the researcher an opportunity to document personal reflections that were experienced during data analysis. Memoing also provided a concrete way to consciously identify and grapple with researcher bias and minimize the potential of its influence on data analysis (Charmaz, 2000).

**Trustworthiness of Data**

In qualitative research, the trustworthiness of data is equated with validity in quantitative research (Glesne, 1999). Trustworthiness is achieved through prolonged engagement in the field that allows for persistent observation and the opportunity to acquire sufficient data to support the study. The data collection process for this study took place over 6 months. A total of 293 patient-physician interactions were documented during more than the 82 hours that were spent in the field recording observations.
Additionally, another eight hours were spent conducting physician interviews; patient interviews took 23 hours. Internists were observed most frequently during 207 interactions. Pediatricians were observed during 82 interactions and the surgeon was observed across four interactions. Approximately 300 hours were spent analyzing the data. Triangulation of data also contributes to the trustworthiness of the study.

A third technique that is used to establish the trustworthiness of data includes member checks (Glesne, 1999). Member checks consisted of reviewing the summary of gathered data with the source of that data to ensure accuracy in understanding the participant’s perspective. The researcher used restatement of verbal information as the means of conducting member checks.
CHAPTER 4
RESULTS

The results obtained from physician interviews, observations of patient-physician interactions, patient interviews, and an emergent model that typifies the patient-physician relationship in acute care are described.

Physician Interviews

Physicians were asked to describe their formal education in establishing relationships with patients. Three physicians had no formal education on how to establish a relationship with patients while in medical school. Yet all of the physicians indicated that the patient-physician relationship was extremely important.

Physicians in this study had been practicing for fewer than 10 years to more than 28 years. Six of the physicians who had practiced for 10 years or less reported they believe that the patient-physician relationship had not changed due to managed care. The other physicians said there was so little managed care in their geographic area that it had little impact on their practice. However, Doctor Puller stated there is “pressure to cycle through large numbers of patients to meet quota or get a decent salary.” Doctor Jonas, who had been practicing for 28 years, stated her relationship with patients had “become much worse” since managed care was implemented. She explained she now spent more time on indirect patient care issues such as obtaining pre-approval for tests rather than spending time with the patient.

Most physicians reported being “happy” to “very satisfied” with their ability to relate to patients although six physicians stated they would like to have more time to
spend with patients. Doctor Watson commented: “It’s a process. I’m better at it than when I started [and I’m] getting better every year.”

There was a lack of consensus among the physicians regarding whether medical students should be formally educated on how to develop and foster a relationship with patients. Six of the physicians who had been practicing medicine for 10 years or less agreed that medical students should be formally educated. They recommended that physicians-in-training should learn how to establish patient-physician relationships by modeling the appropriate behavior.

**Patient-Physician Interactions**

A total of 293 patient-physician interactions were observed over six months. Each physician conducted patient care rounds in a different manner. For example, some physicians rounded independently, others conducted rounds with a fellow or resident. One physician was a silent participant while his resident conducted patient care rounds. Physicians who rounded independently spent more individual time with their patients than physicians who rounded with their team.

There were differences in the number of interactions and the amount of observation time by the physician among subspecialties. Internists who were observed had the most frequent interactions (207) followed by pediatricians (82 interactions) and surgeons (4 interactions). The surgeon spent an average of 11.25 minutes per patient while the internists and pediatricians spent 5.87 minutes and 5.3 minutes respectively (see Table 1). The mean amount of time each physician spent per patient is delineated in Appendix E.
Table 1. Time Spent with Patients per Medical Subspecialty

<table>
<thead>
<tr>
<th>Medical Specialty</th>
<th>Time Spent per Patient Interaction in Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery (N=1)</td>
<td>11.25</td>
</tr>
<tr>
<td>Internal Medicine (N=4)</td>
<td>5.87</td>
</tr>
<tr>
<td>Pediatrics (N=3)</td>
<td>5.3</td>
</tr>
</tbody>
</table>

When compared by gender, female physicians spent slightly more than twice as much time per patient as male physicians (see Table 2).

Table 2. Time Spent with Patients by Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Time Spent with Patients in Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female (N=6)</td>
<td>6.43</td>
</tr>
<tr>
<td>Male (N=2)</td>
<td>3.15</td>
</tr>
</tbody>
</table>

Three major styles of interaction emerged from the patient-physician interactions:

1) physician-centered, 2) process-dominant, 3) patient-physician reciprocity. In the following section, each domain will be defined. In addition, the primary topics that arose from the patient-physician interactions will be discussed and classified according to one of the three styles (see Table 3).

Table 3. Styles of Interaction and Subcategories

<table>
<thead>
<tr>
<th>Physician-Centered</th>
<th>Process-Dominant</th>
<th>Patient-Physician Reciprocity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confronting Patients</td>
<td>Interviewing Patients</td>
<td>Establishing Rapport</td>
</tr>
<tr>
<td></td>
<td>Coordinating Care</td>
<td>Providing Diagnoses and Recommending Treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Asking Patient Permission</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Encouraging Effective Pain Control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Offering Support and Reassurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Addressing Social-Emotional Needs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fielding Complaints</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discussing End of Life Issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discussing Follow-up Care</td>
</tr>
</tbody>
</table>
Physician-Centered

Physician-centered interactions include those where two-way communication between the patient and physician could not occur. This style of interaction is similar to the activity-passivity model by Szasz and Hollender’s (1987) and to Emanuel and Emanuel’s (1992) paternalistic model. These types of interactions occurred when patients were unconscious or unable to speak. Consistent with the methods outlined by Emanuel and Emanuel (1992) and Szasz and Hollender (1987), when these situations arose, the physicians greeted the patient and explained what he or she was doing during the physical examination. The patient, however, was not able to participate in treatment planning or decision-making. Doctors Smith, Blake, and Watson all worked with patients who were unable to communicate. In this study, physician-centered interactions were also observed when a physician confronted patients about adherence to treatment.

Confronting Patients

Doctor Watson confronted several patients about the role smoking played in their medical condition. During an interaction with a patient with chronic obstructive pulmonary disease (COPD), Doctor Watson reminded the patient: “No smoking, OK?” The patient replied that he had stopped smoking since his admission into the hospital. On another occasion, Doctor Watson told a 52-year-old patient that his cough returned due to continued smoking.

Doctor Sheldon addressed smoking while visiting with a 67-yer-old patient who was admitted with chest pain:

“Have you given thought to stopping smoking?” the physician asked. The patient replied that she would stop. “That’s key to your health and we can help you a little bit if you need it,” Sheldon responded. The patient then said her husband was going to quit smoking as well.
Doctor Sheldon praised a 53-year-old patient with an esophageal stricture who had already quit smoking: “I’m really glad you did that. I do think we can make it better.”

Smoking was not the only issue that mitigated discussion of patient adherence to the treatment plan. While working with a 33-year-old patient who was admitted with subtherapeutic anticoagulation levels, Doctor Watson’s initial impression was that the patient had stopped taking his prescribed anticoagulation medication. The following is an excerpt of the discussion:

Doctor Watson asked what required the current hospitalization. The patient replied his anticoagulation levels were very low. Watson asked if he knew why.

The patient explained he recently had several episodes of vomiting and could not eat. “I think the consensus is there’s a problem with how you take your coumadin,” Watson replied. “They don’t need to start that shit again. I take my medicine,” the patient responded. Watson asked the patient how often he took his medication and how long he had been vomiting. He also asked if the patient had any problems with eating during his previous hospitalization. The patient explained he did have problems eating during his previous visit but that he was on medication at the time to reduce the vomiting. “That’s what I mean if we say someone’s compliant. It doesn’t mean they don’t take it. With your vision are you really able to see?” Watson asked. The patient said his brother prepared all his medications for him. Doctor Watson requested the brother come in for some teaching regarding the patient’s medication and asked if that was possible.

The patient agreed to notify Watson when his brother came to visit. Watson then checked the medical record from the previous visit and asked if he was on a certain medication the last visit to help reduce his vomiting. The patient affirmed that he was.

The above examples illustrate some of the situations when physicians used their authority to confront patients about adherence to the treatment plan.

**Process-Dominant**

Process-dominant interactions are defined as those where a medical process or procedure dominated the style of interaction. For example, inpatient rounds were usually comprised by one team member presenting a brief history and update on the patient’s
medical condition while standing at his/her bedside. The attending physician asked questions and guided the discussion as needed. Generally, the patient had a passive role in the process. The attending physician often encouraged the patient to intercede if the information provided was inaccurate or if he or she had something to add to the discussion. Yet the majority of the interaction revolved around the traditional rounding process. Only two types of discussions involved process-dominant interactions: interviewing patients and coordinating care.

**Interviewing Patients**

Physicians frequently asked patients questions to determine the diagnosis, necessary medical procedures, and treatment. For example, Doctor Jonas interviewed the mother of a 16-month-old child who had just been admitted to the hospital to rule out seizures. She started the interview process by introducing herself and sitting beside the child’s mother. Doctor Jonas then asked the mother a series of questions about the baby’s symptoms, behaviors, and recent changes to elicit information that would assist in determining the child’s diagnosis. At several points during the interview, Doctor Jonas shared that two of her own children were developmentally late in learning how to walk but reassured the mother that both of her children are now healthy and successful. Towards the end of the interview, Jonas explained the treatment plan to the mother and provided the results of previous lab tests. The entire exchange lasted 25 minutes.

Doctor Blake conducted a 38-minute interview of a patient with sickle cell anemia. The 23-year-old female could not be the primary interviewee because of limited cognitive ability. Initially, Blake obtained the history from the consulting hematologist. When the mother arrived, Doctor Blake began asked her questions about the signs and symptoms of her daughter’s current problem. Following that discussion, they both proceeded to the
patient’s room. During the physical exam, Blake attempted to interview the patient but she would either not respond or look to her mother to answer. Initially, she resisted the physical examination but consented once coaxed by her mother.

Doctor Higgins conducted a 20-minute interview with the family of a 4-year-old child who had been admitted from the emergency room. Initially, Higgins began talking to the child about his relationship to family members present in the room. She then asked him his age and why he was hospitalized. Higgins then interviewed the child’s mother about the current medical problem and previous lab tests. Towards the end of the interaction, Doctor Higgins provided the mother with a tentative diagnosis and results of recent tests. After discussing the treatment plan with the mother, she then asked her if it “made sense.”

Interviewing patients involves the physician leading and directing the discussion to obtain a history of the medical condition. Physicians are educated and trained in this process to ensure that they obtain an accurate history.

**Coordinating Care**

Physicians often needed to coordinate care between medical and ancillary services. A 47-year-old patient with a tracheostomy had been trying to drink fluids again:

Doctor Watson said: “I understand you’ve been drinking a little and that’s better.” The patient responded: “I took a swallow … and I’m thirsty too.”

Watson suggested having: “…the speech therapist come in and see if you could swallow.” “I’d like a big soda or iced tea,” replied the patient. The patient then asked when he could begin drinking again. Watson replied: “We’ll have to see what the swallowing study says and they may be able to do a bedside study.”

In another case, Doctor Watson had to coordinate multiple services for a 65-year-old patient who was admitted with complications associated with throat cancer. The patient asked if there was any coordination between the inpatient medical team and the
radiation oncology team. Doctor Watson explained his team would contact the radiation team to make them aware of the patient’s admission and current medical problems.

Other examples of coordinating care included a 66-year-old female with cellulitis who needed assistance walking. Doctor Watson referred the patient for physical therapy. In another encounter, a 76-year-old male with a history of alcoholism and respiratory problems was referred for physical therapy to help him walk again. In both cases, Doctor Watson identified the patient’s diminished ability to walk independently and recommended consultation to assist the patients.

Coordination of care was often observed in the acute care setting. Physicians consulted ancillary health care services, requested consultation from other medical services, and coordinated care between numerous consulting physicians. Requesting consultations from other medical services requires the physician abide by a facility-mandated process. The coordination of care often involved the physician collaborating with others outside of the patient’s presence.

**Patient-Physician Reciprocity**

The patient-physician reciprocity style of interaction is defined as one in which the patient and physician actively converse with each other to discuss the treatment plan and make decisions regarding the ongoing medical care. The name of this style was selected to emphasize the importance of thinking of the patient first rather than the physician. This style of interaction is similar to Szasz and Hollender’s (1987) mutual participation model where the patient and physician equally participate in decision-making. The patient-physician reciprocity style is also similar to Emanuel and Emanuel’s (1992) informative model where physicians provide patients with the technical information
regarding the disease and treatment options and empower patients to make decisions based on their own personal values.

This style of interaction was observed most frequently in this study when physicians returned to the patient’s room after completing inpatient rounds without the medical team. During this time, the attending physician had a more personalized discussion with the patient and discussed the latest results from lab or diagnostic tests with the patient. Physicians were observed encouraging patients to ask questions. Not only did the physicians answer their questions, they also solicited patient input regarding the treatment plan. During these interactions, physicians treated their patients as partners and encouraged patients to be more active in their care. Research shows that physicians who use this “patient-centered” style receive higher ratings on patient satisfaction (Cole & Bird, 2000; Levinson & Roter, 1995). Nine topics of conversation involved patient-physician interactions: establishing rapport, providing diagnoses and recommending treatment, asking patient permission, encouraging effective pain control, offering support and reassurance, addressing social-emotional needs, fielding complaints, discussing end of life issues, and discussing follow-up care.

**Establishing Rapport**

Some physicians used humor when establishing rapport with patients or their families. For example, Doctor Frank told the grandmother of one child: “Since you’re her grandmother and it’s obvious you care a great deal about her, I’ll tell you about a bumper sticker I saw. It said ‘Grandkids are the reward for not killing your kids.’”

Similarly, Doctor Smith joked with an 85-year-old female who was hospitalized as a result of a fall that occurred when food she was preparing caught on fire. When concluding the interview, Doctor Smith said: “No more fancy cooking. I think only
bananas foster and cherries jubilee are supposed to do that.” With another patient, Smith commented about a box of a dozen donuts he had in front of him at breakfast: “That’s quite a healthful meal you’ve got there.”

Doctor Watson often used humor with his patients as well. A 66-year-old patient was admitted with chest pain and edema of her legs associated with her heart condition. As a result, the medical team often examined the swelling in her legs. One day during patient care rounds the patient pulled back the sheet to show the medical team her legs without being asked. Doctor Watson commented: “You know you’re always showing us your legs. I don’t know about that.” The patient stated: “Well I know ya’ll want to see them.”

Another patient of Doctor Watson’s was anxiously awaiting discharge from the hospital. The following is an excerpt of his discussion with the 83-year-old patient:

“You don’t want to spend the weekend with us?” Watson asked. “I’ll pretend I didn’t hear that,” the patient responded. Watson continued: “We get lonely here. So many empty beds.” “I know better,” the patient replied. Turning to his medical team Watson asked: “What should we do with this gentleman? Should we let him go home?”

Doctor Higgins had the following interaction with a 9-year-old who was admitted with meningitis:

“Do you remember me? It looks like someone wants to go home,” Higgins stated. The patient shook his head yes. “Then why are you here?” she asked. The patient replied: “I don’t know. I want to go home.” “Who’s going to take you home, the man in the moon?” she asked. The patient said yes. Doctor Higgins continued: “Alright. Let’s see what we can do to get you out of this popsicle joint. He may still have some mild headaches. He should be the same stinkpot. He looks like he’s full of piss and vinegar again. Do you have any questions?” The child’s mother asked: “Can he eat the same things?” Higgins responded: “No. He can’t eat the same thing. No chips, sodas, koolaide. He’s going to eat wheaties with banana in the morning.” The patient’s eyes got wide. His grandmother stated: “She’s just kidding. I was glad about the sodas.”
For some physicians and patients, the use of humor may have diminished the tension and assisted in establishing rapport. Establishing rapport directly supports creating an environment conducive to patient-physician reciprocity.

**Providing Diagnoses and Recommending Treatment**

Explaining the medical diagnosis and treatment plan was commonplace during patient-physician interactions. At times, patients receive a new diagnosis upon admission to the hospital and often they have questions about the condition, prognosis, and treatment. For example, a 36-year-old patient was admitted for a flexeril overdose. She subsequently was diagnosed with an infection of the psoas muscle. In response to questions from her family, Doctor Blake explained how the infection could have occurred and what treatments were available.

Doctor Watson explained the findings of the tests and the treatment strategy to an 83-year-old male admitted with a gastrointestinal bleed. In a separate interaction, Doctor Watson explained test results to a 46-year-old patient who had been admitted with esophagitis. He then asked the patient: “You understand what our plan is today?” The patient said “no.” Watson explained that the treatment options were dependent upon the results and upon the gastroenterologist’s recommendations. At the conclusion of the discussion, Watson asked: “Do you understand now what we’re doing? Do you have any questions?”

In another situation, Doctor Watson discussed the treatment options available for a 66-year-old patient admitted with cellulitis. Knowing the patient was anticipating surgery, Watson asked him if he was getting anxious. The patient admitted he was and asked how long it would take him to recover after surgery. Doctor Watson told him that the length of hospitalization depended on the type of surgery that was required and stated
it would be at least a week. He reminded the patient about the medical interventions he
had already completed to help minimize the stay and what needed to be accomplished
prior to discharge from the hospital. Doctor Watson asked: “Anything else we could get
you or answer for you?” Once outside the room, Watson taught his medical team how to
discuss the possibility of a tumor or cancer with patients in situations like this one.

Some of the discussions regarding a patient’s condition were difficult. For
example, Doctor Higgins had to discuss a 4-month-old infant’s medical condition with
the family. In this case, the infant had been hospitalized due to shaken baby syndrome.
Initially, only the mother and aunt were present although the maternal grandmother was
awarded custody of the infant. Doctor Higgins initiated the discussion by asking:
“What’s your understanding of his body now?” The mother indicated she knew the
child’s movement on his left side would be limited. Higgins told her the infant also
might not have perfect vision. Upon her arrival, the maternal grandmother asked
questions about follow-up care including what medications and tests would be necessary.
She said the infant had a history of asthma and asked Doctor Higgins to explain how to
recognize and treat these signs. After Higgins answered the family’s questions, she
concluded the visit and told them she would be back the next day to answer any
additional questions.

In another situation, Doctor Higgins provided an update on the medical condition
of a 4-month-old infant admitted with croup:

“So what’s your understanding of what’s wrong?” Higgins asked. The mother
indicated she did not know. “That’s bad. I’ll have to do a better job with that,” she
responded. She then explained why the infant’s cough sounded a particular way
and that it resulted from a virus. Higgins stated that she thought the infant could go
home if the parents were comfortable with the idea. Then she told them where to
receive follow-up care.
Doctor Higgins had a similar discussion with the family of a 3-week-old infant who was admitted with urosepsis:

Initially, Higgins asked the mother to recount how the infant became ill and how she tried to relieve his discomfort. Afterwards, she informed the mother that the infant had a bladder infection and would require antibiotics. “It just scared me. I thought it was something I did,” the mother said. Doctor Higgins responded: “No. No.” The mother stated that she felt bad about the infant’s illness. “That’s because you’re the mom,” Higgins relied. She told the mother of additional tests that would be needed while the infant was still in the hospital and asked the mother if she had any questions. Higgins concluded by telling the mother: “Well you did the right thing.”

On one occasion, Doctor Puller was covering for a vacationing surgeon. The surgical fellow requested that Puller examine the patient because of concerns that the muscle flap was not healing. The following is an excerpt of the interaction:

After Doctor Puller told the patient that the muscle flap might need to be removed, the patient asked if another muscle flap would be attempted.

“Well, this is a difficult problem. You, we have a difficult problem. We’ll work together as a team. So we’ll have to put all our heads together and talk about this,” she replied. The patient asked if a surgical mistake had occurred. “I think it was all hooked up OK but it’s difficult to have the absolute right conditions for it to thrive,” Puller responded. The surgical fellow then reminded the patient that he was a smoker. The patient stated he had not smoked all week and asked if the problem could have been too much pressure on the muscle flap. Doctor Puller indicated that probably was not the reason: “At this point I don’t think it’ll make the muscle come alive again and I don’t think there’s a position to make it better.” The patient then asked if he would have a chance to recover from this surgery before another one was attempted. Puller concurred and reassured the patient that he could continue the dressing changes for several weeks.

The above interactions illustrate how physicians explained the medical diagnosis and recommended a treatment plan to the patient and family. In the aforementioned scenarios, both the patient and family collaborate with the physician in decision-making.
Asking Patient Permission

Often, physicians were observed asking patients permission to conduct a physical examination or to allow medical students or interns to actively participate in the examination to see, hear, or palpate some unique aspect of the patient’s presentation.

Internists reminded patients of their right to make decisions about their medical care instead of having the physician make decisions for them. An interaction between Doctor Blake and a 91-year-old patient characterized their collaboration in decision-making. An Israeli who was in the area visiting family had a fainting spell, was hospitalized, and needed heart surgery. Her insurance would only cover the surgery if it was performed in Israel. Using diagnostic tests and consultation with the cardiac service, the physicians determined how critical her condition was. Although they recognized the family’s concerns about the financial implications, they explained that the patient’s condition might be too unstable to safely return home for surgery. The physicians requested the family’s permission to obtain a recommendation from cardiology before making any decision.

Doctor Watson also reminded patients of their right to make their own medical decisions. While talking with a 73-year-old female who had end stage renal disease he explained why dialysis was needed even though the patient was producing some urine. Watson then asked the patient about her family. When she found out that the patient had children, grandchildren, and great-grandchildren, she asked: “Does that make you feel good that they want you to stick around and ask you for advice?” Trying to understand the patient’s hesitancy, Doctor Watson asked the patient about her sister who had received dialysis. The patient shared that her daughter had been on dialysis too. She shared that her daughter “was hurting so bad everywhere [during dialysis]” that she
preferred to pray about it before deciding. Watson reminded her that she had the right to refuse treatment: “But if you’d like to pray about it, I think that’s a good idea.”

Doctor Watson had a similar experience with a 47-year-old patient who was admitted with a urinary tract infection. The patient had multiple sclerosis and a history of frequent urinary tract infections (UTIs). Doctor Watson recommended that the patient begin catheterizations on a regular basis to reduce the number of urinary tract infections per year. After offering a rationale for this recommendation, the patient refused: “I don’t want to do it that way.” Watson reiterated the recommendation but the patient replied: “We’ll keep it this way.” Though Doctor Watson disagreed, she supported the patient’s decision by stating: “From our perspective, when you’re having three UTIs a year, that may not be the best way so I can only offer you the gentle suggestion but it’s up to you.”

Physicians routinely solicited patients’ permission to conduct physical examinations such as auscultation. For example, Doctor Sheldon asked a patient: “Can I listen to your heart for a second? Do you mind?”

Physicians also obtained the patient’s permission for medical interventions or referrals to other services. For example, Doctor Blake recommended a feeding tube for a 53-year-old patient who was diagnosed with aspiration pneumonia due to esophageal cancer. Initially, the patient declined the procedure. During the next visit, Doctor Blake asked: “Have you thought about those feeding tubes?” The patient responded: “No. I’m still thinking about it. Not yet.” Later during the week as the patient’s medical status deteriorated, Blake again suggested the procedure. The patient explained that he was worried about having his feeding tube placed on his left side because he already problems with his ribs. Doctor Blake explained that the tube would not go through his ribs. The
patient expressed concerns about missing scheduled dental and radiation therapy
appointments and asked if the feeding tube would interfere with those appointments.
Blake replied and recommended that they revisit the idea of placing the feeding tube after
the patient went to his scheduled appointments.

In another situation, Doctor Blake explained a medical procedure to the mother of a
23-year-old patient with sickle cell anemia who had limited cognitive ability. She first
asked the mother if she knew what a “PICC line” was. The mother replied no so Doctor
Blake explained its purpose and how it would be placed. She then suggested the mother
speak with the regular physician about the procedure before making a decision.

Like many of the other internal medicine physicians, Doctor Sheldon taught
patients about the purpose of particular medical interventions and solicited their input
before proceeding with treatment. For example, Doctor Sheldon asked a 41-year-old
patient with quadriplegia and respiratory distress whether he wanted special equipment to
help his breathing. The patient agreed to undergo the test that would help determine if
the breathing equipment would be of any benefit.

Physicians often asked patients’ permission for the medical team to examine them.
For example, Doctor Blake explained: “This is a teaching hospital. Would you mind if I
send a student to learn how to take your history?” Similarly, Doctor Sheldon asked a 52-
year-old patient’s permission for students to listen to his lungs: “Do you mind if the
students listen?” Doctor Higgins also asked a 15-year-old patient who had a ruptured
eardrum: “Would you mind if about four people looked at that?” When the patient
indicated it was “fine” with her, the medical students participated in this portion of the
examination.
Asking patients permission regarding conducting an examination, consenting to a medical procedure, or allowing the medical team to actively examine the patient was observed frequently. Physicians asking patients’ permission is classified as the patient-physician reciprocity style of interaction.

**Encouraging Effective Pain Control**

Many of the physicians addressed patients’ pain control needs. Physicians on the internal medicine service were especially attentive to managing pain levels among patients with sickle cell anemia. The following excerpt typifies how pain control was managed:

Doctor Smith asked the patient how he was feeling. The patient reported he was not feeling well. The doctor asked him if he had any idea why his pain had returned and worsened. The patient explained this manifestation was typical of his sickle cell crises and that taking a cold bath the day before had made the condition worse. Doctor Smith then asked: “Do we have you on enough pain medication?” The patient reviewed the changes that had been made in his pain medications but indicated it was still not working. Smith asked the patient if the pain medication needed to be increased. The patient replied “yes” and Smith said they would increase the dosage.

In a similar situation, Doctor Watson asked a 22-year-old with sickle cell anemia: “Do you think we should stay the course or change your pain medication?” The patient responded: “Stay the course.” The following interaction occurred at the next visit:

After Doctor Watson asked the patient how he was doing, he said he was having pain in his arms and legs. Watson then asked if this pain was typical for him during a sickle cell crisis and the patient said it was. When asked why he thought he was having more pain, the patient explained that he had come off the pain medication too soon. Watson then asked: “What should we do? Go up on your pain meds or leave it alone?” “Leave it alone,” the patient stated. After Watson asked how long a crisis typically lasted for him, the patient said it ranged from one day to one week. Doctor Watson concluded the interaction by asking: “Anything else we can get you?”

As shown in the following excerpt, Doctor Blake revised the pain control treatment for a patient with acute intermittent profuria, known for causing extreme pain:
“Still having a lot of pain? … Are we doing anything with your pain control or are you still hurting?” the physician asked. The patient said she was still in pain. Doctor Blake then asked: “So we need to go up on your morphine? Have you tried taking your oxycotin with your morphine?” The patient responded no and began crying. “How can I help you? We need to jump up on your pain and that’ll help. Have you been pressing your [pain medicine] button? Are you getting any pain relief? I’ll get you a good dose of morphine in your veins,” she responded.

During the next visit with the same patient, Blake asked:

“Do you need to stay on the same pain meds? I’m sorry you’re having such a hard time. You let us know when your pain’s better and we’ll start getting you off your pain medicine because only you know that. I know you’re getting discouraged.”

Doctor Blake offered a patient controlled analgesia (PCA) pump to a patient with an abscess of the psoas muscle. The patient declined use of the PCA pump and Doctor Blake respected her wishes.

The above examples characterize the attention physicians paid to their patient’s pain management. Since physicians encouraged patient input when determining a pain management program, this category is consistent with patient-physician reciprocity.

**Offering Support and Reassurance**

Physicians often offered support and reassurance to the patient and family. For example, Doctor Jonas noticed the mother of a 24-day-old infant appeared to be struggling with having to extend the hospitalization several days:

While patting the mother on the back, Doctor Jonas asked: “Is there anything else we can do for you to make it easier?” “No. I just have other kids and I’ll have to figure something out for him,” the mother replied. “We have volunteers that’ll hold him if you need to go and they’re really good so I don’t want you to feel bad,” Jonas responded.

In another example, Doctor Jonas recognized that the father of a 2-year-old boy provided the majority of the child’s care rather than the mother and took the opportunity to acknowledge the bond between them:
Doctor Jonas stated: “Dad’s the one he looks for comfort from.” “I’ve been home with him since he was born since he couldn’t be around other kids so I’m with him 24 hours a day,” the father replied. “It really shows – he’s his comforter,” Jonas responded.

In the following excerpt, Doctor Jonas offered encouragement to a mother who was required to keep her 14-month-old child from drinking or eating before a procedure:

“You were sleeping so peacefully before,” Doctor Jonas said to the child. “He’s a wild man,” the mother commented. “Did he wake up?” Jonas asked. “I think he’s hungry,” the mother replied. “You only have 15 minutes [until the procedure]. It’ll be tough but it’ll be worth it. He’s looking at the bottle. Maybe we should hide it. Would a movie, can we get you a movie?” Jonas asked. The mother affirmed hiding the bottle and starting a movie would be helpful.

Doctor Jonas also acknowledged the care a mother was providing to her 18-year-old son. The patient had Lesch-Nyan syndrome, a disorder resulting in severe and profound cognitive and physical disabilities. Upon meeting the mother, Jonas told her “You’re doing a remarkable job. I just wanted to tell you.”

Doctor Blake provided encouragement to some of her patients and their family. For example, the husband of a patient with acute intermittent profuria expressed his concern about his wife’s pain:

The husband asked: “What’s so different this time? Why has she been having so much trouble getting her pain under control?” Doctor Blake responded: “I’m not sure we know the answer to that. We’re giving her a whole lot more on her PCA and we’re giving some of her pain meds from home.” She then explained how much pain medication the patient was receiving and indicated it was significantly more than the patient had needed during her previous hospitalization. She acknowledged: “But this disease every time can be different and we just have to keep working with it. Between her episodes, does she take it at home?” The husband shared that his wife only took pain medications when she needed them rather than routinely between pain episodes. Blake responded: “I hear your concern about it.” The husband subsequently reduced the tone and volume of his voice and provided Doctor Blake with additional information about the patient’s health when she was not in acute pain.

When Doctor Watson rotated onto the internal medicine service as the attending for the month, he assumed care for a 47-year-old patient who had multiple complications
following surgery for osteomyelitis of the cervical spine. When first meeting the patient during rounds, Doctor Watson acknowledged the multiple difficulties the patient had encountered by stating: “I understand we’re getting to see you after what’s been a horrendous stay.” Towards the end of the interaction, Watson remarked: “Anything else you want to tell me or you’re particularly worried about? I apologize because I’m just getting to meet you but I’m learning all about you.”

Doctor Sheldon acknowledged the challenges a 33-year-old female patient faced after a Cesarean section and thrombocytopenia, a severe bleeding disorder. When Sheldon first met and greeted the patient during rounds she said: “Sorry to hear you’ve had such a tough time.”

Doctor Higgins acknowledged the difficulty of the past 24 hours for the grandparent of a 9-year-old child admitted the night before with meningitis: “I bet you’re exhausted. Did you get any sleep last night? I bet not much.”

These examples characterize how physicians offered support and reassurance to patients and their family. Offering support and reassurance contributes to patient-physician rapport.

**Addressing Social-Emotional Needs**

At times, a prolonged hospital stay or a newly diagnosed disease necessitated psychological or social services. The following excerpt typifies how psychological issues were addressed:

Doctor Blake asked the crying patient: “How can I help you?” She told the patient she appeared depressed and asked if she had talked to anyone about that. The patient responded: “They just look at me like I’m crazy.” The physician continued: “Have you seen anyone here? We have some really good clinical psychology and we don’t want you getting discouraged. Your pain’s very real.” “I talked to Dr. ___ and he fusses at me for letting it get this bad but I hate to call every time I have a pain,” replied the patient. Blake responded: “We need to jump on your pain and
that’ll help and you probably do need to call him. I’m not scolding you because I know you know you best.”

In another encounter, Doctor Blake recommended a psychology consultation for a 63-year-old patient who was admitted with shortness of breath. Doctor Blake asked the patient if she was “having trouble with depression” and stated “we can have someone come and talk to you.” The patient responded: “That’s what I need since I’ve lost my husband.”

A 51-year-old patient with esophageal cancer expressed a need for assistance gaining social security disability. She told the patient whom to contact to obtain the necessary documentation to qualify for social security disability.

Doctor Watson suggested a psychology consultation for a 65-year-old patient who was admitted for cellulitis. Watson had previously worked with the patient. When he asked: “Anything I can get you?” the patient responded “A new body.” As a result, he told her he thought her depression was contributing to her desire to stay in bed. He explained that prolonged bedrest could result in skin breakdown, pneumonia, and the physical decline. He then recommended treatment for depression and medication to help the patient.

The above examples illustrate how physicians responded to psychological or social needs of a patient and family. The physicians asked for the patient’s permission to refer them for social or psychological services.

**Fielding Complaints**

At times, physicians were called upon to respond to patients’ complaints. In the following example, the mother of a one-year-old child complained about the staff. The
child was admitted with a diagnosis of diabetes and an ear infection. The following is an excerpt of the interaction with Doctor Frank:

The mother stated: “They had him on the wrong diet. I told them and they kept doing it. They need to check his blood glucose before he eats and they weren’t and that’s why his glucose was out of whack.” “When that happens, please let us know. Tell the doctor or the nurses,” Doctor Frank responded. “I did. I told three nurses and the doctor,” the mother replied. “Well you’re doing it the right way so keep doing it. I’ll tell the nurses and they’ll get his paperwork [for discharge home] started,” Frank stated. He then spoke with the nurses regarding the incorrect diet and blood glucose readings.

Doctor Jonas received a complaint from the parent of a child who was lodging in a room with three other children and their families. During the physician’s visit, when it became apparent that the child would have to remain hospitalized for several more days. The mother asked if any other rooms were available because of the noise level in her child’s room. Doctor Jonas responded: “I know. I’ll see what we can do. I think they try to keep all the diarrhea people together but you’re right. You’re long term so I’ll try to see what we can do. I can’t promise anything.” By the following day, the child had been moved to a semi-private room. The following is an excerpt of that interaction:

“This room is awesome!” the mother stated. “Good. This is much more calm isn’t it?” Doctor Jonas replied. “I feel like I’m in a spa!” the mother responded.

Doctor Blake encountered a patient who was dissatisfied with her care on a medical-surgical floor following her transfer from the transitional care unit. The patient reported: “I waited 45 minutes for a pain shot because she [the nurse] was on break. I hate this floor. I hate it!” Doctor Blake responded: “How about I send the nursing supervisor?” The patient agreed and Doctor Blake followed up by asking the nursing supervisor to speak with the patient about the complaint. The nursing supervisor then proceeded to the patient’s room to discuss the concerns. Later in the week the physician
asked the patient if the nursing care was better and the patient responded: “A whole lot better.”

Another patient of Doctor Blake’s complained about the nursing care she was receiving on a different medical-surgical floor. The 44-year-old patient with acute intermittent profuria, a painful disorder reported: “Nobody’s concerned but ya’ll [doctors]. The rest of them [nurses] act like I’m crazy.” The following interaction occurred on a subsequent visit:

The patient reported: “It hurts me so bad. She just – it hurted so bad and they got mad with me but it hurted.” “We talked yesterday about going over to ___ unit but they don’t have any private rooms,” Doctor Blake replied. “It doesn’t matter to me. I just want to get better and go home,” the patient responded. “So it’s OK with you if we put you in a room with a roommate? I’m sorry you’re having such a hard time. You let us know when your pain’s better and we’ll start getting you off your pain medicine because only you know that. I know you’re getting discouraged,” Blake replied. The patient continued: “I only call when I need stuff. They didn’t need to holler at me.” Blake responded: “And you’re working on yourself.” The patient stated: “Because there’s a physical and mental side and I don’t want to go over to the mental side.” “Was that your nurse last night?” Blake asked. “No. It was the one that came before last night and she said ‘you need to get it cleaned up in here’ and I’ve been picking up,” the patient responded. Doctor Blake stated: “We’ll get the charge nurse in here and there’s a patient care representative and we’ll get her to come see you tomorrow.”

“Oh I know it’s just a waste of my time and I’m just working on getting out of here,” the patient replied. Doctor Blake responded: “I know.” The patient concluded: “Thanks for listening.”

As a result of the patient’s complaint, the physician had the patient moved to another floor.

During the observation period, physicians fielded several complaints. The above examples characterized how physicians managed patient complaints. Since patients initiated these discussions and physicians responded to patient concerns, fielding patient complaints has been classified as patient-physician reciprocity.
Discussing End of Life Issues

During the observation period, many of the physicians on the internal medicine service encountered patients who were dealing with end of life issues. For example, Doctor Blake assumed care of a 53-year-old female with a long history of rheumatoid arthritis admitted from the emergency room. When initially admitted, the patient requested no medical interventions. The next morning during rounds, the following interaction took place:

Doctor Blake asked the patient if she still did not want any medical interventions or any pain medication. The patient said that was correct. Blake then introduced herself to the patient’s daughter and explained the situation. Blake said she thought the other sister was having difficulty dealing with her mother’s decision.

The daughter confirmed this. The patient reported pain in her hand and that a pillow had helped before so Doctor Blake placed a pillow under her hand. Blake then said: “We’re going to do our best to keep you comfortable. You let us know if I can get you any pain medication.” The physician and the patient’s daughter continued their discussion in the hallway. The daughter asked: “So she’s on her last days?” “Well, last night she came in and she hasn’t been taking any medication at all and she’s clear in her mind so we have to do what she says. If she continues to be short of breath we may want to give her some to make her more comfortable” said the physician. She then suggested social services and hospice to help with arrangements following discharge from the hospital.

Another encounter involved the wife of a 64-year-old man who had a history of multiple sclerosis, a stroke, and difficulty breathing. The patient came from a local extended care facility but no family was present at bedside. As a result, Doctor Blake contacted the wife by telephone to discuss end of life issues such as how aggressive she wanted to be with her husband’s care. Blake asked the wife whether she would want her husband to have surgery if the medical tests indicated it was needed. During the conversation, Blake stated: “I totally hear what you say 100%.”

Doctor Watson asked a 65-year-old patient with a history of cancer about her end of life wishes:
The physician started by asking the patient if her oncologist was planning more chemotherapy. The patient replied she just had a treatment the week before coming to the hospital. Watson then asked: “Are you certain the tumors in your lung are from your ovaries?” The patient confirmed this. “That’s unusual. I’m sorry you have that,” he said. The patient then outlined her past and present battle with cancer. Watson asked: “Has your oncologist, have your doctors talked to you about this continuing to progress or have they said we’ll do the stent and continue to be very aggressive?” The patient said her oncologist talked about more chemotherapy. Watson asked: “If your breathing were to get worse, have you talked to your family about if something were to unexpectedly happen? Have you talked to your family about what you want done?” The patient replied she wanted to go on a ventilator if the cause was only temporary and if “there were prospects of improvement. Well what do you see?” “I’m not seeing anything right now and I apologize if I’m being too direct but while you’re not sick and we can have this conversation, I’d like to know,” he replied. “If I can get eight months and go on my trip to the Mediterranean that’s all I ask,” she stated. Watson responded: “I think your attitude’s great. Obviously the procedure has risks and I’m sure Doctor ___ has talked about that.” “If I can get more info and get through this crisis even if it keeps a lid on it for two years. I’ve gotten three years with a grandchild I didn’t know. I’m not looking for 20 years but if I can get another year. Well I can wheelchair on that cruise if I need to,” she responded. Watson replied: “Good. That’s a good goal to have.”

**Discussing Follow-up Care**

Physicians often discussed follow-up care with patients to prepare for discharge from the hospital. For some patients, this discussion was simple and brief. For others, planning for discharge and follow-up care was more complex. Discharge of a child with failure to thrive was straight forward for Doctor Frank. When the parents were asked what they thought about going home, they said it was a good idea. As a result, the discharge process was started.

An example of a more complex discharge involved a patient who lived in another state:

The patient asked Doctor Smith if she could return home after leaving the hospital. “They can get you on a plane with a wheelchair. Do you feel like you can? How long is it, three hours to [location] and three hours to [home]? Probably what’s best is to get your labs in one week and transfuse you again and get you on a plane if we can. There’s definitely a possibility of getting you out today” the physician responded. The patient said: “Well don’t push it. I have two grandkids
at home and I’d like to get a good night’s sleep.” “Well it depends on the transfusion. I’m not going to send you home at 10 tonight. We just need physical therapy to come see if you need assistance at home,” Smith replied. “I have a walker at home but I’m home alone all day,” explained the patient. Smith replied: “So you need to be able to get around. OK.”

In many cases, follow-up care required a primary care physician. The following example illustrates how physicians assured patients had a primary care physician:

Doctor Blake stated: “Well you need to have a regular medical doctor. Maybe we could help you with that so when you get UTIs you may not have to go to the hospital. Would you rather we find you one in ___ [home area] or at ___[near son’s home]?” The patient indicated his preference but his son said he preferred to get his father’s follow-up care closer to his home. The patient then complained of pain in his big toe. Doctor Blake asked him if this had been a problem before and the patient said it had. She asked if he had been taking any medication for it. The patient replied he had in the past. “You rascal. We’ve got to get your dad to a doctor so they can take care of him,” replied the physician.

For the surgeon, discharge planning included teaching patients how to take care of their wounds. The following excerpt characterizes how Doctor Puller taught patients to take care of their wounds at home:

Doctor Puller told the patient that she needed to leave in the tubes while the fluids were draining from the wound. She told the patient to measure the amount of drainage from the tubes each day. She then told the patient what she could and could not do at home: “Now when I said you could shower, it’s after the tubes come out. Remember we talked about dermabond? This is dermabond. You don’t need any ointment.” The patient said she knew she could not push, pull, or lift over her head. She reported having a little nausea from her pain medications. Doctor Puller said she would send her home with anti-nausea medication. In regards to the outcome of her surgery, the patient said: “I’m so happy, I’m thrilled. Thank you!”

In another case, Doctor Puller taught a 56-year-old female how to care for her incision at home:

Doctor Puller taught the patient how to secure the bandage over her wound. “You know about stripping drains right?” Since the patient was a nurse, she said she did. Puller then asked if she needed home health care or if her husband would be available to help. Based on her response, the physician recommended home health care. The patient asked how often she needed to change her dressing at home. Doctor Puller told her to change her bandage one to two times each day. She then asked the patient if she had a ride home and reminded her not to take a shower or a
bath until the drains were removed. When the patient said she remembered that, Doctor Puller stated: “You need to keep your drains covered. Don’t do anything to stress your incision. No lifting.” The patient said she recalled this. “You know me. Nagging. Alright. We’re happy. You happy?” asked the doctor. Could I keep the same pain medication?” After discussing this and agreeing to keep the pain medication the same, Puller reminded her: “No showering, baths, swimming pool. You have to get out and walk, go to the mall, try that fanny pack I suggested.”

The above examples illustrate the variability in planning for discharge and follow-up care characteristic of acute care. Establishing follow-up care involves collaboration with the patient and/or family and the physician.

**Characteristic Samples of Interactions By Physician**

Each physician demonstrated a unique style of communication and preference for how to conduct patient care rounds. The samples below are intended to provide the reader with a portrait of each physician’s style.

**Doctor Frank**

Doctor Frank spent an average of one to two minutes per patient interaction. When interviewed, he said the resident’s request to lead rounds influenced the amount of time he interacted with patients. Doctor Frank often concluded his interactions with patients by asking: “Is there anything I can do for you?” or “Any questions for me?” When rounding on patients, he introduced himself and explained his role as the attending physician to each family. Although he often stood when speaking to the patient or family, he would sit when he determined it appropriate. During the following interaction, Frank was with a 15-year-old female patient who was struggling with pancreatitis after a motor vehicle accident. The following excerpt illustrates why Doctor Frank modified his position from standing to sitting:

Initially, Doctor Frank stood when asking the patient how she was doing. When she shook her head back and forth to indicate she was not doing well, he asked the
nurse if they were giving her any medication to help her feel better. He then asked the patient: “Is there anything I can do for you?” The patient began crying and asked if she could have more of the medication that made her feel better for a while: “I just don’t know why I keep puking and feel so sick.” Doctor Frank explained that her pancreas was inflamed and how this made her sick. He asked if she had shared this with the other physicians. The patient replied that she did not remember and continued crying: “I just want it to all be over.” He then sat down and said: “I know it’s hard to be in here. Is there anything specific I can help you with? Have you talked to a psychologist at all?” The patient continued crying: “I don’t feel like talking. I feel so sick all the time.” “I know. You’ve been in here awhile and this accident really changed your life. You’ll be getting better,” he replied. After leaving the room, he told the resident to work with the patient on her depression and to consider beginning anti-depressant medication.

Another important example of how Doctor Frank interacted with patients includes the following excerpt from a conversation with a 15-year-old female who had attempted suicide by drug overdose:

Doctor Frank introduced himself and asked: “Is there anything you’d like for me to do for you today?” The patient did not respond. Frank explained: “Well the way the system works is . . . The psychiatrist may want you to stay in the hospital.” “At this hospital? Well if my friend comes, is there a way he can stay longer?” asked the patient. “You can talk to the nurses,” the physician replied.

“Well I don’t think he wants to leave, he’s worried about me and I’m afraid he’ll raise a stink,” responded the patient. “Well I encourage you to follow the rules and to encourage him to or that’s disturbing the peace and the police” [will escort him out of the hospital and may call the police] Frank explained. “I don’t think he would do that. He’s just worried about me,” the patient replied. “Well you can tell him I said you’re liver’s OK and you’ll be OK. I wish only the best for you” replied the physician while putting his hand on the patient’s head.

At times, Doctor Frank offered families reassurance regarding their child’s condition: “This is something he’ll get better from.” He explained that reassurance helped parents to know their child would recover.

He also explained to his medical team his philosophy of how to work with families when diagnostic medical tests failed to provide a definitive diagnosis of the child’s illness. Doctor Frank explained that he invites families to return if their child continues to have a problem. He said this empowers families to return and assures that their
concerns are taken seriously. At the same time, this approach helps prevent possible litigation if the child subsequently becomes ill.

**Doctor Smith**

Doctor Smith was observed introducing team members to patients by their first names. She oriented patients to medical rounds by explaining that the medical student was “going to go over everything. Feel free to jump in if he says anything that’s wrong.” She often concluded patient visits by asking: “Is there anything else I can get you?”

Doctor Smith frequently asked patients about their pain control. This was especially true for patients with sickle cell anemia. The following example characterizes how she allowed patients with sickle cell anemia to direct their pain control:

Doctor Smith asked the patient if the current pain medication dose was working. The patient nodded his head yes. “We don’t need to change it?” she asked. The patient then shook his head no and asked: “You’re taking me off the morphine?” “We just want to make sure you’re getting enough. Are you?” she replied. The patient shook his head yes. “[Do] we need to go up on your pain meds?” she asked. The patient said the current pain medication was sufficient.

Doctor Smith had one patient who had received a liver transplant and was admitted for possible rejection. The patient was not taking her anti-rejection medication, missing medical appointments, and drinking alcoholic beverages:

Doctor Smith introduced herself, the team members, and the rounding process. She then explained: “[He’s] just going to tell us a little about you so I can get to know you a little better.” When the team member said the patient had been drinking one and one-half beers a day, Doctor Smith asked: “Has Dr. ___ told you not to do that?” The patient said yes. “Do you know what that can do to you?” Smith asked.

The patient indicated that she did. Doctor Smith responded: “It can kill you because of your liver. You’re more susceptible to that.” The medical team member continued and reported that the patient had not taken her anti-rejection medications or seen her physician in one month. “Why’s that?” Smith asked. “I didn’t have a ride,” replied the patient. “Do you know we have people that can help you with that? We have a special social worker for liver patients so we can help you with that. We’ve made a big investment [in your liver] and we want you to keep that. Do you like Dr. ___? She’s real nice and she cares about you. Do
you have kids?” the physician asked. The patient said yes. Doctor Smith asked: “Do you get mad when they do stupid things?” “Yes,” replied the patient.

“Are you mad that I said you were doing stupid things?” asked Smith. “No,” replied the patient. “Cause you know what it’s like when you have kids,” Smith responded. The medical team member continued and stated the patient recently received care for a deep vein thrombosis. Doctor Smith asked where the patient received treatment and the patient answered. Smith then asked if she was having her anticoagulation levels checked. The patient stated she had been told to: “But I didn’t have a ride.” Doctor Smith then asked: “Do you now what Coumadin is and that it makes you bleed?” The patient said she did. When the team member finished, Doctor Smith told the patient: “So the bottom line is you’re thinking cleared up with the medication. We’ll have the liver team take a look at you but you’ve been lucky. Are you willing to work with us?” “Yes. Very willing,” replied the patient.

The following excerpt took place on the next visit with the same patient:

Doctor Smith told the patient that the liver doctor was going to come and talk to her: “She’s not sure what we’ll be able to do for you yet. She’s going to do a biopsy but that’s a little trickier since you tend to bleed. What do you think?” The patient said she thought her liver was: “doing alright.” The physician asked: “You’re not concerned about being yellow?” The patient replied: “Yeah, I’m concerned about that.” Smith then sat in a chair beside the bed: “I think it’s a lot more serious than you think so I just didn’t want you to be surprised if it comes back that way. I’m not sure the rejection is reversible and I didn’t want you to have a big bomb dropped on you. It was a long time since you were on those medications. Do you have any questions for me?” The patient said no. Smith then asked the family members if they had any questions. “What medications was she supposed to be taking?” asked one family member. “It’s a really important medicine to prevent rejection since when she gets a liver from someone it tries to get rid of it and the medication prevents that. There’s just not much we’ll know until after the ultrasound,” she replied. “Alright. I’m glad you’re feeling better. I just want you to know that regardless, we’ll help you and work with you.”

Doctor Jonas

Doctor Jonas cared for an infant who was born with ambiguous genitalia. A nurse asked Doctor Jonas to speak with the infant’s 17-year-old Hispanic mother. Doctor Jonas said she had explained the infant’s medical condition to the mother several times. The following is an excerpt of the discussion:

Doctor Jonas reminded the mother that they had talked about the infant missing an enzyme that caused her clitoris to be enlarged. She drew a picture of adrenal gland
and explained the relationship between the adrenal gland, cortisol, aldosterone, salt retention and the size of the clitoris. She reassured the mother that the infant was a girl with ovaries and a uterus. The mother asked: “So she has enough androgens?” Doctor Jonas said she did. She explained that some babies with this disorder require medication to correct their enzyme imbalance. “So she’s 25% that she won’t need the pill?” asked the mother. “Exactly. That’s correct. She’ll always need the cortisol pill. We’re doing a lot of tests because it’s dangerous to send her home without the pill but if we don’t know by Monday, we’ll send her home on the pill because it’s safer. Any questions now?” the physician replied. “No. The questions don’t come now but later,” the mother responded. Doctor Jonas encouraged her to write her questions down.

Doctor Jonas often conducted patient care rounds with her team first resulting in brief interactions with the patient and family. After completing rounds with the team, she returned alone to speak with the patient and family more extensively. Doctor Jonas typically asked the patient or family members if they had any questions or needed anything before concluding her visit.

**Doctor Blake**

Although most physicians conducted patient care rounds in two hours, Doctor Blake averaged four hours each day. She often conducted rounds alone and addressed patient’s care needs in addition to their medical needs. For example, while conducting rounds, Doctor Blake examined a 44-year-old patient who was in extreme pain due to acute intermittent profuria. Noting the patient’s breakfast was present and that she had not eaten, Doctor Blake asked: “You need me to butter your biscuit or can you do it?”

Another example of her style involved a patient who was dying. The patient had requested no medical interventions to prolong her life and was refusing pain medications. During rounds, the patient complained of pain and edema in her hand. Doctor Blake positioned the patient’s hand on a pillow to try and alleviate the pain.
With another patient, Doctor Blake asked: “Anything I can get you?” and the patient responded: “No. I just need a cup of coffee.” Doctor Blake asked the patient how he liked his coffee and went to make him a cup.

Later in the day, she noted a 91-year-old patient had no pillow on her bed. Blake asked the patient where the pillow was. The patient indicated she did not know but that she would just sit up until she got one. Blake went and found a pillow: “Is that better?”

On another occasion, when Blake asked the patient if she needed anything, the patient said she would like a coke and some ice but that she would ask the patient care attendant to get it for her. Blake said she did not see an attendant around so she went and fixed the drink herself.

**Doctor Watson**

The following is an excerpt of how Doctor Watson provided the results of an endoscopy to a 72-year-old patient:

Doctor Watson asked the patient if he remembered the procedure and the patient said no. “Good. You’re not supposed to. I always get worried when you do. Did they tell you about that [results]? You have an ulcer where the bottom part of your stomach [meets] at your intestine. We’re pretty sure, there’s not much of an opening.” The patient responded: “I figure the opening’s about one-fourth of an inch.” “That may be about right because they couldn’t pass the tube to look at your intestine. You may need an operation. It could be a type of tumor. We don’t know. We’ll have to wait until the tests come back. We’ll get an echocardiogram. We don’t think you have a heart problem but since you’ve had a murmur, we want to look at all that in case you have to have an operation,” he explained.

The patient reported some symptoms he was having. “I know the surgeons will want to come and see you. They’ll probably want to take it out. They can’t just shave it. OK?” he replied. The patient agreed. “So we have an answer, a part of an answer. We’ll change you to clear liquids and we’ll stop the erythromycin. Any other questions?” Watson asked.

The following is another example of how Doctor Watson interacted with patients. In this case, a 37-year-old male had been hospitalized following a visit to the emergency
room due to a fever and shortness of breath. After introducing himself to the patient and asking how he was feeling, Watson interviewed him about his current problems. Watson then explained the situation as follows:

“We’re obviously trying to sort out what this is. It sounds infectious. We probably ought to move you to a unit where we can give you a little more oxygen. We may need to put a tube down your throat. We’ll try and avoid it but I can’t promise. I like to give patients a roadmap of where this can go. It could get worse and we may have to put you on a ventilator or you may get better. We don’t know if this is meningitis but I feel better about that. I’m sorry about having to put you through the LP [lumbar puncture] and we weren’t successful so we might have to do it again. Any other questions you have for me?” Watson asked. “Not now,” the patient responded. “You are a puzzle but we’ll keep working on it,” Watson replied.

Unfortunately, the patient died within several days. However, the above characterizes how Watson discussed his findings and treatment approach with the patient by “providing a roadmap.”

Another example of Doctor Watson’s style involved the family of a 43-year-old patient who was transferred to the intensive care unit due to complications associated with hepatitis C and cirrhosis of the liver due to alcoholism. The physician was concerned that the patient’s brother had been drinking heavily before visiting the previous day. He addressed his concern with the family as follows:

After introducing himself to the parents, he stated: “I haven’t had a chance to meet you before. His brother was here yesterday and frankly, he seemed a little inebriated.” The mother denied her son would drink and drive: “He’s hyper about it.” Doctor Watson asked: “He doesn’t have any issues with alcohol?”

“Yes, he does but I don’t think he would show up if he’d been drinking and he just drove in from ___ and he never, never drinks and drives,” she responded.

**Doctor Sheldon**

Most of Doctor Sheldon’s interactions that were observed were fairly routine. One exception occurred with the first patient one Monday morning. The patient was 47-years-
old who had experienced multiple complications during his hospitalization. Upon arrival, a member of the medical team greeted the patient but he did not respond. Doctor Sheldon intervened but the patient continued to be unresponsive. The procedure for cardiopulmonary arrest was implemented and the patient was revived and transferred to the intensive care team. Although no verbal exchange occurred between the patient and physician, this event characterized the unpredictable nature of acute care medicine.

Doctor Higgins

As a pediatrician who specializes in treating adolescents, Doctor Higgins had experience discussing sexuality with teenagers. When treating a 15-year-old female admitted for a urinary tract infection, she inquired as to the teenager’s sexual activity since it was a possible cause of the infection. The following excerpt illustrates how she approached the subject:

While sitting in a chair beside the bed, Doctor Higgins asked the patient if she or her parents had a history of bladder infections. The parents said no. She told the patient she knew she was a cheerleader and asked her what grade she was in at school. She then asked about her plans for the summer. Following this discussion she asked about her pain and symptoms: “Well let me ask Mom and Dad to leave so I can examine you but we may be able to get her out today.” She then sat on her bed and asked about her friends and whether she used tanning booths. When she said she did, Higgins asked: “Has anyone yelled at you yet?”

The patient said she no long went to tanning booths. Doctor Higgins asked: “Are you dating yet?” She said she had and provided additional details about her dating history. Doctor Higgins inquired: “Have you had sex?”

The patient stated that she had. “What did you use to protect yourself?” she asked. The patient responded. “Do your dad and mom know that?” Higgins asked. “Yeah. I’ve seen a gynecologist,” the patient replied. Doctor Higgins then asked if she was interested in getting on birth control. She said no since she did not plan on remaining sexually active. The physician then asked if she smoked or took other drugs. “Oh no,” the patient responded. “There must be some at ___ [school],” Higgins replied. She admitted there was: “Some of the boys I know do.” Doctor Higgins concluded the visit by asking if she had any questions.
As the pediatric attending, Higgins also worked with younger children. The following excerpt illustrates how she interacted with a 9-year-old boy who had meningitis:

“Do you do any sports?” she asked. The patient said no. “What do you like to do?” Higgins asked. The patient stated he liked to play football. Higgins asked: “Are you a runner?” “No, a quarterback,” he responded. After asking about his friends, Higgins said: “Do you know what’s going on?” When he said no, she asked: “Do you want me to tell you?” When he said yes, she squatted down beside the bed: “Have you learned about germs in school yet?” The patient said yes. She explained: “Your germ’s in here [pointing to his skull].” After finishing explaining meningitis, she asked: “Does that make sense?” and he said it did.

These examples characterize Doctor Higgins’ style of communication.

**Doctor Puller**

Doctor Puller was most often observed working with patients during the last day of their hospitalization. As a result, most of her interactions consisted of teaching patients how to care for their wounds. The following is an example of how she taught patients:

When entering the patient’s room, she said: “There he is, curled up in a fetal position.” The patient responded: “I’m comfortable that way. Guess what, I’m going home today.” “Great. This is Kay. She is doing a project on doctor-patient relationships. I’m asking you if it’s OK if she observes,” she asked.

“OK, fine, we fight anyway. I have to come see you Thursday. Same place you saw me, third floor? This drain’s still draining a lot. Do you know from where?” he asked. “No. You asking me to read? You know how I hate to read. You’re going to put some pillows behind you at home so you don’t roll over on it?” she replied. They then discussed how to care for the wound. Puller asked: “I assume that you should have a home health nurse?” That’s why they wouldn’t let me go home. Oh, would you quit pulling that out?” he responded. “I’m sorry. So who will I keep sparing with?” she asked. “You’ll see me in clinic. Don’t you have anyone else?” he replied. “No,” she said. The patient joked: “Oh, you’re going to be bored.” “That’s why I have her [points to researcher.] Oh, it looks great,” she replied. “I stopped laying on it after you yelled at me. I’ve been good,” he responded. “It looks a lot better” she replied.
Another example of Doctor Puller’s interaction with a patient was outlined in the “Discussing Diagnosis and Treatment Plan” section of this chapter. Together, these examples illustrate Doctor Puller’s style.

**Patient Interviews**

The average length of stay was 16.22 days with a range from 2-90 days. Of the 23 people interviewed, 20 (87%) indicated their hospital stay was satisfactory with responses ranging from “fine” to “very satisfied” to “great.” Comments from the three patients who were less than satisfied included “pretty lousy,” “70% satisfied,” to “I liked [the other floor] better.”

In response to whether the attending physician demonstrated interest in the patient’s concerns, (question seven, Appendix B), 18 patients or 95% said yes. The one family who did not agree responded: “They say they are but [we] don’t see it conveyed.”

When asked how the attending demonstrated concern, patients reported that it was through honesty, patience, tone of voice, and body language. The types of questions the physician asked and the physician’s willingness to answer questions also demonstrated concern. Other responses included coordinating a change in rooms, and explaining a procedure as methods communicating interest and concern.

Of the 19 patients and families interviewed, 18 (95%) said the doctor seemed to know what it was like to have their condition. Only family stated the physician did not understand. The parent explained that the child’s disease was “rare” and doctors did not know much about the disease that limited their ability to understand.

Of the 23 patients interviewed, 22 (96%) said the physician provided sufficient, understandable information about their condition. The one family that disagreed
explained that although the attending physician had not provided information, one of the residents from a consulting service had.

When asked if the physician listened to what patients said, 22 of 23 (96%) said yes. The one dissenting respondent stated that although the attending physician did not listen, the residents did.

When asked if the attending physician spent enough time with them, 20 out of 23 (87%) patients/family answered positively. One of the patients who disagreed stated: “none of them [physicians] do.” Another patient said: “I think others need her more than I do.” Two patients who did not think the doctor spent enough time with them were cared for by physicians from the internal medicine service and one patient/family was cared for by the pediatric service.

All 23 patients (100%) interviewed stated they were comfortable asking the attending physician questions. Twenty-two of 23 (96%) patients said they had confidence in their physician.

Patients were also asked to discuss the positive and negative aspects of the hospitalization. The positive aspects related to personnel and amenities. Nurses, physicians, and housekeepers were seen as professional, courteous, and hospitable. Another positive aspect mentioned was that medical students provided information on a daily basis. One patient commented: “even the change in the physicians is good, I get attached in 30 days but the new ones are just as good.” Another patient reported: “having surgery go so well with relatively little pain” was a positive aspect.

Positive aspects of the hospitalization that related to amenities of care included the discount families received at a local hotel and the comprehensive nature of services
available within the hospital for visitors and relatives. Other amenities referred to as positive aspects included assistance from financial services and videogames available for siblings.

Many patients stated there were no negative aspects. One patient commented “not even the food.” Other patients’ comments regarding the negative aspects of their stay ranged from personnel issues to amenities of care. Personnel issues included patient care assistants, nurses, physicians, and physical therapy. Several patients said the patient care assistants were inattentive and provided substandard care. Other patients commented on a lack of communication between the nurses, their failure to provide patient medications as ordered, and excessive delay in receiving pain medications. One family member cited that frequent disruption at night interfered with the patient’s sleep. Another patient reported difficulty understanding the relationship between the physicians, fellows, residents, interns, and medical students. Physical therapy’s failure to arrive at the scheduled time was reported by one patient. Negative comments about the amenities of care included excessive noise, poor quality of meals, and delay in transfer to a floor from the emergency room.

Other comments were received from patients during patient care rounds. Patients complimented their physicians: “I appreciate everything you guys are doing. I know I couldn’t be in better hands. Thanks doc.” At the end of the month when Doctor Blake was rotating off service as the attending, a 63-year-old patient commented: “I won’t see you anymore after today? I’m going to miss you.” The same physician received thanks from the mother of a 23-year-old patient: “Thank you so much. Ya’ll done such tremendous work.”
Doctor Watson also received compliments that were not solicited by the patient survey: “I think you’ve done all you can and we’ve done all we can. You’ve done a marvelous job.”

Patient comments on negative aspects of the hospitalization included: “There’s so many of ya’ll. I can’t remember who I talked to.” Another patient commented: “Why do I have to talk to so many doctors?”

In summary, the majority of patients were satisfied with their relationship with their attending physician and with their hospital experience.

Summary

Eight physicians were observed over the course of 44 days. A total of 293 interactions were observed over 82.5 hours of physician inpatients rounds. Differences were noted in the amount of time physicians spent with patients by gender as well as by medical subspecialty. Each physician had his or her own preferred style of conducting inpatient rounds. Some physicians preferred to round with the entire medical team while others preferred to round independently.

Trends in the content of patient-physician interactions were noted. Samples that characterized each physician’s interactions were provided to allow the reader to gain an appreciation for the individual style of each physician. The majority of patients were satisfied with their relationship with the attending physician and with their hospital experience. Also, the physicians who participated were generally satisfied with their ability to relate to patients.
CHAPTER 5
DISCUSSION

This chapter contains a discussion of the research findings and implications of the results. An emergent theoretical model will be proposed. The relationship between the theoretical framework and the emergent model will be described. Recommendations for future research will also be provided.

Patient-Physician Interactions

Three major styles of interaction emerged from the observation data: physician-centered, process-dominant, and patient-physician reciprocity. Neither Szasz and Hollender’s (1987) model nor Emanuel and Emanuel’s (1992) model accounted for all of the types of interactions observed between patients and physicians in the acute care setting. Consequently, an emergent theoretical model is proposed that incorporates the three styles of interactions.

Physician-Centered

Physician-centered interactions involved one of two scenarios: patients who were unable to speak or physicians confronting patients regarding adherence to the treatment plan. When patients were unable to contribute to the decision-making process because of an inability to actively participate, the physician made most of the decisions about ongoing care. When patients did not adhere to their treatment program, such as a patient with a liver transplant drinking alcoholic beverages, the physician directed the discussion. During those types of interactions, the physician would ensure the patient was aware of the treatment plan, the consequences for not abiding by the plan, and encourage the
patient to resume proper care. Physicians were observed addressing these issues in a
direct and respectful manner. While confronting patients about adhering to the treatment
program, the physician dominated the conversation. This style of interaction is most
consistent with the physician-centered style of interaction.

**Process-Dominant**

Interviewing patients and coordinating care typified process-dominant interactions.

Obtaining a history of the current medical problem as well as the past medical history
involved interviewing patients who were newly admitted to the hospital. Interactions
between the patient and physician that involved history taking were very time intensive.
During medical school, students learn how to conduct a patient interview and these skills
are reinforced during clinical training. Taking a medical history often entails the
physician dominating the conversation.

One of the challenges of practicing medicine in acute care hospitals is coordinating
all the medical and ancillary services involved with each patient. Physicians were
observed referring patients for cardiology, speech therapy, and physical therapy. Once
recommendations from the consulting service were received, the physician was
responsible for ensuring the recommendations were discussed with the patient and
incorporated into the treatment plan. Obtaining consultations from other medical services
required the physician abide by a facility-specific process. In addition, coordination of
care frequently involved the physician collaborating with other providers outside of the
patient’s presence.

**Patient-Physician Reciprocity**

Physicians in this study most frequently utilized the patient-physician reciprocity
style. Patients and physicians made decisions together regarding the treatment plan and
ongoing care. Content of interactions in this category included: establishing rapport, providing diagnoses and recommending treatment, asking patient permission, encouraging effective pain control, offering support and reassurance, addressing social-emotional needs, fielding complaints, discussing end of life issues, and discussing follow-up care.

Some physicians used humor as a method of reducing tension when establishing rapport and engaging the patient or family in the conversation. This finding is especially noteworthy since Lefevre, Waters, and Budetti (2000) noted that physicians who used humor were not sued as often as physicians who did not use humor. Since physicians used humor to establish rapport, it is classified as patient-physician reciprocity.

After interviewing patients about their medical history, the physician discussed the diagnosis and recommendations for treatment with the patient. Effectively explaining the medical condition required the physician use language the patient could understand rather than using medical jargon. The explanation was most effective when the physician allowed the patient an opportunity to ask questions or provide additional input. At times, providing an explanation of a patient’s medical condition was particularly difficult. For example, Doctor Puller managed a potentially volatile discussion of a patient’s medical condition with finesse. The patient had received a surgical muscle flap that was not healing and would require surgical removal. Puller delivered the news in a manner that encouraged the patient’s understanding of the situation without resulting in the placement of blame on the previous surgeon. Since this type of exchange actively engaged the patient, it is consistent with the patient-physician reciprocity style of interaction.
Physicians asked patients’ permission regarding several issues: conducting portions of a physical exam, recommending medical procedures, and allowing physicians-in-training to participate in an examination. In addition, internal medicine physicians often educated patients about their right to refuse medical interventions. The patient and physician would openly dialogue about treatment options and the physician reinforced the patient’s right to accept or decline treatment recommendations. Since these types of interactions involved an exchange of information and dialogue between patient and physician, they are consistent with the patient-reciprocity style of interaction.

Physicians often asked patients how well their pain was being controlled with the current medications. This was especially true for physicians on the internal medicine service who cared for patients with sickle cell anemia. The physician would ask if the medication was controlling the pain and verbally acknowledged that the patient was the expert on his or her pain management. The physician actively sought the patient’s input into the pain management process. The partnership displayed between patient and physician to achieve effective pain control is characteristic of patient-physician reciprocity.

Offering support and reassurance to patients and their families fosters the patient-physician bond and may increase patient satisfaction. A study by Wasserman et al. (1984) concluded that pediatricians who provided encouragement to mothers tended to receive higher ratings of parent satisfaction than physicians who did not offer supportive words. Offering support and reassurance to patients and families is most consistent with the patient-physician reciprocity style of interaction.
Physicians in the acute care setting often needed to address patients’ psychological or social needs. Consequently, physicians were observed recommending psychological services to assist patients in dealing with medical or personal issues. Whether patients have their social-emotional needs met impacts patient satisfaction. Evans et al. (1987) and Irwin, McClelland, and Love (1989) found that patients were dissatisfied when their doctor did not meet their social-emotional needs. Assisting patients with getting their social-emotional needs met is most effective if the physician obtains the patient’s permission to consult social or psychology services. Since the patient and physician discuss issues prior to requesting a consultation, this type of interaction is most consistent with the patient-physician reciprocity style.

One of the most unanticipated trends noted in the patient-physician interactions involved the role of physicians fielding patients’ complaints regarding hospitalization and nursing care. During the observation period, physicians on the pediatric unit as well as on the medical-surgical units addressed patient complaints. Whenever concerns arose, the physician validated the patient’s complaints and took steps to rectify any problems. Managing patient complaints provided an opportunity to ensure “customer” satisfaction prior to the patient’s discharge. Since the patient primarily initiated these discussions and the physicians responded, it is classified as patient-physician reciprocity.

In the acute care setting, one of the most difficult topics physicians addressed with patients related to end of life issues. The physicians in this study demonstrated sincerity, caring, and concern while trying to affirm the patient’s rights. Having the skills to engage in this type of interpersonal communication is essential. Discussing end-of-life
issues is arguably one of the most important times to use the patient-physician reciprocity style of interaction.

Patients often wanted to discuss when they would be discharged from the hospital and allowed to return home. The level of planning for discharge from the hospital varied from patient to patient and often depended on the complexity of the patient’s diagnosis, social support, and rehabilitation needs. As a result, the patient-physician reciprocity style of interaction was necessary to allow physicians to educate patients on their care and to allow patients to ask questions to clarify their understanding of their follow-up. Regardless of the level of complexity of follow-up care required, the physicians in this study clearly demonstrated awareness and skill in addressing this issue.

**Time Spent Per Patient Interaction**

The amount of time spent per patient interaction allowed for analysis of differences between medical specialty services and gender. No published research studies have examined differences between medical specialty services. Data analysis revealed that the surgeon spent twice as much time per patient visit as either the pediatricians or internal medicine physicians. However, with only one surgeon participating, it is difficult to determine whether this finding would hold true for surgeons in general or whether this surgeon is unique in this characteristic. In fact, during the physician interviews, the surgeon herself commented that she thought she was unique in her ability to relate well to patients. As a result of the small number of physician participants and medical specialty services participating in this study, no conclusions could be drawn from these findings.

By gender, the female physicians spent twice as much time per patient visit as the male physicians. This finding is consistent with that of numerous researchers who found that female physicians spend more time with patients than male physicians (Hall & Roter,
However, with only two male physicians and six female physicians participating in this study, it is difficult to determine whether this finding is typical. The findings are also inconclusive regarding whether female physicians demonstrate more empathy and provide more supportive comments than the males as previous research studies indicated (Rosenberg et al., 1997; Wasserman et al., 1984).

**Patient Satisfaction**

The majority of patients interviewed were satisfied with their relationship with their attending physician and with their hospitalization. This finding is consistent with the research of Blanck, Buck, and Rosenthal (1986) and Servellen (1997) that a good patient-physician relationship increases patient satisfaction.

Doctor Blake cared for one of the patients who were less than satisfied. This finding is somewhat surprising in that the doctor not only addressed patient’s medical needs but also attended to their personal needs. Perhaps the patient had expectations that differed from the type of care that was received.

The family that was least satisfied and indicated their overall rating of the hospital stay as “pretty lousy” involved a child who required an inpatient hospitalization once a month. Although the child was admitted under the pediatric service, physicians from the infectious disease service determined the direction of the treatment plan. The family had no previous experience with the current attending physician and was unaware that they were routinely admitted on the pediatric service rather than the infectious disease service. As a result, the family was dissatisfied with the pediatric attending even though they were satisfied with the infectious disease fellow. The parents complained that information provided by the pediatric physicians contradicted information received from the
infectious disease physicians. Due to the severity of the complaint and the level of dissatisfaction of the family, the researcher asked and received permission from the family to communicate their feedback to the pediatric attending so that she could intervene as appropriate. This example illustrates the complexity of patient-physician relationships and coordination of care when multiple services are involved. Interviewing parents of minors rather than adult patients adds another dimension to the complexity of the patient-physician relationship. In this study, the potential for differences and similarities between communication with parents of minor patients and the communications with adult patients were not analyzed.

The majority of patients thought the physician demonstrated concern for them through open, honest communications and a willingness to answer questions. The observations support the patients’ beliefs.

The majority of patients were satisfied with both the quantity and quality of information received about their medical condition. This finding is consistent with previous studies that found the more information patients received, the higher the ratings of patient satisfaction (Blanck et al., 1986; Comstock et al., 1982; Hall et al., 1988.) Although physicians spent only 5-11 minutes per patient visit, most patients stated physicians spent enough time with them. This may have resulted from the amount of time physicians-in-training spent with patients rather than just the time the attending spent with the patient even though the interview question specifically addressed rating the attending physician. Another explanation may be more of a reflection of the patient’s satisfaction with the quality of the interaction with the physician rather than the amount of time spent per visit (Teutschi, 2003). These findings are consistent with previous
studies that the length of time a physician spends with a patient does not correlate with patient satisfaction (Comstock et al., 1982; Korsch et al., 1968; Korsch & Negrete, 1972; Ley, 1988).

All patients were comfortable asking physicians questions. Most patients reported that the physician listened to their concerns. These findings are consistent with Buckman’s (1992) research that patient satisfaction increases when physicians actively listen and allow patients to express themselves.

Other factors that may have affected the high patient satisfaction ratings in this study may have stemmed from the observation that physicians routinely asked patients if they had any questions. According to Rosenber, Lussier, and Beaudoin (1997), physicians who ask their patients if they have any questions receive higher ratings of patient satisfaction. Likewise, many of the physicians discussed psychosocial issues with their patients. Levinson and Roter (1995) found that this practice is associated with higher ratings of patient satisfaction.

Comments from patients regarding the negative aspects of their hospitalization related primarily to one area – nursing services and patient care assistants (PCAs). Patients indicated that nurses were slow to provide pain medications when requested and were uncaring. Patients also stated that the PCAs were slow to assist patients with baths or other needs. This is an area that appears to need attention in this particular hospital in order to improve patient satisfaction.

Although only one patient indicated that the role of the medical team members and the number of team members was confusing, several other patients alluded to this during patient-physician interactions. As a result of this feedback, physicians may wish to more
frequently and overtly explain the role of each team member in the patient’s care to
improve their understanding of the teaching hospital process.

The three less than “satisfied” patients were all cared for by females. However, a lack of patient satisfaction in only 13% of patients interviewed is an insufficient amount for drawing conclusions regarding the relationship between physician gender and patient satisfaction. In addition, the research of both Hall and Roter (1998) and Comstock et al. (1982) found that no evidence existed that patients were more satisfied with female physicians or male physicians.

Characteristics of Physicians

During the observations, the physicians were frequently standing while speaking with patients. However, when the conversation with a patient became intense, the doctor sat down beside the patient. All of the physicians frequently made eye contact with the patient and avoided having barriers such as tray tables between themselves and their patients. According to Blanck, Buck & Rosenthal (1986), eye contact and closeness communicate empathy to patients.

Overall, the physicians exhibited above average communication skills as evidenced by observation of interactions with patients. Doctor Blake clearly excelled in her ability to interact with patients. She not only met the patient’s medical needs but also addressed some of the personal needs that are typically the responsibility of the patient care assistant. Examples of how Doctor Blake met more than the medical needs of her patients included brewing coffee for a patient, bringing a patient a soft drink, and obtaining a pillow for a patient who had none. In her case, the cost of practicing in this manner resulted in her patient rounds lasting four hours compared to two hours spent by other physicians.
Doctor Puller, the only participating surgeon, spent twice as much time per patient compared to the other physicians. The majority of the content of her interactions with patients consisted of teaching patients how to care for their wounds at home. She had a comfortable, professional style with patients without the presence of any arrogance often stereotypically associated with surgeons. She also stated she thought her style was atypical of surgeons. Unfortunately, a lack of additional participating surgeons prevented confirmation of this assertion.

**Physician Interviews**

Although several physicians had no formal education on how to establish relationships with patients, this trend appears to be changing. The three physicians who did not receive formal education on patient-physician relationships had been practicing for more than 10 years. These physicians stated they did not think medical students needed formal education of this nature. In contrast, several of the physicians who had been practicing for fewer than five years either attended courses on relating to patients or currently taught courses designed to teach bedside manner to medical students. These same physicians indicated they thought medical students should receive formal education on how to relate to patients. Interestingly, each physician’s opinion on whether medical students should be educated in how to relate to patients paralleled their own experience.

There was a lack of consensus among the participants about how to teach medical students to relate to patients. This finding mirrors the disparity found in medical schools regarding learning how to interact with patients. Less than half (43.2%) of medical programs include education regarding patient-physician communication. Of the medical programs that do include formal education, the method of instruction often involves conferences, lectures, and teaching during clinical rounds rather than more interactive
and formal activities (Lefevre et al., 2000). However, several of the physicians interviewed in this study indicated they currently teach medical school courses that utilize “standardized patients” that allow students to participate in patient simulation activities. Similar to the continuing education course utilized by Irwin, McClelland, and Love (1989), students are videotaped and then receive feedback regarding their communication skills from their instructors.

The need for formal assessment of medical school graduates in regards to their ability to relate to patients has received a recent flurry of attention in the media. Much of this press centers around the addition of the “Clinical Skills Examination” to the United States Medical Licensing Examination. The addition of this portion of the licensing examination for medical school graduates is designed to assess the communication and interpersonal skills of future physicians. This test was added to ensure patient safety as a result of the variety of education students receive in medical schools associated with patient-physician relations (United States Medical Licensing Examination, 2003). Implementation of this exam is designed to address Branch et al.’s (2001) concerns that medical education must attend to “physician’s attitudes and actions that demonstrate interest in and respect for the patient and that address the patient’s concerns and values (p. 1067).” Hopefully, the recent changes in training will ensure that medical school graduates have developed skills in this area as well as the ability to relate to patients.

When asked whether the implementation of managed care changed the nature of patient-physician relationships, there was a lack of consensus among the physicians interviewed. In general, physicians practicing medicine more than 10 years stated they had noted changes whereas physicians practicing fewer than 10 years reported they had
not noticed changes in their geographic area. However, many of the physicians were aware of the changes managed care had brought about in the practice of medicine. Several physicians commented they noticed an increase in documentation requirements. Another physician discussed patient quotas linked to physician salaries instituted since the implementation of managed care. This finding is consistent with that of Meldrum and Hardy (2001) that physicians reported pressure to increase the number of patients treated each day or face salary penalties for failing to increase productivity.

In regards to the physician’s ratings about their ability to relate to patients, most of the physicians were comfortable with their skill level. Doctor Watson summarized it best by stating: “It’s a process. I’m better at it than when I started [and I’m] getting better every year.” In general, physicians practicing medicine fewer than 10 years displayed stronger skills in developing relationships with patients than physicians practicing medicine more than 10 years. This statement is based on the depth and breadth of the content of the verbal interactions between patients and physicians documented during observations. Many factors may have contributed to this finding. For example, many of the physicians practicing fewer than 10 years reported receiving formal education regarding patient-physician relationships. The addition of this formal training may have provided physicians with stronger skills in relating to patients. Another factor that may account for the differences in skill level is the research findings that medical students’ interpersonal skills decline as they progress through their medical training. As noted with Gordon and Edward’s (1995) and Roter and Hall’s (1992) research, medical students’ interpersonal skills decline as they progress through their medical training as they become more distant and scientific with patients during their residency. Perhaps this
phenomenon applies to physicians as well. In other words, do physicians’ interpersonal skills decline as they become more experienced?

Since there were only two male physicians, it is difficult to draw conclusions regarding the differences between male and female physicians in how they relate to patients. One of the male physicians had more than 10 years of experience and no formal education regarding patient-physician relationships. The other male physician had fewer than 10 years experience and did receive formal education on establishing relationships with patients. The more experienced physician spent one to two minutes per patient whereas the less experienced physician spent over four minutes per patient. Consequently, the characteristics of the male physicians were too diverse and the number of male physician participants too small to allow for comparisons with the female physicians.

By medical subspecialty, the physician from the surgical service spent the most time per patient visit than any other physician or medical subspecialty. However, with only one physician observed from the surgical service, comparison with other services is problematic. In regards to the other two medical subspecialties, physicians from the internal medicine service averaged only 30 seconds more per patient visit than physicians from the pediatric service. As a result, no conclusion can be drawn from the small difference between the lengths of time spent per medical service.

**Theoretical Implications**

Based on the findings of this study, a Model for Analyzing Factors Affecting the Patient-Physician Relationship is proposed (Figure 1). The model is designed to illustrate the complexity of the patient-physician relationship and the many variables that influence the relationship. The model is dynamic and non-linear. The model emerged from the
analysis of data after the researcher observed that proposed models of outpatient care did not take into account the multiple factors that impacted patient-physician relationships in this study. The Model for Analyzing Factors Affecting the Patient-Physician Relationship illustrates the reciprocal and interactive dynamics across levels of interactions within and outside the hospital that may have influenced the nature of the patient-physician relationship. This model differs from those of Szasz and Hollender (1987) and Emanuel and Emanuel (1992) that were based on research in outpatient settings. The proposed model situates the interactions in a larger context of a teaching hospital and provides a more inclusive framework for understanding the range of factors that may affect patient-physician relationships in acute care settings such as teaching hospitals. The model illustrates the interactions between the external influences (legislative mandates, insurance providers, professional regulations), the institution (administrative leadership style, workplace culture), internal variables (nursing services, amenities of care, quality of technical care, other health care services), and the inner core (patient, physician). A definition of each of these variables follows:

**External Influences**

External influences that affect the patient-physician relationship include legislative mandates, insurance providers, and professional regulations. Federal legislation regarding issues related to healthcare often affects the delivery of healthcare. For example, passage of the Health Insurance Portability and Accountability Act of 1996 delineated procedures for maintaining confidentiality of patients’ medical information that all types of healthcare providers must institute. Insurance providers including Medicare implement policies and procedures that also impact the provision of healthcare. Implementation of Diagnostic Related Groups (DRGs) is one of the most widely
recognized examples of how insurance providers affect the delivery of healthcare. DRGs delineate the amount of money the institution will receive based on a patient’s diagnosis regardless of the length of the hospital stay. As a result, physicians attempt to minimize the number of days a patient must be hospitalized to maximize financial reimbursement. Professional regulations such as those adopted by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) also significantly impact the delivery of healthcare. This organization dictates standards of care the healthcare institution must provide ranging from the method and content of documentation to pain management for patients.

**The Institution**

Healthcare institutions vary a great deal in regards to their missions and targeted population. For example, teaching hospitals emphasize education and training of medical students, interns, residents, and fellows. Other types of inpatient facilities focus on the provision of long term care, such as nursing homes, or on rehabilitation of patients with complex medical conditions requiring intensive therapy. Whether the medical institution is for-profit or not-for-profit significantly impacts the philosophy and financial position of the entity. Each of these different types of organizations affects the policies and procedures of the institution that impacts patients and physicians.

The leadership style and workplace culture of each institution also impacts the relationship between patient and physician. Whether administration subscribes to a bureaucratic theory as described by Max Weber or a human relations theory such as Theory X, Theory Y, and Theory Z as described by Douglas McGregor and William Ouchi drives how personnel and processes are managed (Marion, 2002). For example, the bureaucratic approach emphasizes administrative authority whereas the human
relations approach emphasizes the contribution of employees as people. Physicians may have more influence and power working with an administrator who subscribes to a human relations theory rather than an administrator who subscribes to a bureaucratic theory. Ultimately, physicians’ satisfaction with administration may affect their relationship with patients.

Workplace culture refers to the group values, rules, processes, patterns, and lessons learned as part of the “organizational life” (Marion, 2002, p. 226.) It develops over time and varies with each organization. The phrase “the way we do things around here” characterizes the nature of workplace culture (Bolman & Deal, 1997, p. 237.) As a result, physicians, nurses, and healthcare providers may respond to patients differently to conform to the workplace culture unique to each medical organization.

**Internal Variables**

Numerous variables within the institution affect the relationship between the patient and the physician. Some of the internal variables include nursing services, amenities of care, quality of technical care, and other healthcare services. As demonstrated in this study, the negative aspects of hospitalization that were cited most often were about nursing care. Accessibility and quality of amenities such as food services and discounts at local hotels were reported to be a factors that contributed positively to patient satisfaction with the hospital stay. The quality of the technical care provided by the physician also influenced patient satisfaction. Other health care services such as radiation or chemotherapy, physical or occupational therapy, and clinical psychology or social services influenced patient satisfaction.
Core

The innermost core of the model revolves around the patient and the physician. Numerous factors can affect each of these parties and influence the nature of the relationship. The complexity of the medical condition, previous experience with the physician, acuity or chronicity of the medical illness, support or involvement of family members, and socioeconomic status of the patient can all influence the relationship with the physician.

Characteristics of the physician can also influence the relationship with patients. For example, research indicates the gender of the patient and physician impacts the type of relationship established (Hall & Roter, 1998; Rosenberg et al., 1997; Roter & Hall, 1992; Weisman & Teitelbaum, 1989;). The medical specialty of the physician may also influence the relationship. For example, the results of this study indicate a difference between the lengths of time the surgeon spent with patients compared to internal medicine or pediatric physicians. Years of experience as a physician may also influence the relationship. As the physician interviews illustrated, physicians with more than 10 years of experience held different views than physicians with fewer than 10 years experience. Consequently, this may affect their relationship with patients. Likewise, whether the physician received formal education or training on how to relate to patients may influence the relationship with patients.

Although the patient and physician are at the core of the model, interactions between external influences (legislative mandates, insurance providers, professional regulations), the institution (administrative leadership style, workplace culture), and internal variables (nursing services, amenities of care, quality of technical care, other
health care services) must be understood to fully appreciate the complexity of the patient-physician relationship.
Practical Implications

The practical implications of this study involve three major arenas: physician communication style, education and training of medical students, and nursing care.
Physician communication style includes the ability to demonstrate concern and interest in patients, resolve patient complaints, and explain the role and function of members of the medical team. Patients indicated that physicians demonstrated concern and interest through body language, tone of voice, and honesty. The type of questions physicians asked and their willingness to answer questions also demonstrated interest and concern to patients. Consequently, physicians should be cognizant of their body language and tone of voice when interacting with patients. They should be receptive to questions from patients and answer them honestly.

As the findings of this study illustrate, resolving patient complaints contributes to patient satisfaction. As a result, physicians should consistently attend to and rectify patient complaints as they arise to foster a good relationship and contribute to patient satisfaction.

To further improve the patient-physician relationship, physicians should routinely explain the role of team members to patients. Providing patients with a written copy of the names and roles of each team member would help reduce any confusion. Write-on boards at the patient’s bedside would be another method of ensuring patients are well informed about their medical team.

Education and training of medical students is critical to instilling the interpersonal communication skills necessary for today’s physicians. All physicians interviewed for this study agreed that the patient-physician relationship is extremely important. Adoption of the Clinical Skills portion of the United States Medical Licensing Examination in 2004 demonstrates the importance of patient-physician communications nationwide (United States Medical Licensing Examination, 2003). Specifically, the Clinical Skills
Examination parallels portions of this study in its intent to assess medical school graduates’ skills in establishing rapport, interviewing patients, answering patient questions, and counseling patients. Yet numerous researchers have documented a dearth of formal education and training in medical schools regarding how to relate to patients (Branch et al., 2001; Boulton et al., 1984; Gordon & Edwards, 1995; Lefevre et al., 2000). Although this study illustrates that patients were satisfied with the interpersonal skills of their attending physicians, it does not supersede the need for revision of medical school curricula to include formal education and training on patient-physician relations. Medical school accreditors may need to adopt standards that require teaching how to establish and maintain relationships with patients before significant change in curricula occurs.

Complaints from patients regarding care provided by nurses and CNAs indicate a lack of consistent delivery of quality care. Patient satisfaction surveys delivered to patients following discharge from the hospital do not allow the healthcare institution to investigate and rectify issues in the appropriate depth or time frame. A mechanism for interviewing patients during their stay may uncover nursing care issues earlier and in greater depth to allow time to rectify complaints prior to irreparable damage to patient satisfaction.

In summary, attention to physician communication style, education and training of medical students, and nursing care may foster improved patient satisfaction with their hospitalization and relationship with their physician.

**Future Research**

Continued research in non-teaching acute care hospitals should be undertaken to provide a clearer assessment of factors affecting patient-physician relationships. The
participation of physicians-in-training at this teaching hospital may have clouded patients’ perceptions of who contributed to their level of satisfaction. For example, although patients were interviewed regarding their relationship with the attending physician, the amount of time the medical team spent with patients and the amount of information provided by the medical team may have contributed to patients’ positive perceptions of their attending physician.

Additional research that examines the differences in physician interactions with newly admitted patients compared to those with patients following the initial interaction would be helpful in clarifying whether patient satisfaction was significantly influenced by one or both of these two different interactions. Research in these areas could result in validation of or changes to the proposed classification of interactions as either physician-centered, process-dominant, or patient-physician reciprocity.

Limiting the research design to focus on only one medical subspecialty at a time may further illuminate the attributes of a more homogenous group of physicians. The impact of managed care on patient-physician relationships could further be examined by comparing a heavily managed care hospital with a non-managed care hospital.

Examination of the impact of the implementation of the new United States Medical Licensing Clinical Skills Examination in 2004 is also important. Once this addition to the licensing examination for medical school graduates is implemented, the investigation of the impact of the Clinical Skills test on patient satisfaction, litigation, and curricular changes in medical schools would be valuable.

Additional research is also needed to examine the model proposed in this study. Future research in this area may result in support of, changes to, or expansion of the
variables of the model: external influences (legislative mandates, insurance providers, professional regulations), institution (administrative leadership style, workplace culture), internal variables (nursing services, amenities of care, quality of technical care, other health care services), and inner core (patient, physician).

**Summary**

This study utilized a qualitative research design to assess the attributes of patient-physician relationships in a teaching hospital. The majority of patients interviewed were satisfied with their hospital experience and with their relationship with the attending physician. Patients indicated their physician demonstrated concern for them and were satisfied with the quality and quantity of information received from their physician. Patients stated they were comfortable asking their physician questions. Negative aspects of the hospitalization verbalized by patients primarily related to lack of care and attention from nursing assistants.

Physicians averaged 5.3 minutes to 11.25 minutes per patient. The amount of time physicians spent with patients did not seem to affect patient satisfaction as the majority of patients were satisfied with the amount of time their attending physician spent with them. On average, female physicians spent twice as much time per patient visit compared to male physicians. However, only two male physicians participated in this study.

Physicians varied as to the amount of time they had been practicing medicine, whether or not they received formal education in how to relate to patients, and whether or not they believed the implementation of managed care impacted their ability to relate to patients. One reason offered was that managed care had very little impact in their geographical area. All physicians considered patient-physician relationships very important.
Physicians were observed interacting with patients in one of three primary styles: physician-centered (confronting patients), process-dominant (interviewing patients, coordinating care), or patient-physician reciprocity (establishing rapport, providing diagnoses and recommending treatment, asking patient permission, reassurance, addressing social-emotional needs, fielding complaints, discussing end of life issues, discussing follow-up care.)

A Model for Analyzing Factors Affecting the Patient-Physician Relationship was proposed. The model is comprised by external influences (legislative mandates, insurance providers, professional regulations), institution (administrative leadership style, workplace culture), internal variables (nursing services, amenities of care, quality of technical care, other health care services), and inner core (patient, physician).
# APPENDIX A
## PHYSICIAN PARTICIPANTS

<table>
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<tr>
<th>Physician</th>
<th>Service</th>
<th>Gender</th>
<th>Race</th>
<th>Age in years</th>
<th>Number of years practicing medicine</th>
<th>Where did you attend medical school?</th>
<th>What size was your medical school class?</th>
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<td>Jonas</td>
<td>Pediatrics</td>
<td>Female</td>
<td>Caucasian</td>
<td>58</td>
<td>28</td>
<td>University of Pennsylvania (Private)</td>
<td>Medium (125 per class)</td>
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<tr>
<td>Blake</td>
<td>Internal Medicine</td>
<td>Female</td>
<td>Caucasian</td>
<td>34</td>
<td>4</td>
<td>University of Tennessee (Public)</td>
<td>Large (150 per class)</td>
</tr>
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<td>Watson</td>
<td>Internal Medicine</td>
<td>Male</td>
<td>Caucasian</td>
<td>38</td>
<td>3</td>
<td>University of South Florida (Public)</td>
<td>Small (90 per class)</td>
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<tr>
<td>Sheldon</td>
<td>Internal Medicine</td>
<td>Female</td>
<td>Caucasian</td>
<td>44</td>
<td>8</td>
<td>University of Alabama (Public)</td>
<td>Large (150 per class)</td>
</tr>
<tr>
<td>Higgins</td>
<td>Pediatrics</td>
<td>Female</td>
<td>Caucasian</td>
<td>43</td>
<td>10</td>
<td>Northwestern (Private)</td>
<td>Large (170 per class)</td>
</tr>
<tr>
<td>Puller</td>
<td>Surgery</td>
<td>Female</td>
<td>Chinese</td>
<td>45</td>
<td>4</td>
<td>University of Medicine and Dentistry –Rutgers (Public)</td>
<td>Large (300 per class)</td>
</tr>
</tbody>
</table>
APPENDIX B
PATIENT INTERVIEW PROTOCOL

1. For demographic purposes, what’s the patient’s diagnosis, gender, age, race? (Roter et al., 1988)

2. How long have you been treated by your primary physician?

3. How long have you been hospitalized? (Tasso et al., 2002)

4. How satisfied are you with your hospitalization? (Korsch, et al., 1968) Is there any way in which your hospital stay could have been improved? (Tasso et al., 2002)

5. What information were you hoping to get from the doctor today? (Korsch, et al., 1968)

6. What worries you the most about your illness? Why does that worry you? Did the doctor relieve your worries? (Korsch, et al., 1968)

7. Do you think your doctor is interested in your concerns? If so, how does the doctor demonstrate this concern? (Korsch, et al., 1968)

8. Do you think your doctor knows what it is like to have your medical problem? (Comstock et al., 1982)

9. Did the doctor explain your medical condition to you so that you understand it? (Ley, 1988) Did you get enough information about your medical condition and treatment? (Tasso et al., 2002)

10. Does your doctor listen to what you have to say? (Ley, 1988)

11. Do you feel your doctor spent enough time with you? (Ley, 1988)

12. Are you comfortable asking your doctor questions? (Comstock et al., 1982)

13. Do you have confidence in your doctor? (Comstock et al., 1982)

14. What aspects of your stay have been positive? (Tasso et al., 2002) What aspects of your stay have been negative? (Korsch, et al., 1968)
APPENDIX C
PHYSICIAN INTERVIEW PROTOCOL

1. How long have you been practicing medicine?

2. Where did you attend medical school?
   a. Was that a public or private school?
   b. Was that a large or small school?

3. What formal education and training did you receive on the patient-physician relationship? How was this education and/or training provided?

4. How important do you think the patient-physician relationship is today? Do you think the nature of the patient-physician relationship has changed since the implementation of managed care?

5. How satisfied are you with your ability to relate to patients? Are there any aspects of your relationship with patients that you would like to change?

6. Do you think medical students should be formally educated regarding how to develop and foster a relationship with their patients? If so, what methods should be used in educating medical students? Interns? Residents? Fellows?

7. Regarding the patient-physician relationship, what methods do you use to educate and train medical students, interns, residents, or fellows who work with you?

8. For demographic purposes, what is the physician’s gender? Age? Race?
## APPENDIX D
### RECORDING LOG FOR PATIENT-PHYSICIAN INTERACTIONS

<table>
<thead>
<tr>
<th>Date</th>
<th>Physician</th>
<th>Unit</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Pt. Room/ time</th>
<th>Patient</th>
<th>Sitting</th>
<th>Standing</th>
<th>Eye contact</th>
<th>Close to Pt.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Verbal Interaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


## APPENDIX E
TIME PHYSICIAN SPENT PER PATIENT INTERACTION IN MINUTES

<table>
<thead>
<tr>
<th>Physician</th>
<th>Total Minutes and Patients</th>
<th>Range</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Frank</td>
<td>* , 32 patients</td>
<td>1-2*</td>
<td>1.5*</td>
<td>*</td>
</tr>
<tr>
<td>Physician Smith</td>
<td>272, 43 patients</td>
<td>1-19</td>
<td>6.09</td>
<td>4.72</td>
</tr>
<tr>
<td>Physician Jonas</td>
<td>145, 26 patients</td>
<td>2-7</td>
<td>5.80</td>
<td>5.09</td>
</tr>
<tr>
<td>Physician Blake</td>
<td>484, 65 patients</td>
<td>1-38</td>
<td>7.45</td>
<td>7.13</td>
</tr>
<tr>
<td>Physician Watson</td>
<td>179, 37 patients</td>
<td>1-17</td>
<td>4.84</td>
<td>3.30</td>
</tr>
<tr>
<td>Physician Sheldon</td>
<td>278, 61 patients</td>
<td>1-41</td>
<td>4.63</td>
<td>5.34</td>
</tr>
<tr>
<td>Physician Higgins</td>
<td>207, 24 patients</td>
<td>1-7</td>
<td>8.63</td>
<td>4.60</td>
</tr>
<tr>
<td>Physician Puller</td>
<td>45, 4 patients</td>
<td>10-13</td>
<td>11.25</td>
<td>1.26</td>
</tr>
<tr>
<td>Group Total</td>
<td>1600, 292 patients</td>
<td>1-41</td>
<td>5.48</td>
<td>5.56</td>
</tr>
</tbody>
</table>

*Patient visits were so brief they were not specifically recorded but averaged 1-2 minutes each so numbers are approximated.*
LIST OF REFERENCES


BIOGRAPHICAL SKETCH

Kay Tasso, PT, PCS grew up in Lynchburg, Virginia. She graduated *cum laude* with a Bachelor of Science degree in physical therapy from Old Dominion University in 1983. After moving to Roanoke, Virginia, Kay began teaching in a physical therapist assistant program and working for the Easter Seal Society. In 1991, Kay graduated from Virginia Tech with a Master of Education in curriculum and instruction. Following graduation, she moved to Gainesville, Florida, and returned to full-time clinical practice in pediatric physical therapy. In 1994, she was awarded certification as a Pediatric Clinical Specialist. Currently, Kay is an Assistant Professor and Academic Coordinator of Clinical Education in the Physical Therapy Program at the University of North Florida in Jacksonville. She and her husband reside in Ponte Vedra, Florida, with their 8-year-old daughter Christi.