Perspectives of the Patient-Physician Relationship from Economically Disadvantaged Patients

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DISSERTATION

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Dedicated to the participants who took part in this study, the healthcare providers who choose to work in poverty medicine despite daily challenges and roadblocks, and Cyd Cheryl Sullivan.
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Abstract
This qualitative study utilized interpretive phenomenological analysis (IPA) to explore the patient-physician relational experience from the perspective of patients of lower socioeconomic status (SES). Research shows that physicians engage in collaborative care less frequently with patients of lower SES than with their more advantaged counterparts and that lower SES patients participate less during office visits. Information on the patient-physician relational mechanisms that inhibit collaborative care from the perspective of low SES patients is a key gap in this literature. Five adult patients from the lower socioeconomic strata, who were established patients of a primary care physician were recruited from a primary care practice in a rural area and interviewed. Data analysis identified six superordinate themes that best capture how patients experience the relational dynamics of the patient-physician relationship. The results show that physician-patient power asymmetry can be experienced by patients of lower SES as reminiscent of further examples of previous experiences of stigma and oppression. Future visits or aspects of a treatment plan may be avoided following an unpleasant medical encounter or a weakened patient-physician alliance. The emotional reactions of patients contribute to their loss of voice, and some disclosures are viewed as too risky to share with treating physicians. These interviews also showed that personable physicians increase patient comfort and physicians who proactively seek out and address patient dissatisfaction mend ruptures and strengthen the patient-physician relationship. The study describes the mechanisms by which patients of lower SES are susceptible to experiences of stigma and psychological oppression during medical encounters. It offers implications for practice and possible pathways for future research to minimize experiences that are barriers for patients and to maximize the great potential of the patient-physician relationship as a factor in improving the health of a very vulnerable population.
Keywords: physician-patient communication, physician-patient relationship, socioeconomic status, rural primary care, power asymmetry in the physician-patient relationship

This dissertation is available in open access at AURA: Antioch University Repository and Archive, http://aura.antioch.edu/ and OhioLINK ETD Center, https://etd.ohiolink.edu.
Socioeconomic Status is Linked to Health Disparities

Health is driven by a complex interaction of factors (e.g., biological, behavioral, environmental, and social) that coalesce to determine an individual’s overall health status (Adler & Newman, 2002; Alder & Renkopf, 2008). An individual’s socioeconomic position influences the probability that such factors will combine to create conditions that either protect or worsen their health status (Alder & Renkopf, 2008; Link & Phelan, 1995). Per the Centers for Disease Control and Prevention’s National Center for Health Statistics (2015a; 2015b), when compared to their more advantaged counterparts, individuals of lower SES experience increased rates of mortality and health problems such as heart disease and diabetes. Socioeconomic status is intrinsically related to health as it increases an individual’s exposure to disease and decreases access to protective factors (Alder & Renkopf, 2008; Link & Phelan, 1995, 2006).

Education and income are the most fundamental causes of health disparities (Adler & Newman, 2002; Braveman, Cubbin, Egerter, Williams, & Pamuk, 2010; Case, Lubotsky, & Paxon, 2002). Braveman et al. found that increases in income and education incrementally improved health on various health indicators with the poorest and least educated experiencing the worst health and the wealthiest and most educated experiencing the best health. Education influences health outcomes by providing the individual with skills to understand and seek out knowledge of medicine and health. Moreover, education shapes an individual’s future income potential (Adler & Newman, 2002). Income influences health outcomes by providing the individual with the means to purchase health insurance, nutritious foods, and protective assets, as well as providing a means to develop in safer environments (Adler & Newman, 2002). Education
and income also influence health disparities through the provision of resources such as knowledge, power, and prestige, which are linked to interpersonal resources such as social support and social networks (Link & Phelan, 1995). People with greater stores of power, prestige, knowledge, and social connections can more easily avoid disease risks and adopt strategies to protect their health (Link & Phelan, 2006).

**Lower SES Patients Receive Poorer Quality Healthcare**

Healthcare disparities account for a significant portion of socioeconomically driven disparities in health. Agency for Healthcare Research and Quality (AHRQ, 2013) found that the quality of care that poor individuals received was worse than that of their more advantaged counterparts on about 60% of quality measures, encompassing effectiveness, safety, efficiency, timeliness, equitability, and patient-centeredness domains. For instance, the AHRQ Medical Expenditure Panel Survey (2002–2010) found that in 2009, 24.4% of poor adults who needed medical care immediately for an injury, illness, or chronic condition, were unable to access it when needed, compared to 14.5% of middle-income and 9% of high-income adults (as cited in AHRQ, 2013).

**Lower SES Patients Receive Less Patient-centered Care**

Patient-centeredness is an essential ingredient of quality healthcare (Institute of Medicine, 2001). When engaging in patient-centered care, physicians try to understand their patients’ perspectives, are responsive to patients’ physical and psychological needs, and encourage patient communication and shared decision making in all aspects of treatment (Williams, Frankel, Campbell, & Deci, 2000). Patient-centeredness requires physicians to share power and responsibility with patients (Mead & Bower, 2000). The National Healthcare Disparities Report, AHRQ (2013) documented that low-income patients received medical care
that was less patient-centered than high-income patients in the domain of patient-physician communication.

Physicians’ directive communication (e.g., asking questions and giving information) and nondirective communication (e.g., counseling, empathy, and emotional talk) behaviors are influenced by patients’ SES (Pollak, Alexander, Grambow, & Tulsky, 2010; Street, 1991; Verlinde, De Laender, De Maesschalk, Deveugele, & Willems, 2012; Willems, De Maesschalck, Deveugele, Derese, & De Maeseneer, 2005; Wiltshire, Roberts, Brown, & Sarto, 2009). Physicians’ relational style is typically more directive and less collaborative with socioeconomically disadvantaged patients than with more educated, White patients (Fiscella Goodwin, & Strange, 2002; Verlinde et al., 2012; Willems et al., 2005). For instance, a study that investigated physician-parent behaviors in a pediatric healthcare setting, found that physicians engaged in partnership-building behaviors less frequently with less educated parents (Street, 1992). Physicians invited educated parents to ask more questions, asked them to express their opinions and concerns, and accommodated their suggestions and recommendations more often than less educated parents. The work of Street (1992) suggests that physicians’ communication style inhibits communication and decision-making for less educated patients, and communication and decision-making are key to patient participation and effective medical care (Ngo-Metzer et al., 2006; Epstein & Street, 2007). Patient participation during medical visits has been associated with improved adherence to treatment (Schneider, Kaplan, Greenfield, Li, & Wilson, 2004; Sheppard, Zambrana, & O’Malley, 2004), increased receipt of diagnostic and health information (Fox & Chelsa, 2008; Street, 1992), more accurate diagnoses (Fox & Chelsa, 2008; McKee, Winters, & Fiscella, 2012), and better overall health (Epstein & Street, 2007; Stewart, 1995).
Of course, communication is a two-way street, and research indicates that patient communication also differs per social class (Street, 1991, 1992; Wiltshire et al., 2009). Street (1991) found that less educated patients asked fewer questions, stated their opinions less readily, and expressed fewer emotions, worries, or concerns than more educated patients and, as a result, they received less information from their physicians. Researchers postulate that educated patients receive more thorough treatment than less educated patients because their communication style is more active, eliciting more from their physicians (Street, 1991, 1992; Wiltshire et al., 2009), whereas low SES patients receive less information because their less-active communication style leads physicians to assume that they either do not understand the information or are not interested in learning about their health (Street, 1991). This assumption is unfounded; research indicates that lower SES patients want the same amount of information as their more affluent counterparts (Sheridan et al., 2015; Waitzkin, 1985).

**Patient-centeredness Influences Health Outcomes**

Communication may influence health directly through decreased suffering and improved emotional well-being or functional ability (Epstein & Street, 2007). Alternatively, it may impact health indirectly as an outcome of medical encounters. When conversations between providers and patients improve the accuracy of diagnosis and treatment plans, enhance treatment adherence or motivation to engage in healthy behaviors, or influence health beliefs, communication may lead to improved physical health (Street, Makoul, Arora, & Epstein, 2009). A study conducted on breast cancer patients undergoing inpatient rehabilitation found that aspects of the physician-patient relationship (i.e., promoting patient participation and patient satisfaction) were relevant predictors of self-reported improvements in physical and mental health (Farin & Nagl, 2013). The promotion of patient participation was the most significant predictor of self-reported
physical and mental health; however, it had the least enduring effects on the self-reported
physical and mental health of patients of lower SES. Based on this, they argued that providers
could improve self-reported physical and mental health by accounting for the individual
circumstances of socially disadvantaged patients (Farin & Nagl, 2013) and, indeed, physicians
who regularly care for lower SES patients often adapt care to fit their needs (Bernheim, Ross,
Krumholz, & Bradley, 2008; Loignon et al., 2015).

A study that investigated the influence of SES on physicians’ clinical decision-making
found that physicians treated diabetes less aggressively, avoided specialist referrals, reduced or
postponed diagnostic tests, prescribed less expensive medications, and tried to accomplish more
in a single visit with lower SES patients than with their more advantaged counterparts (Bernheim
et al., 2008). These decisions were made in the interest of making care more affordable and
feasible for low SES patients; however, physicians acknowledged that these kinds of choices
could compromise patients’ health. A Canadian qualitative study that examined strategies and
skills used by general practitioners caring for underprivileged patients in deprived urban areas
found that doctors focused on strengthening personal connections by expending considerable
energy on understanding the individual circumstances of their socially disadvantaged patients
(Loignon et al., 2015). Providers stressed the importance of incorporating their knowledge of
each patient’s material deprivation and experiences of stigma into patient-physician interactions
with the intent of improving health outcomes. Understanding the impact of stigma on
underprivileged patients increased providers’ awareness of the “self-damaging attitudes and
unhealthy behaviors that sometimes echoed the hurt, stress and stigma that patients experienced”
(Loignon et al., 2015, p. 234).
Power Differentials Can Undermine Patient-centered Practice with Lower SES Patients

Power is the capacity to change the states of others by providing or withholding resources or administering punishment (Keltner, Gruenfeld, & Anderson, 2003). Resources can be material and social, which include mutuality, empathy, and opportunities for decision-making. Fox and Chelsa (2008) utilized qualitative methodology to understand how chronically ill women experience the patient-healthcare provider (HCP) relationship and to determine how that relationship influences their health. They found that mutuality, empathy, and patient empowerment were essential components of collaborative patient-HCP relationships. Patients who indicated that their relationships were characterized by these qualities reported feeling more connected to their HCPs. These patients experienced an increased sense of security and trust and decreased anxiety, which enabled them to be more authentic in the relationship and receive better care. Participants in relationships characterized by connectedness, and lower power differentials, reported receiving diagnoses that were more accurate and timely.

Participants who indicated that their patient-HCP relationship was characterized by condescension, disrespect, and poor communication experienced their HCP as being unapproachable (Fox & Chelsa, 2008). For example, one participant felt oppressed, alienated, and unable to control her life when perceiving that an HCP utilized her/his power to control her behaviors during medical consultations. In this relationship, the patient reported feeling disconnected from her provider and was unable to work collaboratively with her/him; that is, she was less likely to ask questions, disclose valuable information, and adhere to treatment. Ventres and Gordon (1990) explained that an unequal distribution of power within the patient-physician relationship makes it difficult for patients of low SES to ask for and elicit the information they desire from their physicians.
Dehumanization May Occur in Relationships Characterized by Power Differentials

The hierarchical nature of the physician-patient relationship allows for instances of dehumanization to occur (Haque & Waytz, 2012; Lammers & Stapel, 2011). Dehumanization is the process of consciously or unconsciously preventing another from experiencing fundamental elements of humanness. Dehumanization occurs when a more powerful person denies a less powerful person their unique dimensions of human experience (e.g., the ability to feel pleasure or pain) or properties of agency (e.g., ability to choose, assert preferences, and plan; Haque & Waytz, 2012).

A qualitative study that investigated how homeless women experienced interactions with service providers (e.g., police, shelter workers, and case workers) in the United Kingdom found that women’s perceptions of their experiences were influenced by their experiences of power in interactions and trust for their service providers (Bierdeman & Nichols, 2014). Women in this study described a continuum of experiences from dehumanization to humanization in which greater experiences of power asymmetry resulted in more dehumanizing experiences. The most dehumanizing interactions caused women to feel powerless. When powerless, women were unable to advocate for themselves. A little higher on the continuum lay experiences characterized as alienating; these interactions resulted in the internalization of negative messages that women sensed were projected onto them. In these interactions, women responded with subservient behaviors, which the authors thought might be a precursor to opting out of services.

Stigmatization May Occur in Relationships Characterized by Power Differentials

Stigmatization is contingent on access to power, which allows for the identification of differentness resulting in the creation of stereotypes and the separation of labeled persons into discrete categories (Link & Phelan, 2001). When aspects of labeling, stereotyping, division,
status loss, and discrimination occur in relationships characterized by power differential, the term stigma may be applied. Stigma and discrimination are believed to be fundamental causes of health disparities (Link & Phelan, 1995; Poteat, German, & Kerrigan, 2013).

Physicians consciously or unconsciously apply various negative stereotypes to patients of low SES (van Ryn & Burke, 2000). One study found that physicians assumed that low SES patients would be less compliant with cardiac rehabilitation than their more advantaged counterparts (van Ryn & Burke, 2000). Moreover, on measures of self-control, rationality, intelligence, and desire for a physically active lifestyle, physicians rated lower SES patients more negatively than they rated higher SES patients. These results remained after statistically controlling for other sociodemographic factors (e.g., age, sex, race, and illness). Physicians also rated patients of low SES as less likely to be responsible for caring for a family member or to have significant career demands. Again, these results remained significant after controlling for the number of dependents and hours of work reported. Similarly, Bernheim et al. (2008) found that physicians often described lower SES patients as distrustful or noncompliant.

Schnitiker (2004) posited that a lack of shared attributes (i.e., social distance) might interfere with physicians’ ability to make meaning of socially disadvantaged patients’ behaviors, increasing the likelihood that physicians would rely on general stereotypes rather than information provided by patients to conceptualize and treat patients’ problems. Indeed, power is associated with reduced tendency to understand how others think and feel (Galinsky, Magee, Inesi, & Gruefeld, 2006). Power influences the degree to which one attempts to consider the perspectives of others and decreases their accuracy in identifying the emotions of others, leading them to ignore individual viewpoints and potentially diminishing their capacity to experience empathy (Galinsky et al., 2006). A study on the manifestation and function of stigma in
healthcare with transgender patients found that when physicians experienced uncertainty in medical encounters, they consciously or unconsciously blamed, shamed, or discriminated against transgender patients (Poteat et al., 2013). However, lesbian and gay providers and those who felt a connection to transgender persons were more likely to resist stigmatizing this group. Their resistance to portraying stigmatized attitudes was attributed to a willingness to relinquish some of their power during medical interactions. To understand the perspective of another requires making oneself vulnerable to the possibility of being changed by that other (Jordon, 2011), which necessitates that the provider surrenders a certain amount of power. In situations where this did not occur, Poteat et al. thought that providers had unintentionally used stigma to manage threats of uncertainty to their own medical authority.

**Experienced and Internalized Stigma Influence Patients’ Perception of Patient-centeredness**

A Canadian qualitative study on poverty stigma found that the poor often internalized the negative stereotypes that others projected onto them (Reutter et al., 2009). Researchers found that low self-worth was linked to believing that discrimination occurred in the absence of actual discrimination. When negative beliefs are endorsed, and feelings associated with stigmatized attributes are applied to the self, internalized stigma has occurred (Link, 1987). Earnshaw and Quinn (2012) found that patients with chronic illnesses who perceived that they experienced stereotyping, prejudice, and discrimination from healthcare workers in past medical encounters, expected to receive similar treatment from healthcare workers in future encounters. Patients who expected stigma (i.e., anticipated stigma) to occur in medical interactions were less likely to access care. This finding could be understood and applied to lower SES patients through Prilleltensky and Gonick’s (1996) definition of psychological oppression which elucidates the
path from discrimination to hegemonic self-rejecting views of worthiness to resources.

Psychological oppression is an outcome of political oppression that results from small daily doses of personal devaluation that cause low-power people to internalize the negative images projected onto them by people of higher power and to think that they are undeserving of resources or participation in societal affairs (Prilleltensky & Gonick, 1996).

**Patient-physician Communication Research has just Begun to Understand the Patients’ Perspective**

There is a growing awareness of the need to better understand the patient’s perspective in the context of the physician-patient relationship (Fox & Chelsa, 2008; Kuzel et al., 2004). Kuzel et al. argued that patients and medical providers have different views on patient safety and conducted a study to understand patient experiences of medical errors in primary care practice. From the patients’ perspective, the most common error involved breakdowns in provider-patient relationships. Perceived provider disrespect, insensitivity, or miscommunication accounted for most of the errors described by patients—their reactor panel noted that serious problems resulted from seemingly trivial insults. Technical errors (e.g., adverse medication response and misdiagnosis) related to patient safety were described less frequently. Conversely, family physicians viewed breakdowns in the transferring of information within the healthcare system and ultimate treatment errors as most threatening to patient safety (Dovey et al., 2002). The contrast in findings demonstrates the need to examine patients’ perspectives (Kuzel et al., 2004).

The literature is replete with quantitative studies that analyze how SES influences the patient-physician relationship from physicians’ perspectives (Epstein, Taylor, & Seage, 1985; Willems et al., 2005; van Ryn & Burke, 2000; Verlinde et al., 2012). Fox and Chesla, however, suggested that this research approach tends to overlook subtle aspects of the relationship (e.g.,
the affective tone of patient-physician interactions, and the ways in which providers allow themselves to be vulnerable to change during patient interactions) that are essential to understanding what makes the relationship work for the patient. Several studies have recently been published that qualitatively investigate the patient-provider relationship from the perspective of lower SES patients (Mercer, Cawston, & Bikker, 2007; Raja et al., 2015; Sheridan et al., 2015).

A study that examined the quality of medical consultation from the perspective of lower SES patients in Scotland, found that patients felt cared for when physicians listened and that participation (i.e., being able to talk to physicians) increased when patients felt that physicians withheld judgment and treated them as individuals (Mercer et al., 2007). Raja et al. (2015) explored the experiences of primary care patients at a university-affiliated medical center from the perspectives of underserved and uninsured urban primary care patients. This American study found that dehumanization resulted from physicians’ lack of attention to patient individuality and that patients felt uncared for when physicians did not listen. The lack of American studies investigating the patient-physician relationship from the patient’s perspective is unsettling since our country has greater economic disparity (DeSilver, 2016) and increased morbidity and mortality rates when compared to other high-income countries (Woolf & Aron, 2013).

This Study Seeks to Better Understand the Patient-physician Relationship from the Perspective of Patients of Lower SES

Research on the patient-physician relational mechanisms that inhibit collaborative care from the perspective of low SES patients is a key gap in this literature. The patient’s perspective is needed to help lay the groundwork for more extensive and influential studies. This information is essential to improving the quality of care patients of lower SES receive. The patient’s
perspective will also enhance our understanding of factors that should be included in programs for healthcare workers focused on increasing participation of lower SES patients. Therefore, the purpose of this qualitative study is to better understand the patient-physician relational experience from the perspective of patients of low SES.

**Research Questions**

1. How do patients of low SES experience the dynamics of the patient-physician relationship?
2. What are the patient-physician relational mechanisms that inhibit or foster collaborative care?

**Methods**

**Rationale for Qualitative Approach**

Qualitative methodologies facilitate exploration of phenomena that is not well understood (Mertens, 2010; Smith, Flowers, & Larkin, 2009). This approach enables researchers to give meaning to scientifically under-recognized phenomena and occurrences so that the meaning can then be applied to other settings or situations. For these reasons, an exploration of the patient-physician relationship from the perspective of patients of lower SES is best served using a qualitative method that allows for the interpretation of data per the meanings to which it is ascribed by participants who have experienced it (Mertens, 2010). Furthermore, qualitative research allows the researcher to understand the participant’s experience without inserting preexisting expectations into the experience that they share (Mertens, 2010; Smith et al., 2009).

**Interpretive Phenomenological Analysis**

Cultural, familial, and environmental events continuously shape the lens through which we interpret the actions and intentions of others and thoughts about ourselves (Smith et al.,
PERSPECTIVES OF ECONOMICALLY DISADVANTAGED PATIENTS

Consistent with this study’s social constructivist approach, interpretive phenomenological analysis (IPA) was used to understand the meaning patients derived from relational experiences with physicians. Originating in the field of phenomenology, IPA is concerned with the essence of the experience, emphasizing the individual’s perception of events and the meaning that they make of that lived experience. This practice makes the methodology suitable for understudied populations (Smith & Osborne, 2008; Smith et al., 2009).

An IPA methodology assumes that all the experiences discussed have been socially constructed, and do not represent a singular truth. Although IPA is primarily concerned with the essence of participants lived experience, the result is the researcher’s interpretation of the meaning participants make of their lived experiences. Therefore, the study provides the results of a double hermeneutic: the researcher’s interpretation of the meaning participants make of their experiences (Smith & Osborne, 2008; Smith et al., 2009). Since knowledge and experience are socially constructed, a researcher attempts to understand participants’ experiences from their point of view and with respect for their cultural norms (Mertens, 2010; Smith et al., 2009). This means that the researcher influences participants and participants influence her. To mitigate the chance of using their experiences to understand participants’ subjective experiences, researchers must make their values and biases explicit (Mertens, 2010).

Due to my affiliations with economically and educationally disadvantaged individuals, I acknowledge that this research topic is meaningful to me. I recognize that power differentials may have influenced participant responses by encouraging them to side with what they perceived my position on subjects to be, and that participant disclosure or reticence may have influenced my questions and understanding of their experiences. Conversely, due to my recent affiliation with medical providers, I acknowledge that I may be inclined to view patient narratives from the
perspective of a medical provider or to justify physician behaviors that participants found damaging. Lastly, I assumed that patients who had been poor the longest would experience the most difficulties when interacting with physicians.

**Participants**

**Sample and sampling methods.** The study used purposive sampling to find information-thick cases with the goal of gaining an in-depth understanding of the patient-physician relational experience from the perspective of patients of low SES (Merten, 2010). As recommended by Smith and Osborne, a small sample of five participants was used. Having a small sample allowed me to understand each participant better and conduct a more detailed examination of their text (Merten, 2010; Smith & Osborne, 2008; Smith et al., 2009).

Criterion sampling was used to ensure that participants experienced similar phenomena (Bloomberg & Volpe, 2012). Inclusion/exclusion criteria for participation were as follows:

1. Participants qualified as being from the lower socioeconomic strata if they had no more than a high school degree and an income that did not exceed 130% of the Federal Poverty Level (FPL) as determined by the United States Department of Health and Human Services 2015 Poverty Guidelines. Federal and state programs recognize those with an income of 130% of the FPL as needing financial assistance.

2. Participants were under the care of a physician whom they had seen at least twice in the last year so that they could discuss the relationship in depth.

3. English had to be participants’ primary language because language barriers negatively influence patient-physician relationships (Ngo-Metzger et al., 2006). Due to the small sample size, only patients who communicate with their physicians in English were invited to join this study.
4. Participants were female and male adults—age 18 and up.

5. Patients with and without a chronic illness were invited to participate in this study; however, due to the small sample used, heterogeneity in regards to illness status (i.e., presence and type of chronic illness) was not sought-after.

When working with small samples, researchers usually try to find a homogenous group for whom research questions are significant (Smith & Osborne, 2008; Smith et al., 2009). This sample is homogenous for education, poverty, the frequency with which participants saw their physician, and the primary language of participants. The goal was to collect a minimum of six participants from various geographic locations (i.e., urban, rural, and suburban). Employees (i.e., former clinical supervisors) of the clinics (urban and suburban) in which I was not present actively assisted in the recruitment process for four to five months; however, participant inquiries only came from the rural clinic in which I was present. From this process, I learned that an active presence in a facility is key to effective recruitment. Since all five participants were recruited from the same rural facility, the sample is also homogenous on geographical area.

**Recruitment.** Participants were recruited through my affiliations with the Barre Family Health Center (BFHC) UMass Memorial Medical Center, in Barre Massachusetts (MA) where I completed an advanced practicum in behavioral medicine. Flyers were given to patients by the front desk staff (FDS) at check-in. I encouraged the FDS to continue handing out flyers by frequently checking in with them and occasionally providing donuts. Flyers were also placed in examination rooms and the waiting room, and nurses were apprised of the study so that they could discuss it with patients who demonstrated interest. Discussing the study with the nursing staff was especially helpful in garnering participant inquiries. Both flyers are provided in Appendix A. Interested patients contacted me via telephone.
Ethical considerations and IRB. Researchers are morally bound to conduct research in a manner that maximizes the benefit to harm ratio for participants (Bloomberg & Volpe, 2012). The institutional review board (IRB) of Antioch University of New England (AUNE) reviewed the study. The AUNE IRB served as the IRB of record for UMass Memorial Medical Center. Because ethical issues can arise in any phase of the research process, I remained vigilant throughout the process for factors that could harm participants (Bloomberg & Volpe, 2012). Specifically, I attempted to reduce participants’ experience of power differentials at each phase of the study. First, the interview questions were provided to participants ahead of time to strengthen informed consent and decrease the hierarchical nature of the participant-researcher relationship. Sharing the interview questions before the interview allowed potential participants to make an informed decision about whether to participate and enabled them to prepare to share their narrative, having had ample time to reflect on their experiences. During the interview, I attempted to create an egalitarian relationship by referring to participants as co-researchers (Karnieli-Miller, Strier, & Pessach, 2009) and adopting a relational-cultural approach to interviewing, which emphasizes mutuality, empathy, and empowerment. Utilizing this method, I remained open to being influenced and changed by the participant so that each member of the dyad would experience mattering in the relationship (Jordan, 2011). Lastly, I attempted to empower participants by inviting them to assess the accuracy of the data and to discuss their interpretations of the findings (Karnieli-Miller et al., 2009).

Measures were established to protect participants’ rights and ensure their safety. Since individuals of low SES, as defined by this study, are considered a vulnerable population (Antioch University Investigator’s Handbook for the Protection of Human Participants, 2011) AUNE’s IRB determined that the inclusion of this population was justified and that appropriate safeguards
were implemented to reduce the risk of harm. When sampling from this population, researchers must be cautious when using financial incentives (Mertens, 2010). Therefore, to lessen the possibility of coercion, participants were offered a ten-dollar gift card from a place of their choosing. Four gift cards from Walmart and one from a local grocery store were provided in exchange for his or her participation. Only one participant reported that they chose to participate for the gift card (Participant 4); the others said they wanted to share their story. Consistent with proposed ethical guidelines for working with economically or educationally disadvantaged populations, the consent form—as well as other participant materials—were written in language and with terminology that was familiar to participants, and each step of the project was discussed orally with participants to make sure they understood the process, what was expected of them, and their rights as participants. The informed consent document is provided in Appendix B.

**Procedure**

After receiving a candidate’s verbal commitment to participate via telephone, those with an email account and access to a computer completed the consent form and demographic questionnaire on SurveyMonkey. Interview questions were sent in the body of an email for easy access with the link to SurveyMonkey. Only two of the three people that completed the survey online met the criteria for participation. The applicant that was not invited to participate in the study was sent an email notifying them of the reasons (e.g., did not meet the criteria for inclusion) for which they were not invited to be included in this study. The three participants without access to an internet connection or computer were mailed a package containing instructions for completing the initial information (see Appendix C for instructions for completing the initial information), a consent form, the demographic questionnaire, and the interview questions with a self-addressed stamped envelope for return. All participants could
review the interview questions before completing the demographic questionnaire and consent form as interview questions were sent to participants along with the demographic questionnaire and consent form (via mail) or in the body of an email that contained the link to SurveyMonkey. All descriptive information was entered into a computer and participants’ names were replaced with a pre-assigned number. To further protect confidentiality, all paper documentation is being kept in a locked file cabinet. Signed consent forms will be destroyed seven years after this study has been completed.

To establish a relationship the telephone was used for much of the preliminary contact. As such, applicants chosen for this study were contacted via the phone to arrange a time and place to meet. Most interviews were held in the closest library to the participant’s residences; however, due to difficulty with mobility Participant 5 was interviewed in her home. Each participant was interviewed using a semi-structured interview that took approximately 60 to 90 minutes. After the interviews were transcribed, a thematic analysis was conducted to identify themes and clusters within and across participants’ narrative reports and quality control procedures were applied. The resulting themes and clusters were translated into a narrative that captured the essence of participants’ shared experiences.

Data Sources

**Demographic questionnaire.** The demographic questionnaire asked for participants’ age, race, primary language, educational attainment, insurance status, occupation, and current employment information. Participants had the option of stating their estimated annual income or checking a box to indicate that their income did not exceed $15,200.00 annually. They were asked to estimate the length of time (i.e., years) that they have made at or below their current income bracket because I believed that those that had been poor the longest would experience the
most difficulties in medical interactions. Questionnaires asked about the size of participants’ families (including dependent children) and about their relationship with their current physician (i.e., length of relationship, language spoken with their doctor, and frequency of visits). Lastly, questions about the individual’s health status (i.e., presence and type of chronic illness) were included. The demographic questionnaire can be found in Appendix D.

**Interview protocol.** The best way to collect data suitable for an IPA analysis is through semi-structured interviews (Smith & Osborne, 2008). Semi-structured interviews allow researchers to modify primary questions and probe interesting issues that arise. Moreover, semi-structured interviews allowed both the participant and I to engage in a dialogic process geared towards uncovering the meaning of the phenomenon under study. This method of data collection was used to elicit thick descriptions of the patient-physician relational experience from the patients’ perspectives. I created semi-structured interview questions by collaborating with peers and my dissertation advisor. Creating an interview schedule ahead of time enabled me to think explicitly about the topics covered in the interview and to predict difficulties that could have occurred during the interview process (Smith & Osborn, 2008). In creating the interview, I used vocabulary consistent with an eighth-grade reading level.

Five semi-structured interviews were completed. After greeting the participant, I described the interview procedure (e.g., audio recording), established informed consent, and answered the participant’s questions. The semi-structured interview began with broad, open-ended questions to help establish rapport and encourage participants to speak openly about their experiences (Smith & Osborne, 2008). The semi-structured interview was malleable: All the basic questions and topics were covered but the interview schedule was altered, and different probes were used depending on participants’ interests and concerns. This was done to encourage
participants to expand on responses or to probe areas of interest. Participant 1’s recording was transcribed prior to conducting the next interview; however, due to time constraints the remaining recordings were transcribed after all of the interviews had been completed.

During the interview, participants were asked to describe an interaction they had with a physician that went well and one that did not go as well. Participants were encouraged to describe their interactions in depth. Interview prompts were used to encourage participants to elaborate on responses. The interview protocol:

Tell me about an interaction you had with a physician that went well.

1. Describe your relationship with this physician.
   a. Length of relationship.
   b. Frequency of visits.
   c. Conditions of visitations (e.g., purpose of visit, tone of visit, etc.).
   d. Are your interactions with this physician typically as described?
   e. Is there anything else you would like to tell me about this relationship?

2. What occurred within the first five minutes?

3. How comfortable were you during the interaction?
   a. How do you define comfort? What does comfort feel like?
   b. What happened that influenced your comfort? What did the physician do?

4. What, if anything, did the physician do to encourage your participation? (e.g., asked open-ended questions, asked for your opinion, accommodated your suggestions and recommendations, etc.)

5. How did you participate during this appointment? (e.g., asked questions, shared concerns, voiced opposition, etc.)
6. How did you feel after the interaction/exchange? (e.g., satisfied, frustrated, etc.)
   a. Did you accomplish what you needed during the appointment?

7. How did the interaction affect your trust in the physician?
   a. Did it influence whether you followed the doctor’s advice/recommendations?

Tell me about an interaction you had with your physician that went less well.
(The same follow-up questions were used for question two, with wording altered as appropriate.)

Which experience is more consistent with the experiences you have had with your physicians over the years?

Data Analysis

After transcribing the first two interviews, an application to propose a revision to the data analysis process was submitted to AUNE’s IRB. After the revision was approved, the remaining audio files were uploaded to a secure channel on Rev.com. The service agrees to protect the privacy and confidentiality of participants. All confidential information remains the property of this researcher. Per our agreement, after each interview was transcribed, Rev.com destroyed the audio file. For details on the company’s privacy policy, see Appendix E. Furthermore, beyond geographic identifiers (e.g., names of towns and clinics), protected health information was not discussed during interviews. The audio files of the interviews that were not transcribed by me were reviewed to ensure the transcription was accurate and to note participants’ emotional reactions, pauses, and linguistic nuances. This process helped to re-familiarize me with participants’ perceptions of their experiences.

Excluding the first analysis of Participant 5’s transcript—which served as a lesson on how to most efficiently code data, each transcript was analyzed using the same process. Starting
with one transcript, each experience (i.e., medical encounter) discussed was read several times before sectioning the transcript into meaning units and placing the unit on a table created in Microsoft Word. The electronic document allowed for a more detailed and organized analysis of the transcript than an analysis completed by pen. The table had three columns and was created specifically for the analysis. The main text was positioned in the center column. The right column was used for the initial noting process and captured the core meanings and interesting aspects of what the participant had said (e.g., comments about language use, similarities, differences, contradictions, or affective verbiage; Smith et al., 2009). This section was labeled the exploratory comment section in the analysis document. After doing this several times per meaning unit, the process was repeated with the next meaning unit in the transcript. After the initial noting was complete for the entire transcript, I moved to the left column at the beginning of the analysis document to complete the coding section, which was labeled the coding section. Here, concise statements of what was important in the explanatory comment section were noted to create themes that captured the fundamental meaning and quality of the text. In creating themes, I attempted to capture the psychological essence of the piece while containing enough peculiarity to be grounded and enough abstraction to be conceptual (Smith & Osborne, 2008; Smith et al., 2009). At the end of this stage, the number of themes that had emerged reflected the richness of the text. A total of 178 themes were extracted from the transcripts with the most information-rich transcript containing 78 themes. Although many of the themes appeared similar at this stage, I thought it was important to list themes separately to stay grounded in the particularity of what each participant said.

Next, themes that had emerged were listed in chronological order on a separate document so that I could search for connections among them (Smith & Osborne, 2008; Smith et al., 2009).
With consideration for the research questions, I used five strategies recommended by Smith et al. (2009) to identify patterns between themes: (a) abstraction (i.e., pairing similar patterns to create higher-level themes), (b) subsumption (i.e., recognizing that a series of related themes have emerged to form a theme with a superordinate status), (c) polarization (i.e., identifying themes that show oppositional relationships), (d) contextualization (i.e., detecting contextual, narrative, or cultural themes), and (e) function (i.e., examining emergent themes for their function in the transcript). These strategies allowed me to point to the most interesting and relevant aspects of a participant’s account and to “move the response to a slightly higher level of abstraction and . . . invoke more psychological terminology” (Smith & Osborne, 2008, p. 68). This process resulted in the clustering of similar themes to form subordinate themes. The superordinate themes, which captured the interviewee’s thoughts on the topic, were named. This iterative form of analysis required me to interact with the text. Therefore, as meaning was extracted from the text, I simultaneously checked my interpretation against what the participant had said (Smith & Osborne, 2008; Smith et al., 2009). This process was repeated for each participant’s transcript.

As similar themes arose within each text, I tried to remain consistent in labeling them by frequently referring to the original list of themes. The way themes were expressed allowed me to build connections within a participant’s transcript and across participants’ transcripts, while simultaneously staying grounded in the specifics of what he or she reported (Smith & Osborne, 2008).

After completing the initial analysis for each transcript, a directory of participants’ statements to support identified themes was created. These tables included themes and clusters along with an identifier (i.e., keyword) to indicate where they could be found in the transcript (Smith & Osborne, 2008; Smith et al., 2009). This process yielded 28 themes within four
overarching clusters (i.e., power differentials, patient behaviors and attitudes that impact participation, physician behaviors and attributes that facilitate or inhibit collaborative care, and systems components that impact patient participation). After participants’ tables were complete, I began the next phase of the analysis.

The purpose of the next phase of the analysis was to sort, combine, prioritize, and reduce the data by searching for patterns across participants’ themes. Participants’ tables, which included superordinate theme titles and themes with corresponding statements, were color coded (e.g., Participant 1 was red, Participant 2 was blue, Participant 3 was orange, etc.) and printed. Each table was dissected so that what remained were stacks of themes with corresponding statements. Participants were identified by the color of their themes and statements. Each superordinate theme title and nested theme title was written on a piece of paper. The papers were taped to different sections of two walls. Color-coded themes with statements were then taped under the superordinate theme to which it corresponded. When this was complete, the two walls were fully covered.

Using the five strategies of Smith et al. (2009), I looked for patterns across participants’ themes, focusing on what was most relevant to the scope of the research. Participants’ themes and corresponding statements were moved from one superordinate theme to another. This process resulted in the creation of new superordinate theme titles. Eventually, each participant theme with corresponding statement settled under one of six superordinate themes. These six descriptive superordinate themes contained 20 nested themes and moved the data to a higher level of abstraction. For instance, five of the themes within physician behaviors and attributes that facilitate or inhibit collaborative care were clustered into personable physicians increase patient comfort, two were clustered into primary care physicians who proactively seek out and
address patient dissatisfaction mend ruptures and strengthen the patient-physician relationship, and the rest were dropped. At the end of this process, the identified clusters captured the most information-rich components of participants’ responses. The themes and clusters were then translated then into a narrative to capture the essence of participants’ shared experiences.

**Quality Control**

**Credibility.** Credibility in qualitative research parallels internal validity in quantitative research (Mertens, 2010). A study is believed to be credible if “participants’ perceptions match up with researchers’ portrayal of them” (Bloomberg & Volpe, 2008, p. 112). To enhance the credibility of the study all findings were reported faithfully, even those that did not conform to my assumptions and expectations, and two forms of member-checks were completed. Throughout each interview, I summarized my understanding of each physician-patient experience participants discussed and adjusted my understanding when necessary. Participants were also invited to review a summary of the findings to assess whether the meaning of their experiences was captured.

The two participants with access to a computer received themes and instructions for providing feedback in the body of an email so that it could be easily accessed. Participants without access to a computer received tables of themes, instructions, and both a large and small self-addressed envelope with three to five stamps in the mail (see Appendix F for instruction document). Tables were reformatted so that there was enough space below each theme to provide corrections to my interpretations. Definitions were provided for many of the themes. All participants were asked to respond via mail or email to decrease the chance of receiving biased feedback—it was expected that they would feel more comfortable critiquing the findings in the absence of direct interpersonal contact. However, they were invited to call me if the instructions
were unclear.

One participant contacted me over the phone to provide follow-up information. At the end of our conversation, he was invited to review the themes, provide necessary feedback, and return the revised pages in one of the two envelopes provided. Although he only wrote the information that he had provided over the phone (i.e., “Now finally I can be prescribed pain medications that I very much needed!!! Very low dose but better than drinking. Doing better now. P.S. 2 years of painful nonsense.”), he returned the entire package. Due to the limited response from participants, I believe that asking participants to review 12 to 18 pages of material—less for those who received them via email—may have felt overwhelming. Inviting participants to complete the task over the phone may have increased my response rate.

Transferability. Transferability in qualitative research is like external validity in quantitative research (Mertens, 2010). A study demonstrates transferability when readers can infer from the researcher’s in-depth and detailed descriptions whether similar processes may apply to their setting or community (Bloomberg & Volpe, 2012). To enhance the transferability of this study the setting, relational context, and culture in which it was conducted were carefully described (Bloomberg & Volpe, 2012; Mertens, 2010).

Participants were recruited through my affiliations with Barre Family Health Center (BFHC) UMass Memorial Medical Center. The BFHC is in an economically disadvantaged rural area of New England. The BFHC provides comprehensive health services to families of Barre, Massachusetts, and surrounding areas. Patients are served by ten attending physicians and one clinical psychologist, plus 12 resident physicians and one post-doctoral fellow in health psychology. At the time of sampling, one physician’s assistant was also employed in direct patient care. Physicians and mental health professionals interact throughout the day to enhance
patient care. Under the guidance of a psychologist, resident physicians are regularly assessed on their use of patient-centered care through a two-way mirror. Due to my familiarity with employees, I know that more than half of the experiences discussed by patients were with attending physicians.

**Confirmability.** Confirmability within qualitative research parallels the concept of objectivity in quantitative methods. A study demonstrates confirmability if the findings are a product of the data collected and not an outcome of the researcher’s biases or misinterpretations (Bloomberg & Volpe, 2008). As recommended by Guba (1981), an external audit was conducted to ensure that the data could be traced back to participants and to confirm the data synthesizing process. Specifically, a peer who did not have expertise in the topic but who shares a similar background in qualitative research performed an audit to ensure that the research procedures were correctly followed, the data supported the interpretation, and the interpretations made sense given the data. The audit included a peer review of the participants’ tables with themes and corresponding statements. The reflexive journal used to document the assumptions and personal thoughts that led to understanding an interviewee’s response in a certain way and track the changes made throughout the data analysis process was sent to the auditor along with the tables to aid in her review. The few discrepancies found by the auditor were discussed over the phone. She did not suggest any substantial changes but she did question the theme title of *oppression*. After explaining that oppression was defined as perceived stigma and unjust allocation of resources we came to a consensus that the theme title was appropriate. However, this theme title was later changed to *psychological oppression* to convey the process in which oppressive or stigmatizing experiences might lead to internalized views of the self as undeserving of resources or participation in societal affairs.
Results

Demographic Data

Two women and three men from the lower socioeconomic strata who were under the care of a physician whom they saw at least twice in the last year, were invited to take part in this study. Participants ranged in age from 24 to 54 years old \( (M = 44.4 \text{ years old}) \). All participants identified as White from rural, country, or suburban areas. Annual incomes of participants ranged from $7,680 to $16,000 annually \( (M = 11,670) \). Except for Participant 1, all participants had made at or below their reported income for ten or more years, ranging from ten to 20 years. All participants except for Participant 1 were unemployed, received disability, and reported at least one chronic illness. The twelfth grade was the highest grade attained by all participants. Years with current or last primary care physician ranged from one year (Participant 1) to greater than ten (Participant 5) years \( (M = 4.4) \).

Analysis and Discussion

Qualitative researchers often combine the results and discussion to form one cohesive narrative of participant accounts. When using this strategy, Smith et al. (2009) suggest linking each superordinate theme to the literature and providing evidence through participant quotes to create one meaningful narrative. This approach was chosen to facilitate flow and accuracy while communicating complex findings. To enhance clarity, some specific implications of this research (e.g., steps providers can take to facilitate participation) are also presented in the results and discussion section, whereas the broader or program specific implications are presented later.

The analysis process resulted in the identification of six superordinate themes (see Table 1) that best capture how patients experience the relational dynamics of the patient-physician relationship and patient perceptions of inhibitors of collaborative care. These six superordinate
themes are:

1. Physician-patient power asymmetry can be experienced by patients of lower SES as reminiscent of further examples of previous experiences of stigma and oppression
2. Future visits or aspects of a treatment plan may be avoided following an unpleasant medical encounter
3. Personable physicians increase patient comfort
4. The emotional reactions of patients contribute to their loss of voice
5. Certain disclosures are viewed as too risky to share with treating physicians
6. Primary care physicians who proactively seek out and address patient dissatisfaction mend ruptures and strengthen the patient-physician relationship

Physician-patient Power Asymmetry can be Experienced by Patients of Lower SES as Reminiscent of Further Examples of Previous Experiences of Stigma and Oppression.

Relationships between physicians and their socially disadvantaged patients are inherently infused with power differentials (Ventres & Gordon, 1990). This superordinate theme describes a continuum of experiences (i.e., group differences and social positioning, stigmatization, and psychological oppression) that are influenced by how participants experienced her or his physicians’ power during medical encounters.

**Group differences and social positioning.** Differences between patients of lower SES and their physicians were a source of influence for each participant. Group differences were described in the context of education, intelligence, dress, gender, and authority.

When reflecting on an interaction that did not go well, three participants thought that their physicians’ behavior conveyed that they thought of her or himself as “smarter” (Participant 1) or “better” (several participants) than the patient, which was attributed to having a “doctor’s
degree” by several participants. Participants’ tone of voice and body language suggested that these statements stemmed from perceived inferiority experienced during the interaction. Physician attempts to decrease group differences positively impacted several participants. One participant said that physician dress had influenced her confidence during patient-physician interactions: “They [white coats] do [decrease my confidence]. They come in, it’s like, Dr. So-and-So written all over [them] . . . I think the blood pressure goes up in response to the white coat” (Participant 5). This patient described feeling “more comfortable” and empowered, and has expressed herself easier when physicians do not wear white coats.

Group differences were also described in the context of authority ascribed to physicians. Three participants described being influenced by a physicians’ authority while discussing interactions that did not go well. This idea is encompassed in statements such as, “you know how when your boss says, ‘hey go do this,’ and you really don’t want to do it but you do it anyways?” (Participant 1), and “like a policeman has power over you” (Participant 5). Participants’ connotations and tones conveyed that they had experienced a sense of powerlessness during these interactions. Two participants clearly stated their concern for being “taken advantage of” due to the power physicians hold, whereas Participant 4 feared this would only occur if her physician were male. This concern was discussed in regards to both future and past interactions and caused two patients to speak less during some medical encounters, whereas Participant 4 “wouldn’t talk to [her PCP] him at all.”

Group differences and social positioning can inhibit participation in patients of lower SES. Relational power asymmetry is believed to create feelings of unequal self-worth in those who continually experience less power than is normal (Almeida, Dolan-Del Vecchio, & Parker, 2007; Prilleltensky & Gonick, 1996). Haque and Waytz (2012) suggest that the power of
authority given to physicians through their training and mastery of medical knowledge can result in a lack of consideration for individual differences, which could increase the social distance between physician and patient and allow for dehumanization to occur.

**Stigmatization.** Repeated experiences of personal devaluation result in the internalization of negative images and feelings of inferiority, or stigma, when compared to the dominant group (Prilleltensky & Gonick, 1996). These internalized self-views influence how those with a history of marginalization interpret interactions with others and thoughts regarding the self.

Four participants had experienced discrimination when labeled and linked to undesirable characteristics by at least one physician. Stigma experienced by participants in this study was not attributed directly to socioeconomic standing, but rather, the chronic conditions (i.e., chronic physical and mental illness, disability, and chronic pain) that likely maintain their socioeconomic position. For clarity, this theme has been subdivided into stigmatization due to chronic physical and mental illness and stigmatization due to factors associated with being a chronic pain patient.

**Stigmatization due to chronic physical and mental illness.** Two participants described being labeled and treated differently by multiple physicians for having a “mental disability” (Participant 4), “being in a wheelchair” (Participant 5), and having multiple chronic physical illnesses (Participant 5). Perceiving judgment or discrimination caused participants to experience distress and, subsequently, to participate less during interactions as described by Participant 4, “I feel like people judge me because of my mental disabilities. . . . so I tend to stay quiet.”

Participant 5 expanded on this by sharing her perception of why she receives unequal treatment:

I get in, the nurse comes in and . . . “Oh, he’ll be right in,” and it’s a half hour later. . . . I can hear him in the other room, and I’ll be like, oh okay, I must be next. And then he
leaves that room and goes to somebody across the hall. . . . I feel like he saves me for last because I’m a complicated patient. . . . because I feel like, wait a minute, I got in here before this person, and he went to that room instead! Why is that?

If the participant’s assessment is correct, we would assume that her PCP saves her for last so that he can be more thorough—address multiple problems—during their interaction. Per this interpretation, his behavior is just because his intention is to spend additional time with the patient. However, this practice makes the patient feel like a burden, that is, she feels like she “overwhelms him.” The belief that “complicated” patients are less desirable presents again while discussing her perception of her PCP’s motive for deferring to specialists, “he’ll say, ‘Oh you’ve got to ask your rheumatologist about that.’ Or ‘That’s her thing.’ . . . I feel like . . . It’s too much for him. . . . I’m too much for him. I’m overwhelming.” In both situations, the patient responds by “hurrying” through the visit and does “not address all [of her] my concerns” to reduce the burden placed on her PCP. She then leaves the visit feeling “frustrated” and “bad” about herself, whereas in situation one, we can speculate, that her PCP ended his day thinking he had acted in the best interest of the patient.

The idea that patients with multiple problems are less desirable than healthier patients stems from negative beliefs associated with having multiple chronic illnesses and explains her concern of being “overwhelming.” These repeated experiences of perceived stigma influenced how she views and interprets her providers’ actions. This finding suggests that power asymmetry and ambiguous medical interactions or inadequately shared information might trigger negative internalized self-views leading to failures in communication (Ventres & Gordon, 1990).

**Stigmatization due to factors associated with being a chronic pain patient.** Three participants experienced stigma due to factors associated with having a chronic pain diagnosis.
Participants described their “clean record” (Participant 2) or prescription pain management history to create narratives inconsistent with their perception of persons who misuse substances and to convey disbelief for having been treated “like a criminal or drug addict” (Participant 2). When discussing prescription pain management with their physician, participants believed that providers compared them to “people . . . on heroin” (Participant 2) and “opioid abusers” (Participant 5), which has led to frustration with physicians and the healthcare system in general. This frustration was evident in Participant 5’s use of language (i.e., false starts and stutters):

They won’t even discuss pain. I-, it, they won’t even discuss it. Once in a great while, you need it. You got something going on, you can’t be in pain for this or that, or whatever. I, I-, I don’t [laughter]. So, they change the subject on you . . . feels like [they are saying], I just don’t want to deal with you.

Resisting discussions about prescribing opioids PRN (as needed) for pain management made two participants feel their physicians “didn’t care,” and feeling cared for was described as a necessary part of medical interactions by most participants. The impact of not engaging in these discussions is encompassed in passages such as, “They don’t care . . . It’s just a job” (Participant 2), “I’m . . . just a paycheck” (Participant 3), and “[they] are in it for the money” (Participant 5). In these situations, patients experienced shame or humiliation, felt their pain was viewed as unimportant, and felt less valued than patients without chronic pain.

Conversely, one participant described resentment towards his PCP for overprescribing opioid and opiate medications, resulting in addiction. Upon reflection, the patient thought his PCP’s prescribing practice signaled that she “didn’t care” (Participant 3). He believed that she knew he was addicted to the medication and viewed her continued prescribing of the medication as a way “to be done with me for the whole month, instead of having to deal with this situation.”
This patient did not experience stigma in medical encounters until the physician discontinued treatment—after learning that he had become addicted to the medication:

Doctor shows up and says, “You’re shut off, no more prescriptions, you’re done. I talked to your daughter.” I said, “... You’re not even going to give me anything to help me deal with this?”... [She] Turned around and walked out. Said nothing... Last time I ever saw her even. Then I’ve been blackballed ever since.

Wanting help with his addiction, the patient reportedly called his PCP “multiple times on her direct line and with her nurses” but never received a “call back, no referral even.” Feeling abandoned, the patient managed his withdrawal symptoms by “staying busy” via physical labor and non-opioid substance use to “redirect the stress.”

These narratives highlight the impact of chronic pain treatment in triggering internalized stigma. Possibly due to increased chronic stress and poorer health (Institute of Medicine, 1987), people of lower SES are more likely to experience chronic pain than their more advantaged counterparts (Riskowski, 2014). This finding supports a study conducted on patients with chronic lower back pain that found that patients often felt judged for using opioids for pain management (American Society of Anesthesiologists, 2016).

**Psychological oppression.** Recurrent small daily doses of shame or personal devaluation experienced by the poor are enough to result in psychological oppression (Prilleltensky & Gonick, 1996). Stigma is a necessary component of psychological oppression; however, psychological oppression includes the perception of unfair allocation of resources based on class or group membership (Prilleltensky & Gonick, 1996). This theme describes both a process and an outcome (i.e., psychological oppression). The process is the pathway from perceived inequality and discrimination to the outcome of self-defeating views that influence beliefs
regarding worthiness to resources. Psychological oppression was described by two participants.

Participant 3’s continued narrative depicts the process by which actual or perceived denial of resources by healthcare providers to patients of marginalized groups could trigger psychological oppression. Following his last visit with his PCP, he was “classified as at risk for addiction” and “couldn’t get the [medical] help [or resources]” he felt he needed. He was “labeled as pill shopping” when seeking treatment in the emergency department for injuries and began to expect that he would experience stereotyping, prejudice, and discrimination during all interactions with medical providers. Thus, he did not return to primary care for “eight years.”

The following passage depicts what may follow perceived oppressive experiences in healthcare:

After the issues with her, I didn’t see anybody for nearly eight years. . . . No matter where I go, I’m going to have this problem with them, so I only used the emergency room like when something really bad happened . . . I ain’t going to no friggin doctor. I said I’m done with that because I thought it would end up the same way. . . . When that happened it kind of put a dampener on it, and I’m like, doctors are just, to me I was like, all doctors are a waste of time, . . . I don’t care.

This process was also described by Participant 5. Concerned that shortness of breath was due to “lung nodules,” Participant 5 sought help from a pulmonologist:

What I was hoping to gain [from the visit] was, first of all, that we do some testing, and I’d be able to find out the reason why I was having the shortness of breath. . . . He just didn’t care about that. I felt like he looked right past that to see me in the wheelchair . . . It made me feel like I’m not good enough, and like whatever I do or say isn’t going to really matter. I feel like I didn’t really matter . . . because I wasn’t out running marathons. . . . Right away it put me into this mold like I’m not as good. . . . He was exerting power
and it made me feel like, I’ve got to get out of here. I don’t even want to be here. He thinks I’m lower than a snake’s belly. . . . [If I were not a chair] I think that he would have taken me more seriously. I think he would have wanted to run tests, and wanted to do a lot more. . . . I just felt like if I was a regular person, and I could come in without being in a wheelchair, he would have figured it out.

Feeling blamed for her condition, she experienced shame, humiliation, and her confidence dwindled. Her vulnerability and sense of powerlessness are evident in statements such as, “he was exerting his power [over me]” and “I’ve got to get out of here,” which conveys the threat she experienced during this interaction. Furthermore, we can see how internalized stigma leads to the self-defeating view that resources should only be allocated to those determined to be worthy when the patient indicates that being “in the chair” made her “not good enough” for further testing per the specialist.

These participants’ narrative suggests that repeatedly experiencing inequality and discrimination in medical encounters caused them to internalize the perceived negative images projected on them by healthcare workers. Per Prilleltensky and Gonick’s (1996) conceptualization of psychological oppression, images of inferiority form after an oppressive encounter and wear away self-confidence. When experiences such as this are frequent, oppressed persons eventually develop the tendency to oppress themselves. This tendency is highlighted by the way participants interpreted and responded to unpleasant medical interactions.

This superordinate theme describes a continuum of experiences that are influenced by how participants experienced her or his physicians’ power during medical interactions. This continuum reflects the process through which various components of stigma and psychological oppression are believed to develop. First, the way in which participants experienced their
physicians’ power led them to identify and label group differences. Stigmatization included power asymmetry and occurred when the low-power person perceived that the high-power person had stereotyped or identified one of their negative attributes (Link & Phelan, 2001). Participants who discussed numerous stigmatizing interactions appeared more susceptible to changes in behavior during medical encounters (e.g., increased distress, and decreased participation and trust) than those who discussed fewer stigmatizing interactions, whereas those who discussed psychological oppression seemed the most susceptible to changes in behavior during medical interactions. Participants who experienced psychological oppression during medical interactions that triggered historically rooted beliefs developed the expectation that they would experience stigma when interacting with medical professionals.

**Future Visits or Aspects of a Treatment Plan may be Avoided Following an Unpleasant Medical Encounter or a Weakened Patient-physician Alliance**

All patients avoided some aspect of medical care after an unpleasant interaction but the degree and potential impact of avoidance seemed to be determined by previous medical interactions. The underlying themes that emerged were: patients refused the modality of care in which psychological oppression was triggered, treatment adherence decreased after an unpleasant medical encounter, and experiencing psychological oppression in healthcare led to developing an expectation that most medical encounters will be unpleasant.

**Patients refused the modality of care in which psychological oppression was triggered.** Three participants discontinued the modality of care (i.e., dermatology, pulmonology, and primary care) in which a perceived oppressive event occurred. Participant 5 who was concerned that shortness of breath was symptomatic of cancer said that she “didn’t care [about preventing cancer] after that” because “the experience turned [her] me off to all doctors.”
Likewise, Participant 3 managed his withdrawal symptoms without medical help and self-administration of non-opioid substances, and for “eight years” he only sought medical treatment in the “emergency room.”

If providing answers to medical questions, being personable, and providing empathy were resources, we could argue that the activation of psychological oppression also led to Participant 2’s continued refusal to remove a potentially cancerous growth from his nose. Participant 2 was referred to a dermatologist to remove a growth. Worried about both the procedure and risks of the condition, the patient initiated the conversation by asking if he was “going to die?” When the dermatologist said “you’re only here for this . . . we just need to take another chunk out of you,” the patient felt dismissed and thought that the doctor “didn’t care.” He linked the absence of empathy to an absence of care, experienced distress, and terminated the visit. He describes how the dermatologist could have ensured that he went through with the procedure:

If I were comfortable and they were good to me then, yeah, take another chunk out of me and test it again. . . . If they would have asked me questions, and not been so rude . . . They don’t ask me how I’m feeling, how’s it look, or anything like that. It was like, we just need to take another chunk out of you . . . Nah, I ain’t going back there.

Despite evidence of cancer or health concerns, these three participants chose not to pursue treatment after their first attempt resulted in instances (Participants 3 and 5) or near-instances (Participant 2) of actual or perceived oppression, which may have compromised their health. Consistent with Earnshaw and Quinn’s (2012) findings on patients with chronic illness, participants in this study who experienced stigma and unjust allocation of resources in medical interactions were less likely to access healthcare. However, since the participants for
whom this finding holds true have one or more chronic illnesses, we cannot be certain as to whether patients of lower SES who experienced stigma and unjust allocation of resources in medical interactions but do not have chronic illnesses would be less likely to access healthcare.

**Treatment adherence decreased after an unpleasant medical encounter.** Decreased adherence was directly or indirectly linked to an emotional response (most participants) or decreased trust (Participant 1 and Participant 2) that occurred after a medical interaction or rupture in the patient-physician relationship (Participant 4).

Participant 4’s reason for adhering to treatment was the relationship she had with her PCP. Per Participant 4, her PCP told most of her patients that she would be leaving the Health Center “before she told (Participant 4) me she was leaving.” After learning she was leaving from a neighbor, Participant 4 stopped checking her blood sugars and eating healthy meals, though she continued taking her heart medication because it was managed by a specialist. She also “refuse[d] to use [her] the walker” at home because it was recommended by her PCP. The importance of the patient-physician relationship to treatment adherence is demonstrated here:

I don’t tend to take proper care of myself. I mean, I do live independently but I don’t have a lot of supports out there. I mean, it’s like now I have nobody really. . . . [I was checking my blood sugars] for her.

Paired with the internalized stigma experienced during medical interactions, the chronic stress typically experienced by the poor (Cohen, Doyle, & Baum, 2006; Murdock & Fagundes, 2016), and the patient’s individual psychology (e.g., diagnosis of borderline personality disorder), her strong reaction makes sense.

**Experiencing psychological oppression in healthcare is linked to the expectation that most medical encounters will be unpleasant.** When asked whether most medical encounters
had been good, bad, or neutral, four participants said that most did not go well. One female participant said this was because “most of [her] my doctors were male” (Participant 4), whereas the youngest and least poor participant described his experiences as “about even; 50% good and 50% bad” (Participant 1). Only participants that experienced an actual or perceived oppressive medical interaction developed the expectation that most interactions would be unpleasant. Participant 3 describes the process through which this expectation develops:

Probably mostly me, portraying that feeling over them. It’s like, are they going to be a pain in the ass, or are they going to be nasty? That’s just me portraying them. They could be nice people, they could be nice doctors, but I don’t see it as that way. . . . So, I’ll go to them a couple times and that’s it. . . . I can’t say [appointments] they were like that until recently, I mean until that whole incident with . . . that one doctor.

This patient’s expectations make it difficult to form healthy relationships with physicians. Earnshaw and Quinn (2012) found that chronically ill patients’ interactions with providers are influenced by beliefs associated with past negative interactions. This study supports this finding; however, since the participants for whom this finding holds true identify as having one or more chronic illnesses, we cannot be certain as to whether some patients of lower SES without chronic illnesses perceive medical interactions through past negative interactions.

**Personable Physicians Increase Patient Comfort**

When physicians were experienced as personable, patient experiences of dehumanization decreased, patient participation increased, and physician-patient relationships were strengthened. Physicians were experienced as personable when patients perceived that they listened, cared, were interested in the patient’s life, were authentic (i.e., mutuality), and trusted the patient. The underlying themes that emerged were: listening, caring, appears interested in patients’ life,
mutuality, and trust is a reciprocal construct.

**Listening.** Each participant felt more comfortable and freer to disclose personal information, ask questions, and voice concerns when physicians listened during medical encounters. Listening was described as “a really big deal” (Participant 5) and the “most important” (Participant 3) physician behavior. Participants felt that physicians cared and lacked judgment when they listened. Those who thought that their physician “did not judge” (several participants) them and saw them as “human” or “an equal person” (Participant 5), participated more during medical interactions. Several participants described behaviors that contributed to feeling heard such as, sitting, making eye contact, and shaking hands.

Body language impacted Participant 4’s perception of a physician listening, “He’d come in the room, literally flop onto the chair and keep his arms crossed the whole time. He didn’t seem to want to listen.” Passages such as, “she listened even though I didn’t say much . . . she listened to the fact that I did have a lot of anxiety” (Participant 4) and “if a doctor . . . could read it out of me without me having to tell it . . . that would be awesome” (Participant 1) convey patients’ desire for physician application of active listening skills. Lastly, feeling unheard was often associated with carrying a laptop into exam rooms or “trying to multitask” (Participant 3).

Listening may decrease the chance of triggering internalized stigma by implicitly telling the patient that you see them as an individual and not a label, stereotype, or preconceived idea, allowing them to lower their guard and provide a more thorough and descriptive reporting of history and symptoms. Ultimately, this will lead to more accurate diagnoses (Fox & Chelsa, 2008; Poteat et al., 2013). Research has confirmed these findings. Mercer et al. (2007) found that participation (i.e., being able to talk to physicians) increased when patients felt that physicians withheld judgment and treated them as individuals. Raja et al. (2015) found that feeling unheard
and lack of attention to a patient’s individuality led to dehumanizing patient experiences.

**Caring.** Participants views on what it means for a physician to care for a patient were discussed. Experiencing empathy was experienced as care by most participants. Most participants indicated that demonstrating care is a job requirement or a necessary component of patient-physician interactions. This is encompassed in passages such as, “Why be there if you don’t care? I mean . . . find a different job then” (Participant 2) and “They should be the most understanding . . . That’s the whole point of becoming a doctor is because you care about people and want to help [th]em” (Participant 5). Several participants described medical encounters as pointless if they thought the physician did not care. This suggests that feeling cared for is more important than addressing medical problems and, indeed, two participants refused to pursue preventative treatment because they believed their physician did not care. This confirms research that has found that low SES patients felt cared for when physicians listened (Mercer et al., 2007).

**Appears interested in patients’ life.** Three Participants noted the significance of small talk. They described feeling more connected to their PCP when they followed up on nonmedical conversations from previous visits or expressed interest in their home life. For instance, asking if the patient enjoyed the concert they briefly discussed in his last visit, made Participant 1 feel that his PCP “really cares” and “allowed [him] me to look at her point of view,” which enabled him to engage in treatments that he ordinarily would have refused.

**Mutuality.** Two participants experienced increased engagement when PCP’s expressed emotions during physician-patient interactions. While describing an interaction in which his PCP expressed emotion Participant 2 said, “she was having a hard time [during the conversation] with it . . . [which] helped me get what she was saying.” Relationships were strengthened when physicians shared their feelings. When engaged in mutually empathic and reciprocal
relationships patients feel more connected to their HCP’s (Fox & Chelsa, 2008). Mutuality allowed patients to experience an increased sense of security and trust and decreased anxiety, which enabled them to be more authentic in the relationship and receive better care.

**Trust is a reciprocal construct.** Several participants trusted their physician more after experiencing trust from that physician, which strengthened patient-physician relationships. Experiencing a physician’s trust allowed Participant 3 to end his eight-year hiatus from primary care. Though wary of initiating a relationship with a PCP, the trust he experienced from her implied that she did not view him as he perceived others had, allowing him to relinquish some of the stigma he attached to his role as a patient and form a foundation for a strong relationship. This result is consistent with Bierderman and Nichols (2014) finding that experiencing trust from service providers meant women could move past being the stereotypical untrustworthy homeless person to an individual with agency.

When patients perceived that physicians listened, cared, were interested in their life, were authentic, and trusted them, patient experiences of dehumanization decreased, participation increased, and physician-patient relationships were strengthened. A Canadian study found that physicians strengthened personal connections by spending more time getting to know each patient, using self-disclosure as a strategy to reduce social distance and increase trust, and conveying that they recognize patients suffering through empathy, active listening, and being attentive to patients’ nonverbal gestures (Loignon et al., 2015). The behaviors implemented by this group of physicians is consistent with the physician behaviors that participants in this study described as essential to increasing their participation and comfort in medical interactions.

**The Emotional Reactions of Patients Contribute to Their Loss of Voice**

Voice is defined as the ability to speak for yourself, to remain authentic, and to express
opposition during interpersonal interactions. Participants discussed emotional reactions that inhibited participation during physician-patient interactions. The underlying themes that emerged were: anger and frustration, symptoms of depression, symptoms of anxiety, and suspiciousness.

**Anger and frustration.** Anger and frustration were the most frequently discussed emotions experienced during or after medical encounters. Anger stemmed from feeling misunderstood or unheard and perceiving unequal treatment, discrimination, and marginalization, and caused several participants to feel “powerless.” Three participants responded to their PCPs with “one-word answers” (Participant 4), by “shutting down” (several participants), or “a lack of response” (Participant 1) when angered. Anger inhibited participants’ ability to “advocate” for themselves or question physicians’ authority or decisions, which caused Participant 2 to have an “allergic” reaction to prescribed medication. Participant 5 directly linked power asymmetry to anger, powerlessness, and difficulty advocating for herself:

- You have to advocate for yourself, when they do that you feel like you can’t . . . I felt marginalized, but I also felt angry. . . . I try to speak but can’t, so I just take it one step at a time . . . What I’d like to do is, when I feel like that, is be able to speak up for myself . . . and know what to say like, “That’s not right. That’s not okay what you said to me. You don’t say that.” Not feeling, because, I feel like they’re in power. They have the power. . . . People get taken advantage of because of that reason.

Participants experienced anger, frustration, and powerless when they felt misunderstood or perceived inequity, discrimination, and/or marginalization. Difficulty challenging authority is commonly observed in oppressed groups (Prilleltensky & Gonick, 1996) such as the poor. This finding supports the link between powerlessness and loss of voice identified by Biederman and Nichols (2014) study on homeless women’s perception of their experiences with service
providers. Sheridan et al. (2015) also found that anger and frustration decreased communication in a sample of New Zealand patients, many of whom were poor. Researchers argued that patient responses often convey deep-rooted feelings of anger and frustration.

**Symptoms of depression.** Several participants experienced symptoms of depression after an interaction that did not go well or after a rupture in the physician-patient relationship. Participants described feeling “shaken” (Participant 5), “withdrawn,” and “staying in bed most of the day” (Participant 4). After seeing the pulmonologist, Participant 5 “cried, . . . felt worse about [her]myself” and “shut down.” Her emotional reaction caused her to neglect her daily self-care routine, which could have caused “a rheumatoid arthritis flare-up,” whereas Participant 4 reported that a disagreement with her physician did cause her health to decline. Both, reportedly participated less in follow-ups with their primary care providers.

**Symptoms of anxiety.** Each participant linked nervousness to decreased participation. Statements such as, “I . . . was quieter because I was nervous” (Participant 1), “when anxious . . . I shut down” (Participant 4), and “I think because you just get nervous, . . . you lose your whole train of thought” (Participant 5) highlight this connection. Stress experienced during medical visits caused two participants to forget to talk about issues they had planned to address. Several participants described physical reactions (i.e., increased “heart rate” and “blood pressure”) that occur prior or simultaneous to losing their voice. Participant 5 described having “a strong gut feeling . . . [like] a knot in [her] my stomach, like [she is] I’m going to throw up, [be] nauseous, [or] physically sick “in response to “feeling judged.”

Symptoms of anxiety reduced participation and caused patients to forget what they wanted to ask their physicians. Due to this, physicians should consider the impact of increased stress on chronically stressed populations, such as the poor, during patient-physician interactions.
Zender and Olshansky (2012) argued that when chronically stressed patients experience a slight increase in stress during a medical consultation their chance of experiencing physiological dysregulation increases, and their capacity to interact effectively with the physician, remember instructions, and adhere to recommendations decreases.

**Suspiciousness.** Three participants became suspicious of physician’s intentions following one or several unpleasant medical interactions. This is encompassed in statements such as, “I think they’re testing me” (Participant 2), “and another thing, I don’t know if in the beginning . . . if even then she was lying to me” (Participant 1), and “I feel like something else is going on” (Participant 2). This idea was further elaborated on by Participant 5:

> You start rethinking your thing. . . . Then it makes you . . . Overthink! What do they mean by that? Even if somebody doesn’t mean anything by it, then you start thinking everybody means something by everything they’re saying. . . . Paranoid, that’s the word!

The numerous experiences of inequality and discrimination to which the poor are exposed may cause this group to be more apprehensive of physician behaviors during medical interactions. We know that strong emotions interfere with communication (Fields, Copp, Kleinman, 2006). However, I only found one study that specifically addressed emotions in the context of the physician-patient relationship from the patient’s perspective (Sheridan et al., 2015).

**Some Disclosures are Viewed as too Risky to Share with Treating Physicians**

Participants perceived some communications as too risky to share with treating physicians. The underlying themes that emerged were: risky disclosures in the acquisition or maintenance of medication and expressing dissatisfaction could result in the loss of a valued relationship.
Risky disclosures in the acquisition or maintenance of medication. Three participants described withholding information (i.e., use of alcohol, daily use of ibuprofen, and concerns for adverse medication reactions) due to concern that disclosure would influence what medications their PCP’s decided to prescribe. Conversely, Participant 1 stopped discussing pain with his PCP because he was concerned that she would prescribe “higher pain meds.”

Several participants did not voice opposition to medication decisions with which they did not agree. Concerned that a sleep aid was causing memory impairment, Participant 5 asked her PCP about alternative medications. Her PCP responded by creating a plan to titrate her off the medication. Participant 5 did not express her opposition to his plan and left the visit “wishing [that she had] I’d never mentioned it” because she worried about losing the medication. Her narrative highlights the importance of asking questions in the context of shared decision-making with patients of lower SES. Patient agreement or reticence may not signify that the patient agrees with the proposed treatment plan.

Expressing dissatisfaction could result in the loss of a valued relationship. Concern for losing a valued caretaker relationship led several participants to withhold information from their PCPs. Participant 3 believed talking about pain and pain medication would jeopardize his relationship with his PCP. He described “not [feeling] 100% secure talking [to his PCP about his] . . . back pain.” Likewise, Participant 5 chose not to express opposition to her PCP’s decision to titrate her sleep aid because she believed it would end the relationship. Although this participant had become increasingly dissatisfied with multiple aspects of care (i.e., less thorough physicals, decreased physician responsiveness to phone calls, increased wait times, and titration of a sleep aid), “previous experience” taught her that expressing dissatisfaction was not “safe.”

The following passage describes her thought process:
I like him as a person. So, I don’t want to say anything. . . . I don’t want to anger him. 

I don’t want to rock the boat; I don’t want to have maybe less care because I angered him. . . . I feel like I don’t want to risk it. . . . No, it just doesn’t feel safe.

Cherished relationships with their providers inhibited the ability of participants to advocate for her or himself. Internalized stigma, psychological oppression, and learned beliefs that care in a caregiver relationship are contingent on what is brought to that relationship, influenced the amount and type of information participants shared. As the strength of the connection increase between a PCP and patient from this historically stigmatized and oppressed group, patient disclosure may subsequently decrease as impression management strategies are implemented due to concern for losing a valued relationship.

**Primary Care Physicians Who Proactively Seek out and Address Patient Dissatisfaction Mend Ruptures and Strengthen the Patient-physician Relationship**

This theme was created to highlight how three PCPs proactively sought out and addressed patient dissatisfaction or encouraged expressions of discontent to maintain healthy working patient-physician relationships with three participants. Physician behaviors that inhibit participation post-conflict serve as a comparison. The underlying themes that emerged were (a) controlling conflict by controlling the situation and (b) proactively attending to patients’ emotions repairs ruptures and strengthens relationships.

**Controlling conflict by controlling the situation.** Three participants described sensing that their physicians (one specialist and two PCPs) managed interpersonal conflict by adopting a more directive style when interacting with them. Towards the end of her consultation, Participant 5 perceived that the pulmonologists provided unsolicited advice (e.g., “Oh, by the way, you’ve got to stop taking that. That’s no good for you” and “Not sleeping has never killed anyone”) to
“get off the subject or find something else to harp on.” We can imagine that asserting his medical knowledge gave the pulmonologist a sense of stability; however, the patient believed his comments were intended “to make himself feel better, to make [her] me feel worse, [and] to keep having power over people.” Participant 1’s narrative demonstrates how this theme might look in a long-term relationship. Participant 1 perceived that his PCP was not “cooperating with” him on tasks related to getting his leave of absence (LOA) paperwork completed. As time progressed, his PCP asked fewer questions, stopped returning calls, took increasingly more time to have paperwork faxed to appropriate sources, refused to provide same day copies of paperwork, and spent less time with the patient during visits. In their last interaction, she initiated the visit with a harsh statement that contained what he perceived to be a lie.

Attending to these participants’ emotions during interactions might have kept these relationships from erupting. Although attempting to regulate conflictual interactions may give providers a sense of control, it seems to have the reverse effect on patients. Fox and Chelsea (2008) found that one participant felt oppressed, alienated, and unable to control her life when perceiving that an HCP utilized her/his power to control her behaviors during medical consultations. In this relationship, the patient reported feeling disconnected from her provider and was less likely to ask questions, disclose information, and adhere to treatment.

**Proactively attending to patients’ emotions repairs ruptures and strengthens relationships.** Three participants described PCPs who encouraged expressions of discontent or proactively sought out and addressed patient dissatisfaction to improve relationships. Two male participants portrayed their PCPs as willing to tolerate their anger. Participant 3 said, “If I’m . . . upset, it’s usually . . . because my wife’s upset and when that happens I get upset . . . she [PCP] understands that. She doesn’t take it to heart and I don’t either.” He does not intentionally share
his dissatisfaction and resulting anger with his PCP but values her for understanding his emotional reactions. Conversely, Participant 2 tells his PCP when he is dissatisfied with care. In the following passage, he describes his plan to address frustration caused by waiting in the exam room for an extended amount of time:

I’m going to tell her; I wasn’t too happy. I was thinking you left me there . . . I’ll tell her off . . . I mean she knows when I’m pissed. So, so she’s going to apologize, and I mean she’s been my doctor for so long, she knows how I am, I have no issues, saying that I’m ticked off . . . she doesn’t get bent about it. . . . She says I got a lot of stress.

Participant 4’s PCP encouraged her patient to share how she was feelings about their relationship. Per Participant 4, learning that her PCP was leaving, triggered feelings of “abandonment.” The patient “didn’t [plan to] tell her [PCP]” that she was “upset” but at her next visit, her PCP repeatedly inquired about her emotional state. Though reluctant to participate, her doctor provided continued attention to the patient’s distress. This continued in follow-up visits, which were more frequent. Per Participant 4, she eventually understood her PCP’s perspective and conceptualized her lack of disclosure as an act of caring; though she seemed to vacillate between feeling abandoned and cared for during the interview.

Four patients discussed how five primary care physicians managed conflicts in five different relationships. Both cases (Participant 1 and Participant 3) in which the PCP did not address the discord, the relationship ultimately ended. Conversely, PCPs who proactively addressed conflict—thereby, attending to the ruptures—maintained and perhaps strengthened their relationship to the patient. Expressing discontent allowed disagreements to surface, permitting the physician to identify and address the problem. Since some participants view expressing dissatisfaction as risky, PCPs should actively seek out and address patient
dissatisfaction. Addressing discontent and negative emotions not only heals ruptures but keeps them from expanding.

**Implications of the Research**

The result of this study should be used to find ways to minimize patient experiences of stigma and experiences of psychological oppression within patient-physician interactions. Almeida et al. (2007) recommend that clinicians consider the impact of social inequality, lack of power, and oppression on patients’ pathology. Attending to such factors is crucial when caring for patients reared in conditions of poverty because patients who have recurrently experienced deprivation, inequality, marginalization, and discrimination, are susceptible to experiences of dehumanization through validation of oppressive self-views that trigger feelings of unequal self-worth during encounters with physicians who are not mindful of how their behaviors and attitudes contribute to conditions that lead to oppression (Prilleltensky & Gonick, 1996).

The findings of this study suggest an association between the number stigmatizing events experienced and the likelihood of experiencing stigma during a medical interaction. Participants who experienced psychological oppression during a medical interaction had experienced discrimination in more areas (e.g., disability, chronic pain, and increased number of chronic illnesses) and for greater lengths of time than participants who did not experience psychological oppression. In practice, this means that physicians should gently ask patients about past traumatic events and experiences of inferiority to help determine which interpersonal behaviors are necessary for effective medical interactions and reduce the chance of triggering stigmatized self-views or psychological oppression during patient interactions. When patients’ histories include numerous occurrences of inferiority and distressing events, treating physician should employ behaviors associated with the superordinate theme personable physicians increase patient
comfort (e.g., active listening, empathy, demonstrating interest in patient, attending to emotions, being authentic, and demonstrating trust) during their interaction with patients to decrease the possibility of triggering internalized stigma and psychological oppression, and experiences of dehumanization.

Patients who have experienced long-term poverty complicated by low educational attainment, as a population, contribute more to the overall costs of medical care due to their higher disease load and poorer health habits than their more advantaged counterparts (Epstein, Stern, & Weissman, 1990; LaPar et al., 2010). In a future in which these patients are given reliable access to healthcare, the findings of this study can be used to help physicians decrease rates of alienation and build engagement to reduce patient morbidity, mortality, and the overall costs of medical care.

Physicians and patients contribute to making the care of low SES patients less effective. Practices that are willing to look at these findings head-on can find their own ways to develop physician training experiences that inform and empower providers and staff. These practices will help providers deliver better care and will ultimately see better patient outcomes among their lower SES population.

Future Research

To my knowledge, this study is the first to focus explicitly on the role of stigma and psychological oppression on the patient-physician relationship from the perspective of patients of lower SES. Repeated perceived experiences of personal devaluation can result in the internalization of negative images and feelings of inferiority when compared to the dominant group (Prilleltensky & Gonick, 1996). These internalized self-views influence how patients with a history of socioeconomic deprivation interpret interactions with physicians.
Research that examined how poor patients’ perception of power (e.g., impact of power, when and how patients experience a physicians’ power) compares to primary care physicians’ perception of power in patient-physician dyads could shed more light on the problem power poses to patient participation, and increase physician awareness of the effects of power on disenfranchised groups. Surprisingly, one study found that some physicians believed that power dynamics were absent or irrelevant in their interactions with patients. These physicians did not think that their patients were influenced by power dynamics during medical encounters (Nimmon & Stenfors-Hayes, 2016).

The term dehumanization has recently appeared in the literature (Haque & Waytz, 2012). Though this concept is a step in the right direction, it fails to adequately explain how one comes to feel dehumanized. Future research on patient-physician communication should incorporate theories of social psychology and sociology that seek to explain the processes by which patients of disenfranchised groups come to experience dehumanization. Through the lens of stigma and oppression, the results of this study do not represent new findings. They simply confirm what we know: Patients who have continuously experienced inequality, suffering, deprivation, discrimination, and marginalization are susceptible to experiences of dehumanization through validation of oppressive self-views that trigger feelings of unequal self-worth during encounters with physicians who are not mindful of how their behaviors and attitudes contribute to the conditions that lead to oppression.

Future research should investigate the patient-physician relationship from the perspective of middle and upper-class patients reared in poverty. Those that have transcended a boundary of socioeconomic status may have acquired the ability to challenge discriminatory acts and demonstrate resistance to authority (Lewis, 1966). These patients might be better equipped to
articulate why patients of lower SES hesitate to speak up or challenge their doctor’s authority and why they participate less during medical interactions. In my opinion, we can better understand the constructs that incapacitate us after understanding the viewpoint of those responsible for our incapacitation. Furthermore—and consistent with social constructivist ideology—future studies on the patient-physician relationship from the perspective of lower SES patients or any disenfranchised group should be conducted by researchers who have experienced the stigma associated with the population they study. Stigma researchers that have not experienced stigma understand their data through the application of theories that are difficult to figure out in the absence of lived experience (Kleinman et al., 1995; Link & Phelan, 2001). Those that have experienced a certain stigma may be better equipped to understand the lived experience of participants when using qualitative methodology.

Future research should be conducted with the goal of developing consciousness-raising interventions to help patients of marginalized groups develop the awareness that precedes the ability to question authority. This awareness was observed during my conversation with Participant 5 who expressed the desire to learn to advocate for herself in the context of the physician-patient relationship. Although difficulty communicating when angry inhibited participation for most participants, only she had expressed the desire to communicate more effectively, which could be explained by increased thought to the physician-patient relationship due to having a daughter in the healthcare profession (Lewis, 1966).

This study presents a nascent understanding of how stigma operates against the treatment of lower SES patients in healthcare settings. However, additional research is needed to better understand this pattern and to help patients minimize occurrences of reexperiencing stigma and psychological oppression during interactions with physicians. A clearer understanding of this
pattern would help reduce the impact of stigma on the health of marginalized populations, provide a knowledge-base for developing programs geared towards helping providers understand and manage the impact of their power on disenfranchised groups, and provide insight to its impact on health disparities (Poteat et al., 2013). Assessing the content and function of stigmatizing attitudes at different levels of medical hierarchies would be an important first step in creating stigma reduction interventions for marginalized groups and reducing health disparities (Poteat et al., 2013).

Limitations to the Research

The current study is not without limitations, some of which occur by the nature of qualitative methodology. Since the text is analyzed through the subjective thought processes of the researcher, the data may be biased as the results are partially attributable to my values and beliefs (Bloomberg & Volpe, 2012; Smith et al., 2009). Additionally, since power differentials limit the study, participants may not have presented themselves authentically (i.e., impression management). Despite taking measure to reduce the impact of my power on the participant-researcher relationship (e.g., referring to participants’ as co-researchers and aligning with participants), power differentials undoubtedly influenced the responses given and the overall accuracy of the data. During interviews and while listening to tapes I periodically wondered whether quantitative methodology would provide more accurate results when sampling disenfranchised groups. For instance, at times Participant 5’s responses and word-choice (e.g., power and marginalization) matched my thoughts with such precision that I worried about the influence of my power on her responses. Of note, however, this line of thinking also presented with Participant 4 when she used the word “abandonment,” which suggests that the use of conceptual words contributed to my questioning the impact of my power.
on participant responses. Nevertheless, despite my attempts to level power differentials, participants’ experience of power differentials undoubtedly biased the data to some extent.

The results of this study may be limited by patients’ motivation to participate. Four participants were motivated to participate by anger and a desire for social justice. Two participants explicitly said that they chose to share their narratives to reduce the possibility that future patients would experience what they experienced. Due to this, this study may be limited by a higher than the average number of medical encounters that did not go well when compared to other patients with similar demographics, which would have biased certain findings (e.g., patient expectations that future medical interactions will not go well). This bias might not have occurred if the financial incentive had been greater.

This study is also limited by the small sample size and method. All participants were recruited from the same facility. The BFHC provides integrated medical and psychological care with a high value placed on training physicians’ in methods of patient-centered care, which includes training in motivational interviewing. Therefore, the results of this study may be understated when compared to similar patients from facilities that are not integrated and facilities that are less focused on training resident physicians. Should this study be conducted on similar participants at a different facility, researchers might find that participant narratives highlight themes discussed to a greater degree (e.g., more emphasis on the importance of personable patient approaches or a larger proportion of participants sampled that experienced psychological oppression during medical interaction).

The results of this study might be biased by the proportion of patients in this study with a diagnosis of chronic pain. Three of the five patients who participated in the study discussed the impact of chronic pain on the patient-physician relationship. The results of this study are
certainly linked to the stigmatizing interactions experienced by chronic pain patients. However, income and education status are associated with increased self-reports of chronic pain (Institute of Medicine, 1987) since patients of the lower SES are more susceptible to developing chronic pain due to increased chronic stress and poorer health (Riskowski, 2014). I could not find demographic information on the percentage of lower SES patients who have chronic pain. These statistics are needed to understand better what proportion of lower SES patients experience chronic pain and how the stigma experienced by patients of lower SES with chronic pain differs from the stigma experienced by more advantaged groups with chronic pain. For example, how do upper and middle-class patients with chronic pain experience stigma differently from less advantaged groups with chronic pain during interactions focused on chronic pain matters?

Finally, the study may also be limited by patient difficulty differentiating between various healthcare providers. Patients might not always know with which healthcare provider (e.g., physician’s assistant or nurse) they met. Therefore, some of the provider specific responses mentioned in this study may not have referred to physicians. However, due to my familiarity with employees of the BFHC, I know that most participants described interactions with medical doctors.

**Final Statement**

This study considers the consequences of stigma and psychological oppression on interactions patients of lower SES have with physicians. Physicians’ power can either enhance or inhibit patient participation. Physicians’ power can trigger internalized stigma and psychological oppression, which can result in decreased treatment adherence, refusal to pursue preventative care or refusal to be treated by a primary care physician. Conversely, physicians can utilize their power by acts associated with caring to increase patient participation, motivate patients to adhere
to treatment, strengthen relationships, and address ruptures within the relationship.

People with greater resources of power, prestige, knowledge, and social connections can more easily avoid disease risks and adopt strategies to protect health (Link & Phelan, 2006). Socioeconomic status is intrinsically related to health as it increases an individual’s exposure to disease and decreases access to protective factors. The findings of this study suggest that internalized stigma and psychological oppression also increase patient exposure to disease risk and decrease access to protect protective factors, thereby, providing evidence of yet another element that contributes to socioeconomic disparities in health.

**Personal Statement**

Both my advanced practica and internship in integrated primary care served predominantly poor and underserved populations (one rural and one urban). I have had the opportunity to apply lessons learned from this project to various patient-provider interactions between the primary care providers with whom I have worked, myself, and our shared patients of lower SES. In team meetings, I have informally communicated results (e.g., patient agreement or reticence does not signify that they agree and/or plan to follow recommendations) to improve patient care. Eventually, I began hearing elements of this study reflected back to the group by different team members, which was gratifying.

I have also utilized lessons learned from this project with patients to encourage them to address the problems that arise in their relationships with physicians. These discussions usually included an enthusiastic behaviorist, motivational interviewing, and role-plays in which the patient was encouraged to make themselves vulnerable by expressing their emotions or using I-statements to convey their needs. This has been one of the more rewarding tasks of my practice. For instance, this year I had the opportunity to guide several patients in facilitating this
conversation with their oncologists. Patients that have found the courage to convey their needs reported that their physicians were receptive and that follow-up interactions and their relationship improved.

Due to my affiliations with economically and educationally disadvantaged individuals, this topic will always be meaningful to me. As such, I will continue to incorporate lessons learned from this project and reformulate hypothesis based on new patient experiences to enhance my practice in serving patients of lower SES.
References


Antioch University investigator’s handbook for the protection of human participants (2011). Retrieved from https://sakai.antioch.edu/portal/site/3de75ece-3af0-4324-b3fb-3914f76fc822/page/66a50a41-bf53-4ab3-b40d-cc73f781272e


Table 1
*Master Table of Six Superordinate Themes, Participant Support, and Example Supporting Quote*

<table>
<thead>
<tr>
<th>Superordinate Theme</th>
<th>Participant Support (N=5)</th>
<th>Example Supporting Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician-patient power asymmetry can be experienced by patients of lower SES as reminiscent of previous experiences of stigma and oppression</td>
<td>5</td>
<td>“. . . like a policeman has power over you” (Participant 5)</td>
</tr>
<tr>
<td>Group differences and social positioning</td>
<td>3</td>
<td>“Accused of it and then shut right off. But these other people can shoot dope and OD on it… [and] I didn’t do . . . any of that.” (Participant 2)</td>
</tr>
<tr>
<td>Stigmatization due to factors associated with being a chronic pain patient</td>
<td>2</td>
<td>“[PCP] she (treated the patient differently because she) thinks I’m going to end up in the mental house” (Participant 4)</td>
</tr>
<tr>
<td>Stigmatization due to chronic physical and mental illness</td>
<td>2</td>
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Table 1

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</tr>
</thead>
<tbody>
<tr>
<td>Physician-patient power asymmetry can be experienced by patients of lower SES as</td>
<td>2</td>
<td>“What I was hoping some testing, and I’d be able to find out the reason why to gain (from the visit) was, first of all, that we do I was having the shortness of breath. . . . He just didn’t care about that. I felt like he looked right past that to see me in the wheelchair, . . . It made me feel like I’m not good enough, and like whatever I do or say isn’t going to really matter. I feel like I didn’t really matter, . . . because I wasn’t out running marathons. . . . Right away it put me into this mold like I’m not as good. . . . He was exerting power and it made me feel like, I’ve got to get out of here. I don’t even want to be here. He thinks I’m lower than a snake’s belly. . . . (If I were not a chair) I think that he would have taken me more seriously. I think he would have wanted to run tests, and wanted to do a lot more. . . . I just felt like if I was a regular person, and I could come in without being in a wheelchair, he would have figured it out.” (Participant 5)</td>
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<th>Superordinate Theme</th>
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<tr>
<td></td>
<td>(N=5)</td>
<td></td>
</tr>
<tr>
<td>Future visits or aspects of a treatment plan may be avoided following an unpleasant</td>
<td></td>
<td>“I don’t take nothing now cause of that. I say forget it.” (Participant 2)</td>
</tr>
<tr>
<td>medical encounter or a weakened patient-physician alliance</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Decrease concern for following recommendations and adhering to treatment</td>
<td></td>
<td>“If they keep growing, they can turn cancerous at some point. . . . But, I didn’t care after that.” (Participant 5)</td>
</tr>
<tr>
<td>Patients refuse the modality of care in which psychological oppression was triggered</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Experiencing psychological oppression in healthcare is linked to the expectation that</td>
<td>2</td>
<td>“It’s like, are they going to be a pain in the ass, or are they going to be nasty? That’s just me portraying them. They could be nice people, they could be nice doctors, but I don’t see it that way.” (Participant 3)</td>
</tr>
<tr>
<td>most medical encounters will be unpleasant</td>
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<tbody>
<tr>
<td>Personable physicians increase patient comfort</td>
<td></td>
<td></td>
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<tr>
<td>Listening</td>
<td>5</td>
<td>“She listened even though I didn’t say much.” (Participant 4)</td>
</tr>
<tr>
<td>Caring</td>
<td>5</td>
<td>“Thinking about you as a person, not just doing what she wants.” (Participant 3)</td>
</tr>
<tr>
<td>Appears interested in patients’ life</td>
<td>3</td>
<td>“He acts like a regular guy… That’s what’s really important. . . He talks and he’ll ask me, “You’ve been gone lately, how’s your family? Have you been to see your grandkids?” . . . He’ll come in talking like that, and a lot of them don’t do that.” (Participant 5)</td>
</tr>
<tr>
<td>Mutuality</td>
<td>2</td>
<td>“We’re both very open with each other.” (Participant 4)</td>
</tr>
<tr>
<td>Trust is a reciprocal construct</td>
<td>2</td>
<td>“She’s a little trusting about me. . . That’s probably why I still go see her.” (Participant 3)</td>
</tr>
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<tbody>
<tr>
<td>Anger and frustration</td>
<td>5</td>
<td>“I felt marginalized, but I also felt angry” (Participant 5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I wouldn’t have told her cause I probably would have yelled at her because I’m upset.” (Participant 4)</td>
</tr>
<tr>
<td>Symptoms of anxiety</td>
<td>5</td>
<td>“I . . . was quieter because I was nervous” (Participant 1)</td>
</tr>
<tr>
<td>Suspiciousness</td>
<td>3</td>
<td>“I think they’re testing me” (Participant 2)</td>
</tr>
<tr>
<td>Symptoms of depression</td>
<td>2</td>
<td>“Staying in bed most of the day” (Participant 4)</td>
</tr>
</tbody>
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The emotional reactions of patients contribute to their loss of voice

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Table 1

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<th>Superordinate Theme</th>
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<tbody>
<tr>
<td>Some disclosures are viewed as too risky to share with treating physicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risky disclosures in the acquisition or maintenance of medication</td>
<td>4</td>
<td>“And she says stay on the (medication). . . And I says . . . It started working for a little while but this stuff, it’s just really hurting now. I told her that. And she said just stay on that . . . And, (I said) “ok (voice fades).” (Participant 2)</td>
</tr>
<tr>
<td>Communication could result in loss of relationship</td>
<td>2</td>
<td>“I don’t want to have maybe less care because I angered him.” (Participant 5)</td>
</tr>
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Table 1

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<th>Example Supporting Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care physicians who proactively seek out and address patient dissatisfaction mend ruptures and strengthen the patient-physician relationship.</td>
<td>(N=5)</td>
<td></td>
</tr>
<tr>
<td>Controlling conflict by controlling the situation</td>
<td>3</td>
<td>“My wife had told me when I came back in that she took my daughter into the other room and told her about the medication issue, and I said, ‘Good.’ I said, ‘I’m glad somebody finally said something, because I’ve been trying to tell people all this time’ All of a sudden, me trying to say that it’s a problem turned into me getting attacked by the doctor because I’m doing wrong. . . . Yep. She said then, “This child is not going home with you,” the doctor basically gave her to this psychotic woman . . . Later, we found out the doctor couldn’t even do this.” (Participant 3)</td>
</tr>
<tr>
<td>Proactively attending to patients’ emotions repairs ruptures and strengthens relationships</td>
<td>3</td>
<td>“I just didn’t, I would not confront her but all she kept doing was asking me if I was okay because she noticed that I was quieter than usual. She noticed I was very fidgety. She kept saying, “What’s going on? I know something’s up.” I just, kind of, was fidgety, and agitated. Everything was pissing me off but I didn’t want tell her. . . . because I’m upset that she’s leaving. I felt like, you know, I’m being abandoned, deserted, thrown away like a piece of trash. But after some time she got it out of me.” (Participant 4)</td>
</tr>
</tbody>
</table>
Appendix A

Recruitment Letter and Exam and Waiting Room Flyer

Let Your Voice Be Heard!

Participants Needed for a Study on Patient-physician Communication

Dear Patient,

Learning about the experiences that you have had with your physician could help improve the patient experience for future patients.

• You will be given a $10 gift card for participating.
• The study involves a 60-minute chat, in a place that is convenient to you.
• Identifying information will not be shared.
• You may choose to review the content of our discussion.

If you would like to participate:
• You must be age 18 or greater
• Have no more than a high school degree
• Your family’s annual income must not exceed:
  o $15,800 for a family of 1
  o $21,307 for a family of 2
  o $26,813 for a family of 3
  o $32,319 for a family of 4
  o $37,825 for a family of 5
  o $43,331 for a family of 6
• You have seen your doctor at least twice in the last year

To participate or learn more about this study, contact Myah at the number or email below.
Sincerely,

Myah Caruso
How Do You and Your Physician Communicate?

Participants Needed for a Study on Patient-physician Communication

Learning about the experiences that you have had with your doctors could help improve office visits for future patients.

- Participation involves a 60 to 90-minute chat, in a place convenient to you.
- You will receive a $10 gift card for participating.
- Identifying information will not be shared.
- You may choose to review a summary of our discussion.

If you would like to participate:

- You must be age 18 or greater
- Have no more than a high school degree
- Your family’s annual income must not exceed:
  - $15,800 for a family of 1
  - $21,307 for a family of 2
  - $26,813 for a family of 3
  - $32,319 for a family of 4
  - $37,825 for a family of 5
  - $43,331 for a family of 6
- You have seen a doctor at least twice in the last 12 months

Call or email Myah Caruso for more information and to partake in the study.
Appendix B

Consent to Participate

I am a doctoral student at Antioch University New England, in Keene New Hampshire. I am asking you to take part in my dissertation. This study looks at the relationship between patients and doctors from the point of view of financially and educationally challenged patients.

What I hope to learn from you
I hope to learn about how you experience your relationship with your physician. To clarify, I would like to learn about the ways in which you and your physician communicate and how you feel about that communication. And I hope to learn about the types of interactions that encourage or discourage your involvement during office visits. During our conversation, ask you to describe both an interaction you had with a doctor that went well and an interaction you had with a doctor that went less well.

Why I want to learn about your experience
Learning about the patient-physician relationship from your perspective may help medical staff improve the patient experience for future patients.

If you decide to participate
- I will call you to arrange a place and time to meet. The place and time will be convenient to you.
- We will have a conversation that will last approximately 60 to 90 minutes. During this conversation, ask you to discuss experiences you have had with physicians.
- I may contact you to answer clarifying questions after we have had our conversation.
- You will be invited to review the findings.

Risks of participating
There are no known risks to joining this study. But, some questions may bring up unexpected emotions because I will be asking about the experiences you have had with your doctors.

I do not want you to feel pressured to participate in this conversation. During the conversation, you can choose not to answer any of my questions. You may choose to stop the interview at any time. Your involvement is voluntary and there is no penalty for quitting after signing this consent form.

I respect and will protect your privacy
At all times, information about who you are will be kept separate from what you share. For example, our conversation will be audio recorded but the recording will be identified with only a number. use the recording to take notes about our conversation. Information about who you are will not be in my notes. The study will describe what I learn from all of the participants and will not include names or identifying information. After the study is complete, the recordings will be destroyed.
Benefits to you
offer you a gift card valued at ten dollars. You will receive the gift card even if you choose not to answer some of the questions asked during our conversation. You may find our discussion rewarding. And you may gain satisfaction in knowing that your experiences might be used to improve the patient experience for future patients.

If you have any questions about this study, please contact Myah Caruso. If you have questions about your rights as a participant, you may contact the Chair of Antioch University New England research ethics committee, Kevin Lyness, at klynness@antioch.edu.

By signing this form, you are agreeing to take part in this study. Please keep a copy of this form in your personal records and contact me if you wish to withdraw from the study. Thank you in advance for your time and invaluable contribution.

I read and understand the information on this form. I understand that my involvement is voluntary and I know that I may stop participating at any time. I agree to participate in this study.

Print Name: ______________________________________

Signature: _______________________________________ Date: __________

Please leave both your telephone number and email address. And indicate the best way to contact you to schedule a time to meet.

____ Telephone Number: _______________________________ (Home/Cell/Work)

____ Email Address: __________________________________

This consent form will be kept for at least three years beyond the end of the study. This study was approved by the IRB on [date].
Appendix C

Participant Instructions for Completing Initial Information

Dear Participant,

Thank you for volunteering to participate in a study on patient-physician communication. I have enclosed the following items in this package:

- Two Consent Forms
- One Demographic Questionnaire
- Sample Interview Questions and Prompts
- Self-addressed stamped envelope

Please complete the Consent Form and Demographic Questionnaire and return them in the envelope provided. For your records, I have included an extra copy of the Consent Form. The Sample Interview Questions and Prompts have been provided to help you decide if you want to participate and to let you know what will be asked during our chat.

After I receive the Consent Form and Demographic Questionnaire, I will contact you on the phone to review the documents and answer questions you have. Please do not hesitate to contact me if any of this is unclear.

Thank you for your time.

Sincerely,

Myah Caruso

Myah Caruso, M.S.
Doctoral Candidate, Clinical Psychology
Antioch University New England
Appendix D

Demographic Information Form

Age: _____________  Sex: _____________

Primary Language: _____________

Which of the following describes the area you live in?

Rural _______  Suburban _______  Urban _______

Marital Status: _______

Number of people living in your household: _______

Number of dependent children: _______

With which racial or ethnic group do you identify (check one):

_____ Latino/Hispanic American

_____ European American/White

_____ African American/Black

_____ Biracial or Multiracial (please specify): ____________________________

_____ African American/Black

_____ East Asian or Asian American

_____ South Asian or Indian American

_____ Middle Eastern or Arab American

_____ Native American/Alaska Native

_____ Asian American/ Pacific Islander

_____ Other (please specify): ____________________________

Education

What is the highest level of education have you completed? _______

How many years of education have you completed (excluding kindergarten)? _______
Employment
Are you currently employed? Yes_______ No_______
If no, how long have you been unemployed? Please specify: ______
If yes, what is the title of your job? _____________
Does your income exceed $15,200.00 annually? Yes_______ No_______
Estimated Annual Income (optional): _____________
Estimated number of year that your income has not exceeded $15,200? ________
Do you have health insurance? Yes_______ No_______

Relationship with Physician
Estimated length of time that you have been with your current physician: ________
Number of times you had an appointment with your physician in the last year: ________
Purpose of your last visit (optional): _____________
What language do you speak with your physician during medical exams? Please specify: ________

Health Status
Have you been diagnosed with one or more chronic illnesses? Yes_______ No_______
If yes, what illness or illnesses have you been diagnosed with?
Please specify: ______________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Thank you for completing this survey. Your responses will be anonymous in the reporting of demographic information.
CLIENT NON-DISCLOSURE AGREEMENT

This CLIENT NON-DISCLOSURE AGREEMENT, effective as of the date last set forth below (this “Agreement”), between the undersigned actual or potential client (“Client”) and Rev.com, Inc. (“Rev.com”) is made to confirm the understanding and agreement of the parties hereto with respect to certain proprietary information being provided to Rev.com for the purpose of performing translation, transcription, video captions and other document related services (the “Rev.com Services”). In consideration for the mutual agreements contained herein and the other provisions of this Agreement, the parties hereto agree as follows:

1. **Scope of Confidential Information**

   1.1. “Confidential Information” means, subject to the exceptions set forth in Section 1.2 hereof, any documents or other text supplied by Client to Rev.com for the purpose of performing the Rev.com Services.

   1.2. Confidential Information does not include information that: (i) was available to Rev.com prior to disclosure of such information by Client and free of any confidentiality obligation in favor of Client known to Rev.com at the time of disclosure; (ii) is made available to Rev.com from a third party not known by Rev.com at the time of such availability to be subject to a confidentiality obligation in favor of Client; (iii) is made available to third parties by Client without restriction on the disclosure of such information; (iv) is or becomes available to the public other than as a result of disclosure by Rev.com prohibited by this Agreement; or (v) is developed independently by Rev.com or Rev.com’s directors, officers, members, partners, employees, consultants, contractors, agents, representatives or affiliated entities (collectively, “Associated Persons”).

2. **Use and Disclosure of Confidential Information**

   2.1. Rev.com will keep secret and will not disclose to anyone any of the Confidential Information, other than furnishing the Confidential Information to Associated Persons; provided that such Associated Persons are bound by agreements respecting confidential information. Rev.com will not use any of the Confidential Information for any purpose other than performing the Rev.com Services on Client’s behalf. Rev.com will use reasonable care and adequate measures to protect the security of the Confidential Information and to attempt to prevent any Confidential Information from being disclosed or otherwise made available to unauthorized persons or used in violation of the foregoing.

   2.2. Notwithstanding anything to the contrary herein, Rev.com is free to make, and this Agreement does not restrict, disclosure of any Confidential Information in a judicial, legislative or administrative investigation or proceeding or to a government or other regulatory agency; provided that, if permitted by law, Rev.com provides to Client prior notice of the intended disclosure and permits Client to intervene therein to protect its interests in the Confidential Information, and cooperate and assist Client in seeking to obtain such protection.

3. **Certain Rights and Limitations**

   3.1. All Confidential Information will remain the property of Client.

   3.2. This Agreement imposes no obligations on either party to purchase, sell, license, transfer or otherwise transact in any products, services or technology.

4. **Termination**

   4.1. Upon Client’s written request, Rev.com agrees to use good faith efforts to return promptly to Client any Confidential Information that is in writing and in the possession of Rev.com and to certify the return or destruction of all Confidential Information; provided that Rev.com may retain a summary description of Confidential Information for archival purposes.

   4.2. The rights and obligations of the parties hereto contained in Sections 2 (Use and Disclosure of Confidential Information) (subject to Section 2.1), 3 (Certain Rights and Limitations), 4 (Termination), and 5 (Miscellaneous) will survive the return of any tangible embodiments of Confidential Information and any termination of this Agreement.

5. **Miscellaneous**

   5.1. Client and Rev.com are independent contractors and will so represent themselves in all regards. Nothing in this Agreement will be construed to make either party the agent or legal representative of the other or to make the parties partners or joint venturers, and neither party may bind the other in any way. This Agreement will be governed by and construed in accordance with the laws of the State of California governing such agreements, without regard to conflicts-of-law principles. The sole and exclusive jurisdiction and venue for any litigation arising out of this Agreement shall be an appropriate federal or state court located in the State of California, and the parties agree not to raise, and waive, any objections or defenses based upon venue or forum non conveniens. This Agreement (together with any
agreement for the Rev.com Services) contains the complete and exclusive agreement of the parties with respect to the subject matter hereof and supersedes all prior agreements and understandings with respect thereto, whether written or oral, express or implied. If any provision of this Agreement is held invalid, illegal or unenforceable by a court of competent jurisdiction, such will not affect any other provision of this Agreement, which will remain in full force and effect. No amendment or alteration of the terms of this Agreement will be effective unless made in writing and executed by both parties hereto. A failure or delay in exercising any right in respect to this Agreement will not be presumed to operate as a waiver, and a single or partial exercise of any right will not be presumed to preclude any subsequent or further exercise of that right or the exercise of any other right. Any modification or waiver of any provision of this Agreement will not be effective unless made in writing. Any such waiver will be effective only in the specific instance and for the purpose given.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed below by their duly authorized signatories.

CLIENT

Print Name: Myah Caruso

REV.COM, INC.

Name: Cheryl Brown
Title: Account Manager
March 15, 2016 February 1, 2016

Date: November 24, 2015
Address for notices to Rev.com, Inc.:
251 Kearny St. Suite 800 San Francisco, CA 94108

LIBC/4524740.1

Page 2
Appendix F

Participant Instructions for Member Check

Dear Participant,

Thank you for participating in this study.

Below, are themes that I may be using in the final product of this study. Themes have been identified based on the frequency with which they appeared amongst interviews. Themes capture the fundamental meanings and quality of part of the text (interview transcript).

Under each theme is the quote it is based on. Some of the passages contain more than what was used to extract the theme. This extra material has been included for context and to help jog your memory.

As discussed, you are invited to read through the themes and quotes to assess whether my interpretation conveys what you meant. The passages included may hold several meanings so what you are looking for is that the theme lays somewhere within the quote. In most instances, the part of the quote the theme is derived from is in bold print. If the theme I have chosen is not reflected in the passage, please write a response below the passage and send relevant parts of the transcript back to me.

A large and small self-addressed envelope and five stamps have been included to cover the costs and increase the ease of returning relevant portions of the tables. As discussed, this is optional. I understand this is time consuming and hope you know that you will not be judged should you not have the time or desire to complete this step. Should you have any questions, please do not hesitate to call.

Thank you for your time.

Sincerely,

Myah Caruso

Myah Caruso, M.S.
Doctoral Candidate, Clinical Psychology
Antioch University New England