

# **Patient-Physician Interactions with Minority Communities**

**Ivana Premasinghe**

A qualitative research study: Interviews with patients and  
physicians in the United States

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## **Abstract**

While there are many studies that highlight lack of access as a barrier to healthcare for minority communities, fewer studies examine the actual patient-physician interactions that occur in the doctor's office. This thesis examines patient-physician interactions as reported by patients and physicians, aiming at accounting for their experiences in the general context of healthcare service. Five important topics were discovered within the literature, and these topics were used as the background to generate patient interview questions and physician questionnaires (surveys). The topics were as follows: general information on diversity and accessibility of medical practice, patient-physician interactions, translation services, medical interpreter services, and the medical community.

Through the responses of these interviews/questionnaires, three main themes were revealed as relevant: 1.) Patients' reported experiences about their interactions with the doctors and the healthcare system, 2.) What doctors know and understand about the minority communities they are serving, and 3.) Potential best practices for health care professionals to better serve minority and unprivileged communities (as referred by patients and physicians). These themes and their various subthemes were analyzed and used to generate various proposals and future directions of patient-physician research.

## **Table of Contents**

Introduction .....	4
Theoretical framework .....	5
Methods .....	18
Results .....	21
Conclusions and future directions .....	33
Acknowledgments .....	40
Bibliography .....	40
Appendix .....	44

## **Introduction**

Patient-physician interactions is a “hot topic” within literature of the current decade (Ha & Longnecker, 2010), especially as technology and other advances continue within the medical field and interactions with minority communities increases. However, much of the current discussion on patient-physician interaction with these minority communities comes in terms of access to adequate health insurance, transportation, or doctors (Bulatao, Anderson, & National Research Council (US) Panel on Race, 2004). While this topic is important and relevant to the topic of patient-physician interactions, a less studied aspect of this interaction is the actual dynamic between the patient and physician once the patient makes it to the doctor’s office—specifically in the examination room. How do minority issues, barriers, and aspects of identity come into play and manifest themselves in these interactions? Given patient confidentiality, time constraints, and other aspects of the healthcare process, this is a more difficult topic to explore in the examination room and therefore must be examined through other mechanisms.

My research seeks to address three important topics of this more intimate aspect of patient physician interactions. They are as follows: 1.) Patients’ reported experiences about their interactions with the doctors and the healthcare system, 2.) What doctors know and understand about the minority communities they are serving, and 3.) Potential best practices for health care professionals to better serve minority and unprivileged communities (as referred by patients and physicians). This research aims at developing a deeper understanding of the actual interaction from the point of view of both physicians and patients in order to further our knowledge of healthcare services from the inside out.

As an aspiring physician, this topic is of personal importance to me as well. The importance of patient satisfaction and being able to offer a dignifying service is irrevocable. It is

important for future physicians to examine the issues and difficulties faced by patients in order to be more aware and culturally competent doctors and address the gap between doctors and patients.

### **Theoretical Framework**

In this section, I will discuss the theoretical framework that supports this research. There are five topics that arose from the literature review conducted and those same five topics defined the design of the methodology implemented: surveys and interviews. These topics were as follows: general information on diversity and accessibility of medical practice, patient-physician interactions, translation services, medical interpreter services, and the medical community.

It is important to note that while these topics have been explored through various studies (Bulatao et al., 2004), there are many aspects of patient-physician interactions that have not been explored sufficiently. Due to patient confidentiality, liability, and other similar reasons, it is often difficult to obtain data in order to analyze the actual interactions that take place between patients and physicians during their appointments. Moreover, in order to address this methodological difficulty, researchers often resort to polling demographic and satisfaction results from general census information. Nonetheless, it is necessary to examine studies that have explored patient-physician interactions because although limited, they provide relevant information important to determine future (and innovative) research.

### **Diversity and accessibility of medical practice**

One of the most well-studied aspects of patient-physician interactions is the general demographics and barriers that take place prior to the actual encounter between the patient and

the doctor. These include geographical barriers, interactions with front desk staff at hospital, and lack of proper criteria to see a doctor (Bulatao et al., 2004). While it is important to examine patient-physician interactions that take place within the doctor's office, it is important to first be acquainted with these more general access barriers that impede minority patients from receiving proper access to treatment.

The first aspect that is affected by access is choice of physician, specifically with patients that fall within minority communities (Association of American Medical Colleges, n.d.). Before arriving to the doctor's office, patients must go through the process of selecting their doctor, and while this option is not always directly given to them, it is important to note critical trends when they are given this option. A study conducted by the Association of American Medical Colleges (AAMC) noted that minority patients, "are more likely to choose someone of their own racial and ethnic background" as their health care professional, when given the choice (Association of American Medical Colleges, n.d.).

However, it is not always likely that members of minority communities will have the opportunity to have a doctor of their own racial and ethnic backgrounds. For example, the same study notes that there is a 5:1 ratio of white to Hispanic citizens within the United States, with 13.2% of citizens being Hispanic. Yet, only 2.8% of all physicians in the United States are Hispanic, indicating a clear discrepancy between the percentage of Hispanics within the community and the percentage of Hispanics who are medical professionals (Association of American Medical Colleges, n.d.). Therefore, statistically, a Hispanic person cannot be guaranteed that he or she will be able to have a Hispanic doctor. This gap between Hispanic patients versus Hispanic physicians is projected to continue growing, causing an even larger discrepancy over time.

The AAMC predicts that by 2050, racial and ethnic minorities will account for approximately half of the population in the United States, yet there is no such trend with regards to minority physicians (Association of American Medical Colleges, n.d.). While ethnicity is an important factor, this study also noted similar trends of physician selection with regards to culture. This provides an even more complex aspect to this problem, as a doctor could be someone's ethnicity or race, yet he or she may not share your same cultural beliefs (Association of American Medical Colleges, n.d.). For example, first generation immigrants and second generation immigrants may have differences in their own cultural values, regardless of their overlapping ethnicities. Thus, the concepts of race/ethnicity combined with culture represent one of the primary instances where, while patients may appear to have a choice, patients are not necessarily influencing the type of care they will receive based on shared racial or ethnic background as the doctor they choose.

Another issue to consider within the realm of accessibility is language when interacting with health personnel. While this is notable in interactions between patients and physicians, this is also relevant at the level of non-provider interactions which are defined as interactions between the patient and the front office staff at a health clinic (Calo et al., 2015). Calo et al.'s research on Latinos with limited proficiency in English (2015) discovered that there were many overlapping issues that these patients faced within their non-provider interactions at their hospitals- specifically due to language differences (Calo et al., 2015). Some of the issues they noted were: issues with registration due to multiple surnames and subsequent delays and misidentification of patients, insufficient Spanish language services at the front desk negatively impacting care, and perceived discrimination in front office staff causing mistrust and discomfort with services.

As I mentioned before, the concept of patient comfort and discomfort is an important trend to consider. Various aspects of registration difficulties, lack of Spanish language at the front desk (for Spanish monolingual or Spanish dominant speakers), and perceived discrimination are themes that play both a theoretical and historic role in Latinos and the access to healthcare on a larger scale (Calo et al., 2015). While it is apparent that the United States could become the largest Spanish-speaking country in the world by 2050 (“U.S. Will Be Biggest Spanish-Speaking Country by 2050, Says Scholar - New America Media,” n.d.), it is still apparent that lack of access to language resources plays a pertinent role in patient care and comfort levels. The issue of language holds true not only for Spanish speakers, but for many others as well (Meuter, Gallois, Segalowitz, Ryder, & Hocking, 2015), yet this is exacerbated by the presence of indigenous languages spoken by immigrants from Mexico and Central America.

Another crucial aspect of accessibility is access to adequate health insurance for a patients in general and patients from minority groups in particular. One study particularly highlights the problems of insurance for Hispanic patients, noting that, “Hispanics are substantially more likely than non-Hispanic whites or African Americans to lack health insurance,” noting that the rates of uninsured Hispanic adults and children are two to three times higher than the rates for non-Hispanic whites (Doty, 2003).

The inequities in reference to health insurance creates a clear difficulty for Latino patients in terms of access to basic medical care, limiting access to the healthcare system as a whole. Doty’s 2003 study notes that of the Hispanic people who had health problems, only 69% percent of them had at least one medical visit within the past year, as opposed to the percentage of white (83%) and African American (84%) of adults with significant health problems. While lack of insurance may not be the only cause of these differences, it plays a significant role, as

visits to the doctor's office often require insurance as paying from pocket is not always a viable option (Doty, 2003).

### **Patient-physician interactions**

Although there are barriers that cause initial discomfort or difficulties before arriving at the visit with the doctor, it is important to consider the issue of patient-physician interactions highlighting the actual interaction between the patient and doctor in their appointment. It is important for doctors to take into account various aspects of the patient identity and world view in order engage in healthy interactions with their the patients.

One of these aspects involves the doctor's perception on the identity of their patients, and the assumptions made when communicating with them. Specifically, it is important to examine the discourse. When looking at discourse, research examines the ways in which people have been socialized, and uses this concept as a primary factor that influences the communication and forms of speech that one uses when interacting with others (Ron Scollon, Suzanne Wong Scollon, & Rodney H. Jones, 2012).

Since one's actions are largely based on discourse and interactions within one's communities, the patient-physician interactions is also susceptible to this model. More concretely, we can apply the framework of situation-bound discourse versus identity-bound discourse to the study of patient-physician interactions take into account (Ron Scollon et al., 2012). Situation-bound discourse encompasses the more professional context, while identity-bound discourse examines aspects such as generation, gender, and sexuality. Individuals are a part of multiple discourse systems at the same time, influencing our interactions in more way than one (Ron Scollon et al., 2012.)

The concept of overlapping discourses also lends to the use of the phrase “discourse systems” as opposed as “culture”, implying that culture is not just associated with ethnicity and nation of origin but culture is shaped and informed by discourse systems. Therefore, through the concept of discourse, it becomes clear that doctors must acknowledge the fact that they (themselves) and their patients have overlapping discourse systems, and that both their situation-bound and identity-bound discourse are relevant within their own interactions. It is also important for doctors to take into account all of these various aspects of identity that inform interactions (age, gender, ethnic identity, etc.), as opposed to solely examining the concept of culture as race and ethnicity (Ron Scollon et al., 2012).

Aside from the doctor’s own need to consider various aspects of the patient’s identity, it is also important for doctors to become aware of various psychological responses to specific type of patients that could inherently affect their treatment of these patients. One such phenomenon is implicit bias (Chapman, Kaatz, & Carnes, 2013).

Implicit bias refers to the unconscious stereotypes and attitudes that affect understanding, actions, and decisions. This often comes manifests itself in various social identifiers, such as of a particular race, ethnicity, or other identifying group.

One study attempted to examine implicit bias within the medical field, through the use of the Primary Care Assessment Survey, which was given to 2908 patients regarding the communication, interpersonal treatment, trust, and knowledge of their clinicians (Chapman, Kaatz, & Carnes, 2013). They coupled this survey with tests of implicit bias, to determine whether there was an association between physician ratings and amount of implicit bias. Implicit bias was measured through a standard Implicit Association Tet (IAT), where participants must sort photographs of various ethnicities and subsequently sort words such as “joy, wonderful,

agony, horrible” into “good” and “bad” categories. After sorting these, the two stimuli are combined, and participants must quickly select which ethnicity corresponds to a “good” or “bad” word to assess implicit associations with various ethnicities and good/bad qualities. The researchers noted a low level of bias among clinicians, but more importantly, they noted that clinicians with greater implicit bias were rated lower in patient-centered care, specifically by black patients more so than their white patients. It was also noted that Latino patients gave clinicians lower ratings than the other groups in general. Thus, implicit bias may come into play on various levels of patient identity, including race. The study notes the importance of exposing physicians to bias-reducing strategies, which serve as methods of consciously becoming aware of patient’s perspectives and focusing less on their cultural identifiers (Chapman et al., 2013).

### **Translation services**

Translation services come in many forms, one of the most common being automated translation on a phone system. However, these phone systems are not available to all clinics, and do not include all languages within their servers. Therefore, it is sometimes necessary for doctors to resort to different methods of translation.

In occasions, doctors must resort to the use of Google Translate to communicate with a patient. One of the primary concerns with the use of this such translation method is the accuracy of the translation, as translation does not consider context and often utilizes a direct translation of words, as opposed to looking for more accurate words in the foreign language to describe something. This becomes even more burdensome in the medical field. Although Google Translate includes key words and phrases in other languages, it does not necessarily translate medical terminology accurately. One study in 2014 tested the use of Google Translate within the medical community to determine its accuracy. While one doctor told a patient’s spouse, “Your

husband had a cardiac arrest,” this translated into, “Your husband had an imprisonment of heart” in her language of Marathi (Sumant Patil, 2014). In another instance, the translation of, “Your child is fitting” was changed to, “Your child is dead,” when translated to Swahili. These examples are just a few of the numerous cases that note the difficulty with utilizing an automated translator to convey crucial medical information to patients and loved ones.

While translation can cause difficulties in understanding on the patient side, due to loss of correct meaning in the automated translation, it is also important to note that translation can have an effect on physicians as well. Proper translations from the patient’s native language to the physician’s language are imperative to providing patients with proper remedies for their illness. Improper translation can cause serious effects for patients, as seen in many famous cases, such as the story of Willie Ramirez, a famous baseball player who became quadriplegic due to a faulty translation. The Spanish word for food poisoning is “intoxicado,” yet without a proper translation of this word to English, it can be misconstrued as the word “intoxicated.” When the doctor misunderstood this word, he prescribed Ramirez with a remedy for drug overdose, rendering him quadriplegic since he did not actually have an issue with drugs (Sumant Patil, 2014). Therefore, it is important to note the importance of translation not only from the point of view to inform the patient, but also in order to properly inform patients to provide them with adequate care.

### **Medical interpreter services**

While translation services provide the patients with translation, it is apparent that these automated services are sometimes faulty. Also the use of less personable methods of translation can often take some the emotion out of the doctor-patient dialogue. For these reasons among others, many health care facilities chose to utilize medical interpreter services instead, where a

real person provides the translation between doctor and patient. While this concept appears to better the automated translation errors and provide more personable interactions, it is also crucial for these interpreters to be properly trained.

One study examined how cancer physicians communicated with limited English proficient (LEP) patients, specifically focusing on interpretation services (Rose et al., 2010). Within the Los Angeles Women's Health Study, it was noted that, "42 percent [of physicians] reported using trained medical interpreters, 21 percent telephone interpreter services, and 75 percent reported using untrained interpreters to communicate with LEP patients" (Rose et al., 2010). However, the study went on to confirm that, "only one-third of physicians reported good availability of trained medical interpreters or telephone interpreter services when needed." This addresses two important aspects of medical interpretation, one being the clear lack of trained medical interpreters, and the other being actual availability of these trained interpreters.

While it appears that untrained medical interpreters are filling the gap for needing more interpreters, it is also necessary for these interactions to use correct translation, as lack of proper care could have, "troubling implications" for effect patient-physician communication, which is critical during cancer treatment and other forms of treatment (Rose et al., 2010).

The argument for more medical interpreter services is strong, nevertheless, it is also important to realize why these services are not always present in a given hospital. Aside from the lack of actual interpreters, health care facilities must also consider price as an important factor when deciding how many interpreters they can have at their clinic (Shaddox, 2011). It is noted that, "interpretation services are costly and paid for by hospitals, clinics, and individual doctors" (Shaddox, 2011). There are two types of interpretation services: in-person and telephone interpretation services. In-person interpretation encompass the larger cost burden, as professional

interpretation for Medicaid patients has and, “estimated [cost of] \$4.7 million yearly” (Shaddox, 2011). While the federal government is expected to reimburse half of this amount, the rest of this large sum of money must be paid by hospital funds, clinics, and out of doctors’ salaries.

This larger cost of face-to-face interpretation also then becomes difficult for smaller practices with less funding, who are often incapable of paying for in-person interpretation service. However, telephone interpreter services are also costly, as this is a pay-by-minute service. Since it is often stated that interpretation can double the time of an appointment, the price quickly becomes noticeable. Thus while the need for interpreters is large, clinics must also take into account the funding they have allotted for medical interpretation services (Shaddox, 2011).

### **The medical community**

While it is important to consider all of the aspects from the point of view of the patient, it is also important to examine the other side of this situation, the side of the physicians. To determine the effects of patient-physician interactions in order to improve them, it is important to explore the physicians’ viewpoint.

However, this is a more difficult field to study. Examining the actual physician opinions and their interactions with patients is difficult due to a number of reasons, including confidentiality and a lack thereof much information from the actual interactions. The current literature on the topic discusses research that has evaluated patient satisfaction surveys and other similar information to gage more qualitative descriptions of these interactions, specifically to examine the physician point of view and patient satisfaction of the physician’s interactions ((Johnson, Roter, Powe, & Cooper, 2004).

One aspect of the patient-physician interaction (from the perspective of the physician) is affect, defined as emotional tone (Johnson et al., 2004). Affect can be studied in how it potentially changes interactions depending on with whom the physician is interacting. One study examined the patient and physician levels of positive affect when interacting with White patients versus African American patients (Johnson et al., 2004). In this study, physicians gave ratings of their positive affect when interacting with their patients, which ranged from 1 (low/none) to 6 (high). The ratings were based on interactions between patients and physicians during their appointments. Ratings were shown to be lower when the physicians were interacting with African American patients. The researchers defined affect a key component to interactions, as it encompasses both the tone and the, “unspoken subtext” of the dialogue between a patient and physician. Furthermore, the physicians were shown to be more verbally dominant with African American patients than with White patients, also noting that the visits with African American patients were less patient centered (Johnson et al., 2004).

Another aspect of these interactions comes from patient satisfaction surveys, specifically going back to see the opinions and perspectives of the minority populations. One study in Britain conducted a General Practice Assessment Questionnaire for patients that were white, black/black British, Asian/Asian British, or Chinese- specifically examining why minority patients tend to give poorer care evaluations after their visits (Mead & Roland, 2009). Through rating many aspects of care, it became apparent to researchers that the ethnic minorities gave substantially lower ratings on time spent waiting for consultations to begin and continuity of care than their white counterparts. The researchers made a point that there may be different expectation of care across different ethnicities, which is something that must be taken into consideration in order to honestly meet patient expectations. They also noted that, “issues

relating to communication with practice staff played a part in explaining lower evaluations of appointment waiting times among black and Chinese patients compared with white respondents,” (Mead & Roland, 2009).

On that study, it is important to note that after researchers adjusted for ratings of receptions and general practitioner communication, there was not as noticeable of a difference in rating between black and Chinese patients compared to white patients. Thus, this suggested that cultural dissonance and language difficulties may have caused the ethnic minorities to rate their care more negatively than the white patients. Therefore, while the examination of waiting time and duration of care may seem more indirect in their relation to direct patient-physician interactions, it is important to consider that these differences in ratings and ideas signify potential differences in cultural expectations (Mead & Roland, 2009).

While it is important to examine patients’ opinion of the patient-physician interactions, it is also important to examine what physicians *do* know about barriers facing minority communities (Pinto, Mccaskill-Stevens, Wolfe, & Marcus, 2000).

One study examined physicians’ perspective on what was preventing minority patients from taking part in clinical trials. They noted that many fewer minority patients participated in these clinical trials compared to white patients. When discussing potential reasons, the physicians noted that the patients and their families were sometimes fearful of the research, had a lack of information, and held a perception that physicians do not given clinical traits to minority communities.

Some examples show that forty five percent of doctors noted that racial bias was a barrier to African American enrollment in clinical trials. Another study noted that Asians were less

familiar with the term “clinical trial” or more likely to incorrectly define the term “clinical trial” compared to non-Asians (Paterniti et al., 2005). It is important that physicians continue to have these such conversations to begin to examine potential barriers in minority access to healthcare resources. Through physician advocacy and understanding, they can begin to create a more communicative and comfortable setting for successful patient-physician interactions to take place.

### **Implementing the theoretical framework**

Five topics of importance were discovered through the literature, and were incorporated into the theoretical framework: general information on diversity and accessibility of medical practice, patient-physician interactions, translation services, medical interpreter services, and the medical community. The literature on diversity and accessibility of the medical practice highlights difficulties of language, health insurance, and doctor selection. Research on patient-physician interactions discusses various aspects of bias and identity that can influence interactions between patients and physicians. Literature on translation services and medical interpretation services highlight the potential benefits and difficulties of these services for patients and doctors. Finally, research on the medical community examines differential treatment and interactions with patients based on various aspects of their identity. These give topics and their relevant themes were used to create the questions for the physician questionnaire and patients interviews in my study. Questions were created with regards to identity of patients and physicians, accessibility of the practice, experiences with medical interpretation services and translational services, and questions regarding the treatment and interactions with patients.

## **Methods**

The purpose of this study was to examine the questions of doctor-patient interactions from the point of view of the physicians and the patients to develop more insight into these perspectives from both points of view. Therefore, the methodology reflects this goal through the incorporation of patient interviews and physician questionnaires. The full list of questions from the interview and questionnaire can be located in Appendix 1 and 2. The overall theme that were explored through the questions in the interviews and questionnaire were as follows: general questions, patient-physician interactions, medical interpretation, translational services, and the medical community. The interviews and questionnaire took place over a one year time frame, and both were approved by the Duke University IRB.

### **Physician methods**

Physicians and health professionals were given an online questionnaire to complete. The questions were open-ended questions where the participant was able to type answers of any length. The survey was completed by physicians, nurses, and nurse practitioners.

The physician questions were selected through analysis of important themes that appeared in the literature review. For example, the literature review emphasized translation and medical interpretation services; therefore, questions were formed to assess physicians' opinions on these topics. Similarly, the literature review emphasized importance aspects of patient-physician communication and differences in groups that both parties identified with. Therefore, this questionnaire includes some questions related to various differences between the physician and patients, as well as questions about communication dynamics between the patient and physician.

The physician questionnaire follows a general trend of questions about ethnicity differences between the doctor and patient, geographical accessibility of the office, questions about the dynamics of interactions between patients and physicians, as well as various questions about any medical interpreter or translational services. For a complete list of questions from the physician questionnaire, please see Appendix A.

There were 10 healthcare professionals that completed the questionnaire. They were from various locations in the United States. Specifically, five doctors, one nurse, one nurse practitioner, and three medical students completed the survey. Five of the participants identified themselves as members of a minority community, while five expressed that they were not members of a minority community. No other demographic questions were collected from the participants.

### **Patient methods**

Patients participated in one-on one interviews. The questions were open-ended, and additional questions could be added based on the responses of the patients (ex. to ask patients to elaborate on an experience, etc.) Patients of various demographics participated in the interview, including patients of various ethnic minority groups.

Again, since the themes of medical interpretation and translational services were pertinent in the literature review, questions on these topics were included in the patient interview. Similar to the physician questionnaire, this interview also asked questions about the various identity differences between the patient and the physician, as well as questions about patient-physician communication. The interviews were audio recorded and patients were given

compensation for participating. No personally identifiable information was collected for the interviews.

As a whole, the questions about patient cover a variety of topics relating to demographics, ease of access to the doctor's office, medical interpretation and translational services, and questions about the ways that doctors can improve their knowledge and ideas about the minority communities that they serve. For a list of all of the questions listed in the interview, please see the Appendix B.

As part of the process of working with human subjects, in order to fulfill this research, I presented and was approved an IRB protocol.

The purpose of this study was to examine the questions of doctor-patient interactions from the point of view of the physicians and the patients to develop more insight into these perspectives from both points of view. Therefore, the methodology reflects this goal through the incorporation of patient interviews and physician questionnaires. The interviews and questionnaires are listed below, and all follow the five themes laid out in the introduction: general questions, patient-physician interactions, medical interpretation, translational services, and the medical community. The interviews and questionnaire took place over a one year time frame, and both were approved by the Duke University IRB.

There were seven patients who completed the interviews. They included five people who identified as Asian (three South Asian and two East Asian), one who identified as Latino, and one who identified as Caucasian. Three of the participants were between the ages of 20-30, two between the age of 50-60, and two between the age of 10-20 years old.

## **Results**

As discussed in previous sections, the literature review included five sections. These sections helped to design a questionnaire for physicians and the interviews with patients.

Through the responses from the questionnaire and the interview, three major themes were noted.

These are listed below:

- 1. Patients' reported experience about their interactions with the doctors and healthcare system*
- 2. What doctors know and understand about the minority communities they are serving*
- 3. Best practices for health care professionals for better serve minority and unprivileged communities.*

Theme 1 focused on the answers obtained from the patient surveys, while theme 2 focused on answers obtained from the physician surveys. Finally, theme 3 encompassed information that was conveyed in the patient surveys and the physician surveys. Participants were asked questions according to the questionnaires (for physicians) and interview questions (for patients) that are listed in the methods section. The interviews were conducted and then three themes were created from the compilation of interviews. Within each theme, there are 3-5 subthemes/topics that will be discussed below. All quotes are taken from the physician questionnaires and patient interviews.

### **Patients' reported experience about their interactions with the doctors and healthcare system**

To address the first theme, I conducted a thematic analysis of the patient interviews. There were four subthemes that came about through the results of my studies: patient dignity, the need for more information, cultural competence, and ease in the process.

The first subtheme is patient dignity. The concept of patient dignity can be separated into various aspects, including patient comfort/ease with the doctor, and being treated as a person. With regards to comfort, patients emphasized that they wanted to feel comfortable during their visit. To arrive at this state of comfort, one of the patients expressed that she feels more comfortable during her visit when her physician asks, “questions about school and said I look good.” She notes that it is, “such a difference,” when comparing this to her experience with a different doctor’s office, where they did not ask these questions. Hearing these questions beginning of her appointment makes her feel more at ease, less anxious. Other patients appreciate comfort in the actual diagnosis setting. One patient expresses that it makes her more comfortable when he explains that some of her changes in health, “are natural,” and are, “something that happens to everyone as you get older.” The extra few statements of kindness from her doctor help to add comfort and ease to her interaction. Another patient notes that he feels that his doctor, “is a very good listener,” which makes him feel more comfortable.

According to patients a warm up conversation is a nice contrast from just talking about disease or sickness. Patient comfort also was relevant in other contexts as well, specifically in medical interpretation. Patients who informally interpreted for an elderly family members noted that their family member, “felt much more comfortable when their family member was in the room with them providing information.” Overall, informal interpretation by a family member is not best practice and should not be recommended as a regular means of interpretation services. However, it *is* relevant that patients felt more comfortable with their family member in the room, engaging in this conversation with the patient and the physician.

The idea of comfort and speaking about other topics other than illness transition smoothly into the second theme: being treated as a person. Patients note the importance of, “making [them]

more of a person rather than just a patient,” during their interactions with their physician. Patients emphasized that they want to be treated as more than just an illness when she was speaking to her physician. Patients also note the importance of physicians to be, “kind and compassionate” to help patients feel like they are more just their disease. What patients interpret as kindness can also be included in the overarching concept of dignity. The concept of warm up conversations and kindness both lower patient anxiety levels that are produced by a visit to the doctor’s office. Patients regard both of these practices positively, and note that these enhance their experience with the doctor.

The second subtheme was the patients’ need for more information, which encompasses multiple aspects of the patient-physician dynamic. First, patients noted that they more information about her prescriptions from the doctor, instead of just receiving the form to give to the pharmacy. One patient notes that, “sometimes the medical words or diagnosis is hard to understand,” and it would help when her doctor, “wrote down a medication or prescription” to help her better understand the information. Another patient mentions that it is helpful when the doctor gives more context around the diagnosis and its cause. She notes that her doctor tells her, “when you are growing older, this is what happens to [this part of the body],” which helps her to put her health information in context. Patients also indicated that they like more information about the vaccines they are taking. One patient notes that it is very helpful when his doctor uses, “diagrams and pictures to explain what he thinks the problem is.” Aside from more information relating just to the illness of the patient, patients also noted that they wanted more general health information, such as, “explaining what protein is and why [it] is important,” as well as pamphlets of food pyramids or food plates, showing the correct proportions of different types of food to eat. Specifically, patients noted that it would be, “great if these pamphlets were also in different

languages,” such as the patients’ native languages, so that they are better able to understand the information provided to them. This “information” concept is equivalent to expressing the need to be educated beyond the context of the visit.

The third subtheme, cultural competence, was also heavily expressed by the patients. Specifically, patients noted the importance for physicians continue to develop, “just a general sense of cultural awareness within healthcare,” and to become more aware of prevalent issues faced by these communities. They emphasize that, “it’s important for doctors to not just acknowledge that there are cultural differences, but to actively try to address them in meetings rather than passively be tolerant to patients bringing them up.” Additionally, patients noted that it is not just enough to know about these minority health issues, but that physicians should have a better understanding of the differences between minority cultures and the physician’s own culture. For example, one patient said that her culture values herbal medicine and home remedies, yet her physician does not make any acknowledgment of these options when treating her. While she noted that this was not necessarily bad, she thought it would be very interesting if the physician was actually aware of the importance of these remedies in her culture and would maybe take these into consideration, by, “speaking to these [patients] about Non-western medical practices and specifically bring them up themselves.” Other patients note that the doctor should more generally, “get to know [patients] what their world views are,” and to, “have a dialogue with the patients to find out whether they go about doing certain things differently.” Similarly, other patients note that it is helpful when doctors, “educate themselves about the prevalence of certain illnesses among different ethnic groups, to better understand potential causes of the illness.” Some patients note that an early step in this process is for doctors to, “become aware of

where they fall,” in terms of knowledge of culture and empathy towards patients of different cultures, in order to work towards better cultural competency.

The fourth subtheme was ease in the process. Aside from insurance<sup>1</sup>, geographical access to the doctor’s office also limited some patients in selecting their doctor. Location and distance tended to be large deciding factors when selecting a doctor, and public transportation costs would often play a role in the selection process for people who lived in urban cities. One patient stated that, “the major [way I selected my doctor was due to] convenience,” and other patients note that the, “biggest thing in terms of access was how long it would take to get there.”

In general, these themes highlight many important aspects of patient satisfaction. What we can observe is that the complexity of the system (insurance, proximity) affects many times negatively how patients engage with the process of making doctor appointments and selecting a practitioner. It is likely that this complication conditions the patient as he/she arrives at the doctor’s office. For example, if a patient already did not receive their top choice of a doctor based on demographic categorization, or the patient has had difficulties with health insurance, these events already create a sense of discomfort and hardship for the patients before they even enter the doctor’s office. Therefore, encountering a more welcoming and dignified office is important for a patient.

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<sup>1</sup> Insurance was an issue that was pertinent to all patients as opposed to just a minority group. Patients noted that there were not sufficient insurance options for different types of families. For example, some patients lived by themselves, but their insurance included benefits for child dental care. Thus, although the patients did not have children, they still had to pay the extra cost of child dental care, since there were no insurance options for their specific living condition. Since insurance was pertinent to all patients, it was rendered important, but not pertinent to minority communities specifically. Therefore, further discussions of insurance were irrelevant to my study.

As for information, it is possible to examine this sub-theme in terms of what patients or physicians lack or need. For doctors, this is information about patients cultures and the contexts of their lives. For patients is communication about vaccines, prevention, and health related topics.

The theoretical framework for this research also discussed the importance of cultural awareness and treatment of patients (Chapman et al., 2013; Ron Scollon et al., 2012). Cultural competence can also fall within the realm of the discourse model, which was highlighted by Chapman et al. (2013). Cultural competence and proper treatment of patients are both important for the patient-physician dialogue. When physicians do not take into account issues faced by minority communities, there is a lack of awareness that can alter the discourse between both groups. This could also potentially influence aspects of physician behavior, such as implicit bias or general affect (Johnson et al., 2004) . All of these aspects can thus affect patient satisfaction, and may have played a crucial role in some of the experiences that patients highlighted in their responses in my interviews.

### **Doctors' knowledge and understanding about minority communities they serve**

To examine the second theme, I analyzed the results of the doctor and healthcare professional questionnaire. Five themes emerged through this analysis: access to the office, translational services and medical interpretation, opportunities to work in minority communities, need for transcultural training, and empathy.

In terms of access to the office, some doctors seem to understand that access to the doctor's office plays a crucial role in medical process. Some doctors admit that their offices are in urban areas that are, "not easily accessible by public transportation all the time," or that, "there

is transportation, but can be difficult.” Others noted that their urban offices were, “easily accessible by private/public transportation.”

Another important theme was the doctor awareness of the importance of the medical interpretation and translational services, when needed. They noted that translation and interpretation were rather beneficial for the overall interaction between patients and physicians. The majority of responses to these services were positive, with doctors stating that translational services were, “necessary and useful”; however, some doctors countered that translational services were, “cumbersome and relatively inefficient”, yet these responses were not elaborated on. Others noted that these services can be, “time consuming”, or that, “it [made] the interaction more challenging, but good care can still be provided.”

Other physicians pointed out that these services can be useful, but that this, “depends on cost”, as these are rather expensive services. It is important to point this out, as it is noted in the literature review that the government does not always reimburse the expensive medical interpretation services, and the burden of cost then falls on the clinics themselves.

Finally, some physicians also noted that they preferred medical interpretation services over translational services, due to the presence of an actual person conducting the services as opposed to a machine. Specifically, the participant noted that translational services were, “useful and necessary for effective patient-physician interaction, although not as useful as the use of a human medical interpreter.” Others pointed out similar trends: that these were, “better than translational services because of the presence of a translator at the bedside.” This begins to point to the importance that something such as comfort could have on the another person in the room. Similar to the discussion of medical interpretation and comfort in question 1, this is something

that physicians also highlight as important to the services, which appears positive since doctors and patients both point out this importance.

Doctors also point out that they would like more opportunities to work in minority communities, which is not something that they are exposed to during their actual residency or medical school training. When asked questions about how they would like to gain more information about issues that face minority communities, physicians specifically note that they would like more opportunities to work in these communities in order to become more knowledgeable about them. One doctor says that, “this all comes from experience. Experience in urban and free clinics would be useful.” Specifically, many physicians think that people should get the opportunity to have these experiences during their time training to become a doctor to develop transcultural understanding. Specifically, one doctor pointed to, “better teaching/training opportunities for medical students/residents [in] more free clinics in underserved areas.” However, medical students and residents do not always get the opportunity and flexibility to select where they will do their training, and if they do, there are not always many low-income clinics that they can select from. Therefore, while medical students might want the opportunity to learn in these communities, they do not always have the opportunity.

Similar to the previous theme, doctors also note that they would like to learn more about minority communities as a whole, specifically during their medical training. One doctor notes that they should include, “more exposure to minority groups/more off site rotations in areas that are populated with minority groups/underserved.” While this also ties into the concept of experience, this is again not something that the doctors can necessarily control. Again, this appears to be a situation where a systematic change is necessary, in order to give doctors, the opportunity to do this.

Finally, doctors brought up the concept of empathy as an important practice when interacting with their patients. Some doctors who were members of minority communities felt that they had gained a better sense of empathy from their personal experiences. One medical student noted that she felt she was more empathetic of her minority, immigrant patients after watching her own parents go through similar situations with the healthcare system and physicians. She notes that she, “[tries] to empathize with patients whose medical literacy may not be as great or whose first language may not be English, when trying to think about [her] parents’ interactions with the medical system.” Another physician said she felt that she could empathize more with her female patients, as she is also a woman. One doctor notes that her own status as a member of a minority community, “helps [her] to be more knowledgeable and compassionate” towards her patients. Therefore, it is apparent that some doctors are aware of their own experiences and how these help to shape positive interactions between them and their patients who share similar backgrounds and experiences.

In this section, it is clear that some doctors are indeed aware of some of the important aspects of difficulties of certain minority barriers that were touched upon in the interviews, such as transportation and the importance of interpreters. However, it is also clear that there are many issues are not necessarily in the doctors’ control, such as the cost of medical interpretation. Similarly, doctors who want to learn more about minority issues and minority healthcare do not always have the opportunity to do so. Doctors have only a limited number of choices for their medical school rotation and their residency programs, so a student cannot necessarily elect to do their studies in a low income community or with a specific demographic population unless this option is provided by the school. Therefore, it is important for the concept of changing medical

school rotation programs to provide students with more opportunities to be exposed to these types of experiences.

The concept of the financial burdens of medical interpretation was a theme that was consistent with the literature review (Shaddox, 2011). Other aspects of access, such as transportation, were also consistent with information found in the literature review about minority healthcare issues (Bulatao et al., 2004). Additionally, the concept in the literature of a patient selecting a physician who shares similar qualities to themselves is also apparent in the results presented on empathy. However, the literature review did not find many examples of physician interest in learning more about minority communities and gaining this experience during their training. It is possible that there have not been enough studies conducted that analyze the topic from that point of view.

**Potential best practices for health care professionals to better serve minority and unprivileged communities (as referred by patients and physicians).**

To analyze the third theme, I examined both of the interviews/questionnaires together, to determine what patients and physicians considered can be improved in the healthcare system and in patient-physician interactions. Again, various subthemes emerged through the analysis of these responses: structural changes, deeper understanding of the three-way communication between doctor, patient, and interpreter, hiring more volunteer medical interpreters, and providing more information for patients. These themes build off of one another and highlight many important aspects that were emphasized in answers from both the patients and physicians.

With regards to structural changes, there are many important aspects that were highlighted by patients and physician. These underscore the importance of the medical system to give doctors the opportunities they need in order to learn more about and have more exposure to

minority communities. The specific structural changes that were mentioned will be highlighted in the following subsection, “conclusions and future directions.” These changes relate to more information for the doctor as well as the patient, new training opportunities for physicians in underserved communities, and also cultural competency training.

With regards to the three-way communication between doctor, patient, and interpreter, it is important to examine the role that empathy and patient comfort play in these interactions. There are currently very strict rules about how medical interpreters must interact in the triadic group, including what they are allowed to say, and the desire for them to not show any sense of empathy towards the patient. However, it is not always clear to all of members of the interaction what the role exactly should be, giving members of the group a less clear understanding of exactly what the expectations are. While patients can feel comfort knowing that interpreters share their common language, the interpreters are instructed not to show emotion, i.e. patients cannot necessarily derive means of emotional comfort from the interpreters. Also, the notion of comfort is relevant to this discussion. As previously mentioned, one of the main benefits that patients enjoyed from using their family member as an informal interpreter was the trust and, “added comfort to the interaction,” that they felt when a loved one was interpreting for them. Another benefit is trust, one patient says that his grandparents, “definitely trust [his] mom and either [him] or [his] sister,” when they translate for them. These feelings of trust and comfort may be something that can be incorporated into the actual concept of medical interpretation, so it will be important for systems to better examine why this comfort arises with loved ones, and how this same emotion can be manifested in the professional setting of medical interpretation.

Other patient cite that the dynamic between doctor, interpreter, and patient could be examined more to make sure that patients fully understand what the doctor and interpreter are

explaining. Although the language with the interpreter is the same, there are other aspects that affect the comprehension of the medical message given by the interpreter. Patients note that this is relevant when patients', "education backgrounds [are different from the doctors']", and that is not something that translators are privy to." In these situations, patients note that it can be helpful for this dynamic to somehow add more instances where the translator asks the patient, "do you understand?" in order to make sure that the patient understands the medical terminology as well as the explanation of the medical jargon in the language of communication with the interpreter.

Physicians note the importance of having, "on site medical [interpreters] available in all offices as an integral and essential member of [the] office [and] team." However, it was also noted that there tends to be a shortage of professional medical interpreters, especially at some of the smaller clinics. This is also problematic for clinics that cannot afford to pay many interpreters. In these cases, patients note that, "having volunteer medical interpreters in the clinics," and training them so that they are able to provide adequate services in times with more patient demand and little money. While hiring volunteer interpreters is an admirable first step, it is also important to train these interpreters so that they are aware of the customs and proper communication to foster a beneficial interaction with both the patient and the physician.

Finally, patients seem to want more information. This information can come in many ways, including more general information about general health, such as being nutritious and some information that is unrelated to the specific illness that the person faces. As previously mentioned, patient suggested having pamphlets of food pyramids and plates to indicate to patients what proportions and types of food should be consumed. One patient noted that there could also be some culturally relevant general health information, such as, "more information about a balanced meal, but not [necessarily] an American balanced meal, but a balanced

traditional [Non-Western] meal,” since she traditionally eats non-western food in her own culture and would like to know health tips specific to her own cultural cuisine. Likewise, there could also be more wealth of information about specific individual needs. One patient noted that she would like more information about the prescriptions she receives, or about the vaccines that she is taking at the doctor’s office that day. Therefore, it is apparent that more information could be given both in more general terms and in terms to the actual diagnostics of the patient.

This section highlights many themes that are similar to the first two themes, including information, empathy, hands-on experience, and interpretation. Therefore, this also highlights similar aspects that were discovered in the literature review. Yet again, it provides a few examples (such as doctor training in minority communities and comfort with interpreters) that were not explored directly in the literature review but still play a clear role in the interactions.

### **Conclusions and Future Directions**

In this study, I identified a problem in the medical realm relating to patient-physician interactions. I then explored bibliography and developed a research proposal. Following this, I implemented questionnaires and interview that offered me information about both doctors and patients’ experiences and observations- specifically about their interactions at the doctor’s office and interaction with the healthcare system.

Based on the information provided in this study and the themes that have emerged through examining personal experiences of patients and physicians, it is apparent that there are a few notable future directions that emerge from this topic. It is important for doctors to have

cultural competency training, so that they are better able to deal with the diversity of different culture and ethnicities of people that they will interact with.

For patients, it is important to give them more information about the healthcare norms and common practices in the United States, preferably before their visit to the doctor. It is important for these people to be aware of common practices, understand that asking questions at the doctor is normal, and learn about the general demeanor, eye contact norms, using their tablet, and more that occurs when interacting with the doctor. Providing patients with this information will help them to better understand how these interactions will assist in the process of cultural awareness on their part as well. It will also be useful to have tangible methods of communicating this information to the patients, such as handouts, videos, or a medical staff member explaining this information to them when they find a new doctor. As a whole, it is important to implement systematic changes that allow both doctors and patients to have access to the necessary information they need to better understand the perspective of the other party, and to have more tangible and hands-on methods of gaining this information.

While this study provided valuable information and personal experiences of patients and physicians, there are some inherent limitations of the study. One limitation was time. This study was conducted in two separate one-year periods, one focusing on physician questionnaires and the other focusing on patient interviews. The limited amount of time allotted for this study combined with the busy work hours of patients and physicians made it difficult to recruit a sufficient amount of participants in the study. These same reasons provided reason to conduct physician questionnaires that the doctors could fill out on their own time, as opposed to face-to-face interviews. In future studies that have less time constraint and more participants, it could be beneficial to recruit members who have worked in different vulnerable communities. It would

also be interesting to include other medical personnel in the research, since front desk interactions were also noted to have an effect on patients' experience at the doctor's office (Calo et al., 2015).

Aside from future studies and research on this topic, the information that was presented in this thesis lends itself to various structural proposals that could be examined in the future. These proposals could be on the systematic level or on the research level as well. One such method could be to conduct more studies on patient satisfaction. When examining the literature for this, the overall amount of literature was relatively scarce compared to studies that mainly focused on the actual geographic, health insurance, and access barriers faced by minority communities.

Conducting more studies based on patient satisfaction surveys could provide more information without breaching doctor-patient confidentiality that tends to prevent the actual conduction of observations while observing the appointment. Aside from just creating and conducting more patient satisfaction surveys, it is also important for the contents of these surveys to expand. Instead of only including the patient satisfaction with their medicine and the diagnosis of the doctor, it could be useful to include questions on these surveys about communication between patients and physicians, physician cultural competency, and other aspects relating to the dynamic between patients and physicians. This could allow more information to be derived from these surveys to better assist researchers and physicians.

On a systematic level, one proposal could be to implement methods to provide patients with more information about medical interactions and doctor-patient interactions in the United States. As seen through the interviews, cultural differences can sometimes have an influence on how the patient views/interprets specific interactions between him/herself and the doctor. For

example, some of our patients from Spanish speaking countries noted that they had learned that the doctor is right, and that the patient should never ask questions to the doctor. Others learned to never question the doctor. These cultural differences could cause a very particular dynamic between patients and physicians; therefore, it could be useful to patients if information was provided for them about the fact that it is okay to ask questions to the doctor, explain to them why the doctor needs to look at their tablets while speaking to them, and more information that may be interpreted differently in different cultures.

Additionally, there could also be more information present online about the doctors. One patient pointed out that she and her family would always select doctors based on online reviews of the doctor. The patient noted that since she was Indian, she always wanted an Indian doctor. Once she selected her doctor and interacted with her, it became apparent to her that while her doctor was also Indian, there were still many cultural differences between the two- based on the number of generations that the doctor's family had lived in America versus her own.

Therefore, just knowing the ethnicity of that one doctor did not necessarily help her to determine similarities between them culturally. Providing more information about doctors online, such as a picture, their school, languages spoken, and countries they have practiced in can help patients to develop a better idea about the doctors and their background to help them better select a doctor that meets their preferences.

Likewise, change can be implemented to train doctors and other office staff members in cultural competency. As noted in the literature review, cultural competency is relevant even before arriving in the room with the doctor, and staff at the front desk and other medical personnel should also be aware of this topic. Providing health personnel and office staff with

cultural competency training could help to insure patient comfort or at least help to reduce any miscommunications between both patients and physicians.

Finally, it is important for medical programs to give patients the opportunity to work in low-income or minority communities. It is important to expose doctors to different situations early on in their training, in order to help them develop cultural competency. While training in cultural competency is useful, firsthand experience in medical practice within these new communities could provide the doctors with more personal experiences and opportunities to learn about other cultures and types of people that they will be serving. Adding residencies or medical school rotation in some low-income clinics could give doctors some of the early exposure that they need.

While there are many changes that can be made to help patients and physicians better understand information that is critical to their interactions and experiences. These systematic changes take on many forms- directly altering the experience of the patients and/or the physicians. While it may appear easy to blame healthcare professionals or patients for a particular lack of communication or fault in the interaction, it is important to examine the systematic reasons that these faults appear in the first place. Therefore, researchers must step back and examine the overall healthcare system in addition to examining patient-physician interactions themselves.

Although there are many structural proposals that hold merit for future directions, this thesis also highlights the value of personal experience and understanding this topic from multiple perspectives. Therefore, it is also critical to spread information and awareness about these issues on a more personal, individualized scale.

My study was designed to highlight personal experiences of patients and physician in order to help identify some of the gaps and needs of both doctors and patients in order to bridge this gap. On my own part, I will continue to communicate my findings to patients and doctors alike. I also plan to take some of this information to groups that assist international patients with getting health appointment, such as El Centro Hispano. I am looking into the idea to create a small pamphlet for Hispanic patients and other minority patients who are unfamiliar with some of the customs of the United States healthcare system. The pamphlet could give them some information about some of these customs, and provide them with necessary information in their target language. I am also looking into the idea of creating a video that conveys some of this information, and plays them in the doctors' offices or in centers such as El Centro Hispano for people to watch before they go to their doctor's appointment.

When thinking about my own experiences, I also analyze what I will take from this study to my time in medical school and as a doctor. After conducting this research, I have a very specific set of beliefs that I will carry with me throughout my medical school experience. This experience has made me pay closer attention to the medical system as a whole and the curricula that medical school students must follow. I have begun to see classes on empathy emerge in these systems, which I believe is a step in the right direction. As a future doctor, I would like to have videos in my own clinic to explain to the patient how their visit will go.

For example, if I only have a short amount of time allotted for each patient, I would explain this to them in the video. I would also emphasize that they are encouraged to ask questions for clarification and to learn more about their conditions or treatment. I would also like to walk into my patients' rooms and explain the structure of the meeting to them in person, so they will not need to question why I am typing information on my computer while talking, or

why I might need to ask them certain questions. I would like to create a comfortable atmosphere for my patients and to learn more about their individual cultures and experiences through my time treating them. I believe that while there are many changes that need to happen on the systematic level, patient-physician interactions can also be altered and improved through a greater awareness of the issues and barriers faced by minority communities. I hope that my research experience will provide me with a good starting point to further explore this topic.

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## **Appendices:**

### **Appendix A: Physician Questionnaire**

#### **I. General questions:**

1. Are you a... (doctor, nurse, medical student, nurse practitioner, other)
2. What types of patients do you usually see during a week in terms of ethnic diversity?
3. Describe the demographics of your clients' ages and genders.
4. If your office located in an urban area? Is it easily accessible by transportation?
5. How is ethnic and/or gender diversity manifested in your hospital or private practice with respect to staff and other medical personnel?
6. How is ethnic and/or gender diversity manifested in your hospital or private practice with respect to patients?

#### **II. Patient-physician interactions:**

1. Are you a member of a minority community (Yes, No, Other)
2. How has this influenced the way that you interact with your patients?
3. Do you take into account differences in culture or language when treating a patient? explain.
4. How long do you meet with people who don't speak your language? Explain.
5. Do you feel that you spend more, less, or equal time with patients that speak a different language? Explain.
6. Are there ever times when you believe your medical opinions have been influenced by cultural differences between yourself and your patient? explain.
7. Does your physician-patient interaction change when your patient is of your gender versus another gender? Explain.

8. Do you feel a different level of comfort interacting with your own gender vs. another gender? Explain.

**III. Translation services:**

1. Have you previously used translation services? (Yes, No, Other)
2. What is your view of translation services in the medical field?
3. If you could alter these services in any way, how would you do so?

**IV. Medical interpreter services:**

1. Have you previously used a medical interpreter? (Yes, No, Other)
2. What is your view of medical interpreter services in the medical field?
3. If you could alter these services in any way, how would you do so?

**V. The medical community:**

1. Do you feel that the medical community is aware of intercultural aspects pertaining to helping members of minority communities that have language, cultural, or financial barriers to medical access? (Yes, No, To some degree, Other)
2. How do you believe the medical community can expand its knowledge about minority communities in vulnerable situations?
3. How do you believe the medical community can improve its care to minority communities in vulnerable situations?

**VI. General comments:**

1. Do you have any general comments that you would like to add?

## **Appendix B: Patient Interview Questions**

### **I. General questions**

#### **Demographic questions:**

1. What is your age range? (go by 10s)
2. How do you describe yourself from these categories: Caucasian, Asian/Pacific Islander, Native American, Latinx, African American, mixed, other,
3. What languages do you speak? (English, Spanish, other)
4. What is your occupation/profession?
5. What is your hourly income out of the following ranges: below \$5 an hour, between \$5-\$10 an hour, between \$10-\$15 an hour, between \$15-20\$ an hour, between \$20-\$30 an hour, above \$30 an hour, do not wish to answer, unemployed, or uncertain.
6. How many hours a week do you work?
7. How often do you visit your doctor?
8. Is this doctor the same ethnicity as you?
9. Is their first language the same as yours?
10. What is your language of communication with your doctor?

#### **Accessibility questions:**

11. Is your doctor's office easily accessible?
12. What method of transportation do you use to get to the doctor's office?
13. Have you ever missed an appointment due to lack of transportation?
14. Based on your method of transportation, how easy is it get to the building or office?
15. Do you get reminders for your appointments? If so, how (text, email, etc.)

### **II. Patient-physician interactions**

1. Do you feel that your ethnicity, income, or language has impacted your accessibility to this doctor?
2. Which of these is the one that has challenged your accessibility to healthcare the most?
3. Do you feel like your doctor takes into account differences in cultural practices, ethnicity, income, or language when speaking to you at your appointments?
4. How long does the doctor spend with you? Could you estimate within this range: less than 5 minutes, between 5-10 minutes, between 10-15 minutes, between 15-20 minutes, between 20-25 minutes, between 25-30 minutes, between 30-40 minutes, between 40-50 minutes, between 50 minutes to 1 hour, above 1 hour.
5. When you are with the doctor, who talks more- the doctor or you?
6. Do you feel that the doctor shows empathy when he communicates with you?
7. Does the doctor make eye contact with you?
8. How is the doctor's body language when they speak to you?
9. Do you have a sense that you are well informed after leaving the doctor?
10. Do you think that the doctor respects your cultural differences?
11. Do you feel comfortable with your doctor?
12. Were you able to select your doctor? If so, how did you select your doctor? Did it have anything to do with ethnicity, culture, language, gender?
13. Do you go to the doctor's office by yourself or with other people who help you with certain interactions and/or decisions?

### **III. Translation services**

1. Have you used translational services before?
2. Did you think this was effective?

3. How did this make you feel personally?
4. Did you feel comfortable when using this device with the doctor?
5. How did this service impact your interaction with your doctor?
6. How could this service be more effective?

#### **IV. Medical interpreter services**

1. Have you used medical interpreter services before?
2. Did you think this was effective?
3. How did this make you feel personally?
4. Did you feel comfortable when using this person with the doctor?
5. How did this service impact your interaction with your doctor?
6. How could this service be more effective?
7. How does having an extra person in the room make you feel?
8. Who do you make eye contact with- the doctor or the interpreter?
9. Who does the doctor make eye contact with more- you or the interpreter?
10. If you have used both, which did you prefer?

#### **V. The medical community**

1. Do you feel that your doctor is knowledgeable about the problems that patients face with regards to language, cultural, or financial barriers to medical access?
2. What could doctors do to be more knowledgeable about culture, language, and income of their patients?
3. What could doctors do in general to be more empathetic and make patients feel more comfortable?
4. What would you like to see change within your community with regards to healthcare?

5. What type of information do you think that the community needs from the medical community? How do you think this information should be distributed?

**VI. General comments**

1. Is there anything else that you would like to add about your experiences?

# PATIENT-PHYSICIAN INTERACTIONS

October 2018– March 2019

**Have you ever been to the doctor's office?**

**Do you want \$20? If so, we need you!**

## General information

- Calling all North Carolina residents above the age of 18!
- We are conducting short interviews from October 2018– March 2019
- The only requirement is that you have been to the doctor's office before!

## Our research

- We are analyzing patient-physician interactions from the patient and the physician point of view
- We conduct interviews with patients to better understand their interactions at the doctor's office
- Interviews are 30 minutes to 1 hour long
- All interview responses will remain anonymous
- You will receive \$20 for participating

## How to get involved

- Email Ivana at [ikp3@duke.edu](mailto:ikp3@duke.edu) to schedule your interview!
- Select a time and location that is the best for you!

We hope to see you soon!



## Questions?

If you have any questions about our research goals or how to get involved, contact Ivana at [ikp3@duke.edu](mailto:ikp3@duke.edu).

# INTERACCIONES ENTRE PACIENTES Y MÉDICOS

octubre 2018- marzo 2019

**¿Ha visitado un consultorio médico?**

**¿Quiere \$20? Si es así, ¡lo necesitamos!**

## Información general:

- Estamos llamando a todos los residentes del Carolina del Norte mayores de 18 años
- Estamos haciendo entrevistas cortas durante octubre 2018 a marzo 2019
- El único requisito es que usted haya visitado un consultorio médico

## Nuestra investigación:

- Estamos analizando las interacciones entre pacientes y médicos desde el punto de vista de ambos
- Estamos haciendo entrevistas para entender mejor sus interacciones en el consultorio médico
- Las entrevistas serán aproximadamente 30 minutos a una hora
- Todas las respuestas serán anónimas
- Recibirá \$20 por su participación

## Como puede participar:

- Para programar una entrevista, mande un correo electrónico a Ivana en [ikp3@duke.edu](mailto:ikp3@duke.edu)
- Elija un día y lugar que sea bueno para usted!

**¡Espero que nos veamos pronto!**



## ¿Preguntas?

Si tiene preguntas sobre las metas de las investigaciones o como puede participar, manda un correo electrónico a Ivana a [ikp3@duke.edu](mailto:ikp3@duke.edu).

## **Appendix D: Recruitment Scripts**

### **Personal contact script:**

Hi, I'm Ivana, and I am a senior at Duke University. I'm conducting a senior thesis in Spanish about patient-physician interactions with minority communities. Right now, I am looking at this topic from the patient point of view and am conducting interviews with anyone above the age of 18 who has ever been to the doctor's office. The patients don't need to be from a minority community. I will be conducting interviews in person or on the phone with patients who are interested in participating. The interview can take at least 30 minutes, depending on how elaborate the responses are. Do you know anyone who might be interested in doing an interview with me? People will receive \$20 for participating, and the responses will remain anonymous. If you know anyone, tell them to please email me at [ikp3@duke.edu](mailto:ikp3@duke.edu) for more information and to schedule an interview!

### **Introductory email or letter:**

Hi, I'm Ivana, and I am a senior at Duke University. I'm conducting a senior thesis in Spanish about patient-physician interactions with minority communities. Right now, I am looking at this topic from the patient point of view and am conducting interviews with anyone above the age of 18 who has ever been to the doctor's office. The patients don't need to be from a minority community. I will be conducting interviews in person or on the phone with patients who are interested in participating. The interview can take at least 30 minutes, depending on how elaborate the responses are. Do you know anyone who might be interested in doing an interview with me? People will receive \$20 for participating, and the responses will remain anonymous. If you know anyone, tell them to please email me at [ikp3@duke.edu](mailto:ikp3@duke.edu) for more information and to schedule an interview!

### **Follow up email for people that email to be a part of my study:**

Hi, my name is Ivana, and thank you for reaching out to me about my study. Please let me know a good day, time, and location that works for you for the interview. At the interview, I will go over more general information about my project and will explain the interview process in more detail.

### **Second blurb for Facebook:**

Have you or a loved one used a medical interpreter at the doctor's office? What about translation services- such as translating machines or automated phones? Do you want to make \$20? If so, consider participating in a brief interview on patient-physician interactions.

For my senior thesis, I am conducting one-on-one interviews on patient-physician interactions from the patient point of view. The interviews are anonymous, and you will get \$20 for participating. We are specifically looking for people who have used interpretation services or have a loved one who has used these services at the doctor's office. We will also interview people who have informally interpreted for their loved ones. Email me (Ivana) at [ikp3@duke.edu](mailto:ikp3@duke.edu) for more information or to schedule an interview!