

A Narrative Study of Patient Encounter Accounts of Physicians, Nurses, and Medical
Receptionists after Two Decades of a Paradigm of Patient-Centered Care

by

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Dedication

This dissertation is dedicated to my parents, my father Dr. Gul-Ahmad Akseer and my mother Mrs. Guhar Akseer who have provided support and encouragement from the very beginning. It is also dedicated to my spouse, Kamilla, for her presence, patience, emotional support and encouragement throughout the many years of graduate school. And of course, I dedicate this work to our sons Arian, Roman and Arman who have been a great source of motivation and inspiration.

Abstract

Despite recent well-known advancements in patient care in the medical fields, such as patient-centeredness and evidence-based medicine and practice, there is rather less known about their effects on the particulars of clinician-patient encounters. The emphasis in clinical encounters remains mostly on treatment and diagnosis and less on communicative competency or engagement for medical professionals. The purpose of this narrative study was to explore interactive competencies in diagnostic and therapeutic encounters and intake protocols within the context of the physicians', nurses', and medical receptionists' perspectives and experiences. Literature on narrative medicine, phenomenology and medicine, therapeutic relationships, cultural and communication competency, and non-Western perspectives on human communication provided the guiding theoretical frameworks for the study. Three data sets including 13 participant interviews (5 physicians, 4 nurses, and 4 medical receptionists), policy documents (physicians, nurses, and medical receptionists) and a website (Communication and Cultural Competency) were used. The researcher then engaged in triangulated analyses, including N-Vivo, manifest and latent, Mishler's (1984, 1995) narrative elements and Charon's (2005, 2006a, 2006b, 2013) narrative themes, in recursive, overlapping, comparative and intersected analysis strategies. A common factor affecting physicians' relationships with their clients was limitation of time, including limited time (a) to listen, (b) to come up with a proper diagnosis, and (c) to engage in decision making in critical conditions and limited time for patients' visits. For almost all nurse participants in the study establishing therapeutic relationships meant being compassionate and empathetic. The goals of intake protocols for the medical receptionists were about being empathetic to patients, being an attentive listener, developing rapport, and being conventionally polite to patients. Participants with the least

amount of training and preparation (medical receptionists) appeared to be more committed to working narratively in connecting with patients and establishing human relationships as well as in listening to patients' stories and providing support to narrow down the reason for their visit. The diagnostic and intake "success stories" regarding patient clinical encounters for other study participants were focused on a timely securing of patient information, with some acknowledgement of rapport and empathy. Patient-centeredness emerged as a discourse practice, with ambiguous or nebulous enactment of its premises in most clinical settings.

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Table of Contents

	Page
Abstract	iii
List of Tables	viii
List of Figures	ix
CHAPTER ONE: INTRODUCTION.....	1
Preface.....	1
Background on Clinician/Practitioner-Patient Interaction.....	2
Situating the Study within a Compelling Interest	7
Situating the Study within the Researcher’s Worldview	11
Theoretical Perspectives	13
Theoretical Framework.....	14
Researcher Positionality.....	18
Research Problem and Purpose of the Study	19
Goal Statement.....	22
Summary	22
CHAPTER TWO: REVIEW OF RELATED RESEARCH LITERATURE.	24
The Differences in Views of Medical Body and “The Lived Body”.	26
The Rejected Body.....	35
Non-Western Perspectives on Human Communication	38
Physician-Patient Interaction in Clinical Encounters	43
Successful Clinical Encounters from the Literature	49
Medical Receptionists and Patient Encounters	62
Paradigms Influencing Clinical Practice	64
Chapter Summary	69
CHAPTER THREE: METHODOLOGY	76
Narrative Inquiry	80
Data Collection	87
Ethical Considerations	91
Qualitative Data Analysis	92
Reflexivity.....	97
Trustworthiness.....	105
CHAPTER FOUR: FINDINGS	113
About the Participants in the Study	114
Findings Phase I, a) Within Group and Cross Group Analysis by Interview Questions Combined with Open, Axial, and Selective Coding.....	116
Challenges.....	120
Communication Skills.....	133
Evidence-Based Versus Narrative Medicine (Physician and Nurse).	154

Hopes and Desired Changes (Physicians).....	162
Qualities for Successful Physicians, Nurses, Medical Receptionists Career Choices (Physicians)	167
Typical Day Physicians, Nurses, and Medical Receptionists	176
Professional Training and Plans for Further Training	177
Approaches in Dealing with Patients form Diverse Cultures	183
Therapeutic Relationship (Nurse and Medical Receptionist)	194
Preferred Method During Interview (Physicians).....	199
Findings Phase II, a) Manifest and Latent Content Analysis of Communicaiton and Cultural Competency Website (CCC), b) CCC Website with Charon, c) Policy Documents for Physicians, Nurses, and Medical Receptionists and d) Policy Document with Charon ..	205
Phase III, Mishler and Charon across All Data Sets	235
CHAPTER FIVE: DISCUSSION AND CONCLUSIONS	258
A Model of Patient Encounter Accounts of Physicians, Nurses and Medical Receptionists after Two Decades of a Paradigm of Patient-Centered Care	266
Conclusions.....	269
Strengths and Limitations of the Study.....	292
Recommendations and Implications	294
References.....	298
Appendix A: Interview Guide Physicians.....	302
Appendix B: Interview Guide Nurses.....	320
Appendix C: Interview Guide Medical Receptionists	321
	322

List of Tables

Table		Page
1	Five Narrative Features.....	50
2	The Three Movement Within Narrative Medicine	53
3	Integrating Narrative Medicine and Evidence Based Medicine Features.....	70
4	Summary Chart Chapter Three	95
5	Summary of the Dominant Themes from Theoretical Frameworks.....	110
6	List of Themes and Subthemes from Open, Axial, and Selective Coding	118
7	Open, Axial, and Selective Coding on Transcripts Example.....	119
8	Summary of the Within Cohort Analysis by Interview Questions	214
9	The Selective Coding, Findings Examined Within the Context of Charon’s Narrative	233
10	Requirements for Becoming a Physician/Nurse/Medical Receptionist.....	245
11	Manifest and Latent Content Analysis of the CCC Website And the Policy Documents	253
12	Charon’s Narrative Medicine Features as Applied to the Documents and CCC Website	255
13	Mishler’s Narrative Structure Elements as Applied to the Website and the Policy Docs	257
14	The Dominant Themes from the Literature that Speak to the Participants’ Experiences of Patient Encounters	267

List of Figures

Figure		Page
1	A conceptual diagram of participant-patient encounters	271
2	Participants' experiences of patient encounters	274
3	Participants' experiences of narrative medicine	276
4	Participants' experiences of narrative medicine	277
5	Narrative arc: Medical Receptionists.....	278
6	Narrative arc: Nurses	280
7	Narrative arc: Physicians	281

CHAPTER ONE: INTRODUCTION

Preface

The title of this thesis introduces its intent. It is a narrative study of physicians', nurses', and medical receptionists' accounts of encounters with patients. These accounts necessarily contain not only the descriptive details of what happened from the perspectives of the informant providing them, but also the pre-reflective and, likely, unreflected upon, premises of the disciplinary discourses which were the basis of each informant group's professional education, its preparatory and formative influences.

These accounts of encounters with patients also exist within a larger discourse, professional and sociopolitical context, the espoused commitment to patient-centeredness as an overarching master narrative (or paradigm) of healthcare delivery, and practitioner education. Hence, this narrative study must examine not only these insider accounts from the informant groups, but also the discourses which influenced the education and preparation of the informant groups; that is, the discourses of the paradigm of patient-centered care.

This project then, is a narrative study of insider accounts and their professional and disciplinary discourses of education, preparation, and standards of practice. Translated into the parlance of research methods, it is a narrative study of interview (informant group accounts), and curricula, policy documents, and standards of practice (disciplinary and professional discourses). Further, it is a narrative study of a particular context, medical healthcare; therefore, it is best served by narrative approaches developed for medical healthcare contexts. Elliot Mishler's (1995) and Rita Charon's (2005, 2006a) narrative approaches have been used extensively in medical education and practice, and are the pre-eminent approaches at work in this study. Further and as a final prefatory comment, narrative study in this project is an explication and

subsequent critical application of narrative elements operating within the accounts and professional/disciplinary discourses, and the relationships between these narrative elements and the overarching espoused paradigm of patient-centered care.

Background on Clinician/Practitioner-Patient Interaction

The concept of “patient-centeredness” was introduced by Balint (1957) over 5 decades ago and has been studied in health research for the past few decades. Patient-centeredness gained its popularity in healthcare in the late 90s (Bechtel & Ness, 2010). However, despite being the most frequently discussed topic in medical practice (Bechtel & Ness, 2010; Boyle, Dwinnell, & Platt, 2005), it may not be entirely responsive to patients’ needs as its development has been mainly physician-driven with limited patient input (Bechtel & Ness, 2010). Communication is believed to be central to the delivery of patient-centered care (Boyle et al., 2005; Levinson, Lesser, & Epstein, 2010). Skillful communication with patients helps to build trust and understanding, and may require the clinician to engage in further questioning to explore fully what the patient hopes to achieve (Boyle et al., 2005; Hughes, Bamford, & May, 2008). Improving communications between clinicians and patients, including patients in the process of care and decision making, has been documented to improve health outcomes because of increased patients’ compliance and better comprehension for the clinicians (Boyle et al., 2005; Hughes et al., 2008).

Western medicine views the body as a “corpse” rather than viewing it as a “lived body” (Wendell, 1996). The impact of Western medicine’s view of the human body may leave the patients with the idea that the everyday experiences of their own bodies are wrong (Wendell, 1996). In addition, there are differences between meanings of illness and disease for clinicians and patients (Aho & Aho, 2008). The patients’ unusual changes in their bodies are considered

illnesses and, to clinicians, diseases that need to be cured (Aho & Aho, 2008). Illness is understood as an individual's subjective embodied experience and feelings, where disease, on the other hand, is a reference to the objective and scientific descriptions of the so called abnormal bodily changes (Sundstrom, 2001). Further, physicians and patients view the body differently. The physician's view is the biomedical approach to the body, whereas the patient's view is a lived body approach (Connolly, 2001). There has been relatively little research exploring a holistic picture of patients' situations in healthcare and exploring a broader embodied experience of patients' medical conditions (Connolly, 2001; Komesaroff, 2001; McWhinney, 2001; Toombs, 2001). Despite the recent well-known advancement in patient care, such as patient-centeredness (McWhinney, 2001), evidence-based medicine and practice (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996) in the medical field, there is rather less known about its effects on the particulars of physician-patient encounters (Toombs, 2001). The emphasis in clinical encounters is mostly on treatment and diagnosis (Flynn, Greenhalgh, Long, & Tyson, 2012) and less on communication competencies for medical professionals. In addition, medical training is primarily concerned with developing technical and scientific skills that help clinicians in diagnosing diseases (Mishler, 1984; Timmermans & Angell, 2012). Medicalized approaches believe that changes in human bodies are changes in chemical, hormonal, electrical, or neurological and mechanical functions, leading to an approach that is atomistic and primarily concerned with human organisms (Aho & Aho, 2008; Mazis, 2001; Mishler, 1984; Komesaroff, 2001; Sundstrom, 2001). In this perspective, medical training emphasizes viewing the person as a client or patient rather than a whole person. To gain more control over the interview process, clinicians will ask more close-ended rather than open-ended questions (Mishler, 1984). Application of a check list protocol by clinicians supersedes patients' experiences of illness and

their agenda (Dew, 2012). This also allows for the dominance of a biomedical explanation of a patient's experience of illness over a patient's real life experience (Goldenberg, 2006; Mishler, 1984; Wendell, 1996). Clinicians tend to control the medical interviewing process by opening and closing each series of questions. In addition, physicians tend to gain control through selecting the discussed contents during the interview and also being selective in listening to the quantity of details provided by the patient (Jagosh, Boudreau, Steinert, McDonald, & Ingram, 2011; Mishler, 1984). There is no official training for physicians' communication competency particular to diagnostic encounters, even though some standards for communication with the main emphasis on ethical and behaviour issues have recently been included in the revised Medical Council objectives (CLEO-2s, C2-LEOs; College of Physicians and Surgeons of Ontario, 2008). Medical education and residency training may recognize but do not emphasize the importance of physician-patient communication (Connelly, 2005).

For patients who live with illnesses and loss of health, scientific descriptions of their condition alone cannot help them find meaning in their suffering and cope with their bodily loss (Charon, 2001). For practitioners, their view of illness is as a process that can only be measured and understood through clinical observations and laboratory tests (Aho & Aho, 2008; Toombs, 2001). Medical literature is focused on biomedical explanations of the human body (Broom & Tovey, 2012; Mishler, 1984; McWhinney, 2001; Toombs, 2001). The science of biomedicine terrorizes the art of caring (Timmermans & Angell, 2012). The assumptions in biomedical models undermine patients' lived experience of illness and, thus, result in challenges and variations in opinion between physician and patient within clinical practice (Connolly, 2001; Komesaroff, 2001; McWhinney, 2001; Mishler, 1984; Toombs, 2001; Zaner, 1995). Patients' medical records are often filled with clinicians' understanding and interpretation of patients'

experiences of illness. There have been few or no records filled with patients' reflections and feedback about the clinician's understanding of their experience of illness (Charon, 2006a; Mishler, 1984). In order to consider the patient's experience of illness as accurate, it has to be objectified and confirmed by biomedical exams (Timmermans & Angell, 2012; Mishler, 1984; Wendell, 1996). Physician domination of medical interviews has been reported consistently in physician-patient interaction (Byrne & Long, 1976; Hauser, 1981; Mishler, 1984; Morgan, 2008). According to Mishler (1984) and Zaner (1995), physicians' attempts in medical interviewing are directed toward domination and the imposition of the language of medicine on a patient which not only controls the process of interviewing, but also fails to reach a mutual understanding between physician and patient. This dominance impairs interaction in ordinary language by reconstructing the lifeworld (the embodied experience of illness) information into a technical language of medicine, and in sum, leads to the objectification of the patient, and misrepresentation of the lifeworld experiences of illness.

Healing can be simply attended to through listening to people and watching them talk as this can make them feel better when they have someone listening to them (Jagosh et al., 2011; McWhinney, 2001; Rollnick, Miller, & Butler, 2008). In such cases, it is important for clinicians to sit down and listen to patients rather than reading their charts while they are with their patients (Brykczynski & Lewis, 1997; Charon, 2006a; Mishler, 1984). It is also important to give patients a sense of control over their lives and bodies. Clinicians, therefore, need to develop better communication skills and act as good listeners, facilitators, and resource people, who can gain patients' trust and provide them with guidance, emotional support, information, and education to enable them to access better care (Brykczynski & Lewis, 1997; Charon, 2006a; Jagosh et al, 2011; Royal College of Physicians and Surgeons of Canada, 2007). Gaining patients trust in interactive

interviews, trying to connect with the patient's lifeworld, as well as including a patient in decision making and learning to live with his/her specific health and illness conditions, are all emphasized by several authors (Benner, 2001; Broom & Tovey, 2012; Brykczynski & Lewis, 1997; Flynn et al, 2012; Mishler, 1984).

Additionally, a positive relationship between cultural competency training and effective patient outcomes has been reported in a small number of studies (Lie, Lee-Rey, Gomez, Bereknyei, & Braddock, 2010). However, authors in other studies (e.g., Beach et al., 2005; Betancourt , 2004; Betancourt & Green, 2010; Hickling, 2012; Paez, Allen, Beach, Carson, & Cooper, 2009) believe that providing and understanding culturally effective care can, indeed, increase quality of care among patients. Cultural competence can ensure clinicians' preparedness in providing quality care to diverse populations. Healthcare professionals are required to receive training in cultural competence to effectively address racial disparities in healthcare (Beach et al., 2005; Betancourt, 2004; Betancourt & Green, 2010). Lack of healthcare professionals' understanding in acknowledging, understanding, and managing sociocultural variations in their patients' beliefs and behaviours may challenge effective physician-patient interaction, and threaten patient satisfaction (Betancourt & Green, 2010). Hickling (2012) also emphasizes having clinical competence and empathy in addition to cultural competence in the therapeutic relationships.

With the growing challenges and emerging chronic illnesses, and emphasis on improved quality of services for patients, healthcare professionals are expected to deliver the best possible services for their patients (Huff & Yasharpour, 2008; Morgan, 2008). Therefore, there is a need for focusing on the importance of interaction between clinician and patient rather than solely on the diagnosis and treatment of disease (Morgan, 2008; Eveleigh et al., 2012). An individual's

health is closely affected by his/her cultural beliefs, which often include the individual's family, community, and other factors that play a role in cause and effect of illness. In Western medicine, illness is often viewed as patho-physiological changes in the body rather than changes in the whole person within the perspective of their culture (Huff & Yasharpour, 2008).

A conceptualization of the clinician and patient relationship in medical care has yet to be articulated (Eveleigh et al., 2012). Experience of illness from the perspective of patients have been explored by many researchers in the last 2 decades (e.g., McWhinney, 2001; Mishler, 1984; Stein-Parbury, 2005; Toombs, 1992b; Wendell, 1996, etc.). I have summarized briefly, in the preceding paragraphs, the results of these studies. We have had over a decade of patient centered medical education and care. Now is an opportune time to reinvestigate physicians', nurses' and medical receptionists' experiences with patients from the healthcare providers' perspectives.

In the sections that follow, I will demonstrate how I have used the steps suggested by Jones, Torres, and Arminio (2006) for situating the research. I explain and justify the choices of using a qualitative research approach, narrative inquiry, and elaborate on this research methodology. The theoretical framework for this study is introduced here in Chapter One, including the concepts of narrative medicine. It is followed by the problem statement which identifies the concerns in medical discourse to which this research responds. Additionally, this chapter also introduces the research questions and purpose of the study.

Situating the Study within a Compelling Interest

My theoretical interest in exploring the clinician-patient interaction in diagnostic and therapeutic encounters and medical receptionists in intake protocols is partly because of the results of my previous research on women who have experienced trauma and their access to community supports (Akseer, 2008). Part of the results indicated that women's experience of

social exclusion, isolation, and lack of access to the social determinants of health was due to their social workers' a) incompetence and reductionist approach, and b) inability to understand the impacts of trauma on the personal and social lives of the participants and what it was like for the participants to cope with experiences of trauma in a broader embodied and environmental experience. Community support workers' reductionist approach in participants' intake protocol raised several questions about intake protocols in general and clinical encounters in particular. My interest in exploring communication competence among clinicians gradually developed after hearing a large number of patients' narratives and dilemmas concerning interaction with their clinicians in clinical encounters. Another source that contributed largely to this interest was through review of phenomenological literature on lived experience and embodied experience of illness.

My interest in using narrative inquiry is related to the way I make meaning in my life through narrative and make sense of my personal actions and my social interactions through narrative. I construct my realities through narratives. The more I focus on my stories, the more I know about my life and the lives of other people. Using narrative inquiry as a methodology for this study seemed to be both authentic and appropriate to convey the experiences of the study participants. Bruner (1991) argues that scientific and narrative ways of knowing are fundamentally different. While science concerns itself with the establishment of truth, narrative's concern is to endow experience with meaning. My interest was to explore the meanings of the participants' constructed experiences rather than factual truthfulness of their experiences.

Narrative is a way of knowing about clinicians and patients as people (Engel, Zarconi, Pethtel, & Missimi, 2008). In addition, narratives are individuals' ways of giving meaning to their experiences. The use of narratives has gained popularity in patient care as an influential

concept that helps clinicians understand the reasoning process as well as interaction and information sharing in healthcare settings (Engel et al., 2008). As described by Mattingly (1998), narrative is often constructed through the combined efforts of different players involved in patient care; therefore, describing the narrative elements of different players including physicians, nurses, and medical receptionists will bring a deeper understanding of patient care in everyday medical encounters.

The rationale of narrative research is to study personal experience and meaning making in an orderly manner. Narrative research can offer a helpful arrangement for how events have been constructed by active subjects. Narrative inquiry is used to gain a deeper understanding of peoples' unique life experiences. Narrative inquiry focuses on experiences of a small number of people as opposed to a large group and giving voice to those whose stories have not been heard before (Clandinin, 2007). In narrative inquiry, life experience is described and analysed in the form of a story. In narrative research, the data can be collected in the form of a life story, interview, or a literary work. The data can be used to identify differences among individuals and learn about social phenomena, historical periods, or personality (Lieblich, Tuval-Mashiach, & Zilber, 1998). Narrative inquiry is a way of understanding an individual's experience (Clandinin & Connelly, 2000). In my study, particular attention was paid to two key tenets of narrative inquiry: temporality and contextuality. Temporality helped understand how participants' stories shaped over time, from a particular vantage point (Carr, 1986; Mishler, 1995). Further attention to temporality and contextuality facilitated my understanding of how and in what way particular stories were being told (Mishler, 1995).

It was through qualitative social science, particularly sociolinguistics, that medicine came into narrative realms, as a means to represent and understand physician-patient interaction

(Mishler, 1984). Qualitative research methods can facilitate closing the gap between scientific evidence and clinical practice (Green & Britten, 1998) by providing a complementary set of information that would more effectively inform practice. The reason for using a qualitative research design was due in part to the lack of empirical literature on clinician-patient interaction in diagnostic and therapeutic encounters. The exploratory nature of qualitative research allowed me to describe participants' perspectives and experiences in everyday clinical encounters and the meaning of their experiences which could not be as effectively conveyed by quantitative techniques. The inductive nature of qualitative design allowed me to document participants' experiences, priorities, and current knowledge in diagnostic and therapeutic encounters and intake protocols.

Interpretivism discards the positivist idea that the methods used productively in other fields, such as chemistry and physics, can be effectively used in studying human behaviour (Willis, 2007). Naturalism is about understanding interaction between clinicians and patients in clinical encounters. Interpretation is about exploring the meaning that participants of the study bring to clinical encounters (Britten, 2011). Qualitative research helps to get a deeper understanding of the issues in physician-patient interaction and the involved challenges. Further, I suggest that a team of experts in narrative medicine, Goyal et al. (2008), to better evaluate and study broader inevitable changes in physician-patient encounters using an interpretive qualitative approach is more appropriate.

Kreiswirth (2000) described two perspectives on ontological and epistemological status of narrative including naturalists and constructivists. My views are in agreement with constructivist narrative as the belief in constructivists' narratives is in construction of stories from interaction with a lived being through time and meaning (Mishler, 1995). Carr (1986) states

that human experience of everyday life has a narrative structure which includes a temporal pattern of events (beginning, middle, and end) as well as a narrator and an audience.

Situating the Study within the Researcher's Worldview

Unlike quantitative postpositivist methods, which employ deductive methods to reduce ideas to a small set of testable variables that constitute a hypothesis, in a constructivist paradigm the goal is to look for patterns of complexity to generate new ideas (Creswell, 2003). Willis (2007) describes ontology and epistemology as follows: "Ontology is about what can exist and what is real, and epistemology is about knowledge" (p. 10). In constructivist paradigms, the researcher's goal is finding multiple realities, each contingent on social and experiential situations, rather than a single reality. Realities can be varied in their form and content, but are still valid as they are based on expression of an individual's thoughts, feelings, and indications of personal experiences. In the constructivist paradigm, the use of subjective epistemology (the assumption that we cannot separate ourselves from what we know) and relativist ontology (the assumption that reality we know is constructed intersubjectively) are adopted (Denzin & Lincoln, 2005).

According to Atkinson (2002), there are three guidelines for narrative inquiry. First, the role of investigator is as a nonjudgmental storyteller who focuses on establishing connections and personal relevance of the participant's narratives. Second, a participant's accounts can stand independently and contribute to insights into the participant's experiences. Third, each participant's story discloses something about his/her life. To develop deeper understanding about physicians', nurses', and medical receptionists' perceptions and experiences in everyday clinic, a narrative study of the meaningful events, clinical encounters, and life experience of the participants was used. Following Wengraf's (2001) framework for narrative inquiry sampling,

purposeful sampling was used to recruit 13 participants who met the inclusion criteria for the study. I used a narrative inquiry perspective to guide the design of my study. In addition, following Wengraf, I elicited narrative elements by asking the study participants to describe significant events and patients with whom they had unique experiences either positive and/or negative. Further, I asked the study participants to describe some challenges they had experienced in the everyday clinical encounters. I expected the findings of the study to take the shape of consolidated narrative, comprised from several levels of inductive analysis. The consolidated character allowed for many possible narrative or story elements to be present within a larger narrative structure (Mishler, 1995). I provided a review of the relevant literature to better inform my research. I used the concept of narrative medicine to offer insights on clinicians' and patients' relationships. I engaged in interacting with the target participants and interpreting their views, signifying a willingness to engage with multiple constructions of reality (Guba & Lincoln, 1994). I continued to provide more background information and rationale for selecting a narrative inquiry approach as a research design. As suggested by Patton (2002), as a researcher one should be attentive to and conscious of the intellectual, political, communal, linguistic, and ideological origins of one's own view and voice as well as the perceptions and voices of those who are being interviewed and those to whom the researcher reports. Therefore, through my engagement in reflexivity, I provided details about my role as a professional and my personal interests in the research which added to the trustworthiness of the study.

As suggested by Clandinin and Rosiek (2007), the ontological assumptions of a narrative epistemology also include exploring temporal and contextual reasons of how and why the stories unfolded the way they did. The main point of the study's theoretical foundation was to pay attention to different narrative elements in participants' accounts. I used narrative emplotment as

an active and temporal process to reconstruct participants' accounts in connection to their role in events, interactions, and outcomes (Mattingly, 2007).

The research method has to be in agreement with the research question and the topic chosen (Holloway & Wheeler, 2010). My primary interest in using narrative inquiry is the richness of data grounded in people's experiences within their stories and in the ways in which narrative functions both shape and describe life experience. I constantly think about my experience as a graduate student, a healthcare professional, a researcher, and a parent and, in all my roles, narrative structure makes more sense as both a form and content of experience. My social experiences in interaction with my peers, advisors, and instructors in clinical settings with my patients and other clinicians, as well as a parent in my interaction with my family, can all be understood as narrative structures. In all of these different roles, I came to discover narrative as a way of organizing how and why I make meaning in my own and other people's lives. I believe that narrative is the way we create and recreate our realities and ourselves. I also believe the narrative study is an appropriate approach for the study of human beings.

My research questions are focused on exploring how interactive competencies in diagnostic encounters and intake protocols are shaped by and presented/performed through the influence of cultural, disciplinary, and professional narrative elements and structures.

Theoretical Perspectives

According to Crotty (1998), a theoretical perspective is "the philosophical stance informing the methodology and thus providing a context for the process and grounding its logic and criteria" (p. 3). Positivism and modernism are theories associated with quantitative research that seek to predict human behaviour and enhance generalization to a larger population (Crotty, 1998). These theories have been criticized for oversimplifying individual uniqueness.

The main difference between quantitative and qualitative approaches is not merely in the type of data collected, but in the foundational assumptions, beliefs, and “givens” that are thought to be true (Willis, 2007). The traditional views in quantitative research rely on positivist or postpositivist paradigms. Qualitative research gained its position in the late 19th and early 20th centuries and allowed for studying subjective aspects of human existence. These approaches became aligned with what has come to be known as a constructivist paradigm (Creswell, 2003). In a constructivist paradigm, qualitative data are used and the emphasis is on the importance or relevance of the results to real life. Further, in a constructivist paradigm, it is recognized that individuals develop subjective meanings of their experience and create subjective understandings of their everyday world (Creswell, 2003). According to Jones et al. (2006), researchers in the constructivist epistemology are interpreters. My study is grounded in a constructivist epistemology. The results from this study will contribute to the literature on practitioner-patient encounters and relationships. In addition, the study will help understand physicians’, nurses’, and medical receptionists’ experiences in interpersonal clinical and therapeutic encounters.

Theoretical Framework

According to Jones et al. (2006), the theoretical framework “offers suppositions that inform the phenomenon under study. The theoretical framework links the unsettled question to larger theoretical constructs” (pp. 24-25). Literature on narrative medicine, phenomenology and medicine, therapeutic relationships, cultural and communication competency, and non-Western perspectives on human communication provide the guiding theoretical frameworks for the study. Narrative medicine is a combination of theories, from narrative studies, literary studies, aesthetic theory, and qualitative research methods in social science (Charon, 2006a).

Clinicians with narrative competence have the capacity to understand patient stories, to see events from their patients' points of view, to recognize the uniqueness of each patient's experience of illness, and to reflect on their own experience (Charon, 2006a). Narrative is an extension of the interpretive approaches in qualitative research in which the focus is to understand and represent the rich data within every account and story. In contrast to conventional medicine that largely relies on the expertise of the professionals, narrative approaches rely more on the expertise and resourcefulness of the sufferer (Mishler, 1984). Narrative structure can be applied as a treatment method in helping patients to consider a reconstruction of their life story and cope with the lived experiences of illnesses in a better way (Charon, 2006a). Narrative is a promising approach for gaining an in-depth understanding of individuals' lives (Bruner, 1991; Polkinghorne, 1995).

Narrative evidence-based medicine is focused on practitioners' centrality for biomedical external evidence in association with salient evidence based on patients' embodied experiences found in patients' accounts of their experience (Goyal et al., 2008). According to Charon (2006a), "narrative ways of knowing and experiencing the world and self are held in common by healthcare professionals and patients" (p. 39). Charon (2006a) further adds:

narrative medicine—or medicine practiced with narrative competence—is at once attuned to the individual patient, replenishing for the individual professional, dutiful in generating and imparting medicine's knowledge, and cognizant of the responsibilities incurred by the public trust in medicine. (p. 10)

The primary focus of narrative medicine is on understanding an individual's worldview and valuing his or her use of language, or discourse. Narrative medicine also helps in understanding medical knowledge and narrative oriented physician-patient interaction, as well as narrative

through a social science research lens. It helps in understanding medical practice and physician-patient encounters as a great source of knowledge beyond the gold standard of randomized controlled trials (Charon, 2006a). Narrative medicine provides the means to understand the personal connections between clinician and patient, the meaning of medical practice for physicians and their team, as well as the relation of medicine to the society. In addition, it offers simultaneous improvement for physicians, nurses, and social workers in the effectiveness of their work with patients, themselves, co-workers, and the public (Charon, 2006a; Goyal et al., 2008). According to Charon (2006a) the philosophy to bridge physician-patient relationship based on common understanding is in the practice of narrative medicine and advancing competence in these narratives. Narrative allows people to link their past, present, and future and helps them understand the meaning of their own lives. To explore interactive competencies in diagnostic interviews, therapeutic encounters, and intake protocols, it is important to understand a physician's approach to patients in clinical encounters, a nurse's approach in therapeutic encounters, and a medical receptionist's role in intake protocols.

Review of the related literature from *Phenomenology and Medicine* edited by Toombs (2001), *The Rejected Body* by Wendell (1996) and *Non-Western Perspectives on Human Communication* by Min-sun Kim (2002) helped explore the underlying complexity involved in clinical encounters between practitioners and patients. The theoretical frameworks drawn from the relevant literature will help clarify the preference of medical practitioners in their focus mostly on biomedical explanations of the human body (Mishler, 1984; McWhinney, 2001; Toombs, 2001). The assumption of a biomedical model undermines a patient's lived experience of illness and, thus, results in challenges and variations in opinion between physician and patient in clinical practice (Connolly, 2001; Komesaroff, 2001; McWhinney, 2001; Mishler, 1984;

Toombs, 2001). Medical practitioners need to have some understanding of, and integrate themselves in, changes that illness can cause in the patient's lifeworld as opposed to only looking for objective facts and validating them.

Cultural competence refers to an individual's ability in establishing effective interpersonal working relationships that discard cultural differences (Cooper & Roter, 2003). Developing cultural competence is crucial among professionals in dealing with clients from diverse cultural groups. A lack of cultural competence among professionals can lead to interpersonal conflict, misinterpretation, and frustration among clients from diverse cultural backgrounds (Kim, 2002). Patient-centeredness strongly supports individualistic Western cultural views that include active patient participation in a diagnostic interview; this approach does not seem to be equally effective in communicating with patients from non-Western cultures. Therefore, Kim et al. (2000) suggest a mutual decision-making process based on patients' preferences as a preferred method for practitioner interaction with patients from non-Western cultures which is well reflected in a narrative medicine approach (Charon, 2006a). These variations will be discussed in greater detail in Chapter Two, Theoretical Framework.

To explore physicians' competencies in diagnostic interviews, and nurses' and medical receptionists' interactive competencies in therapeutic encounters and intake protocols, there are four main areas that needed to be reviewed: (a) the current approach in clinician-patient interaction; (b) the connection between physicians' competency in diagnostic interviews and nurses' and medical receptionists' competence in therapeutic encounters and intake protocols and the overall patient care; (c) differences between scientific conceptualizations and embodied experiences as a significant part of health disparities (ethnicity, gender, education or income, disability and geographic location); and (d) the relation between physicians', nurses' and medical

receptionists' communication and cultural competence and its effect on patient outcomes beyond the individual organisms, potentially influencing their lives, families, work places, and societies.

The purpose of my study was not to generate a theory and/or confirm theory but rather to describe, analyse, and interpret the perceptions and experiences of physicians, nurses, and medical receptionists in interactions with patients in their everyday clinical encounters. Further the aim of my study was beyond exploring physicians', nurses', and medical receptionists' job satisfaction or dissatisfaction. My study explored how physicians', nurses' and medical receptionists' personal communication choices in medical encounters helped/hindered forming alliances with patients.

Researcher Positionality

According to Jones et al. (2006), a researcher's positionality is examined through the researcher's relation with participants of the study and the research topic. In addition, positionality is connected with the research paradigm, theoretical perspective, and research methodology (Jones et al., 2006). My experience of using narrative skills in my encounters with patients helped me establish rapport and gain patients' trust during the early stages of the encounters. In addition, an increasing body of literature supports the importance of narrative as it relates to patient care (Engel et al., 2008).

As a committed professional trained in medicine and with a research background in applied health sciences, I understand scientific methodology and clinical reasoning; for example, collecting clues, processing the information, coming to an understanding of a patient problem or situation, and evaluating outcomes. My medical background and qualitative research experience helped my engagement with potential participants. I was conscious of the influence from my different roles during the research process as medical professional, researcher, and graduate

student. I was committed to being cognizant of the influence of my gender, race, socioeconomic status, and sexual orientation, as well as my decision to leave surgery as a speciality and move into a more public medical educative role as a health professional.

The attempts in narrative study are made to explore people's perspectives on events and how people make sense of these events through the accounts they provide and stories they tell. By using a narrative inquiry approach, my goal was to listen to accounts of the study participants' experiences and perceptions as described by them. It allowed me to create a robust, descriptive representation of clinicians', nurses', and medical receptionists' experiences of everyday work. As suggested by Engel et al. (2008), a narrative approach helped me explore the following areas in medical encounters: listening skills, expressing empathy, interpretation of a patient's experience of illness into medical language, writing reflective notes, and engaging in medical ethics. It also allowed me to continue to question and be aware of my own assumptions about patient centred care.

Research Problem and Purpose of the Study

The research problem that the study addressed included a lack of empirical literature on the physicians', nurses', and medical receptionists' encounters with patients. For example, research on optimal methods of conducting diagnostic interviews is very limited and there is little research on developing rapport and empathy in clinical encounters (Miller, 2010). Similarly, the impact of rapport and empathy on the outcome of the diagnostic interview has not been studied extensively. Further, the impact of structured and unstructured approaches to interviewing in clinical discourse is not adequately explored (Miller, 2010). To my knowledge the perceptions and experiences of medical receptionists in clinical encounters has not been explored to date. Including medical receptionists' perceptions and experiences in clinical

encounters will help clinicians make more informed decisions about particular interactions in their everyday practice.

The purpose of this qualitative inquiry was to explore, via a narrative study, the interactive competencies in diagnostic and therapeutic encounters and intake protocols within the context of the physicians', nurses', and medical receptionists' perspectives and experiences.

According to CanMEDS (2005; Royal College of Physicians and Surgeons of Canada, 2011), interactive competencies include shared decision making and effective and dynamic interaction with patients, families, and other stakeholders. Interactive competence in the context of a patient-centeredness approach is crucial in establishing rapport, gaining the patient's trust, formulating diagnosis, delivery of information for establishing mutual understanding, and facilitating a shared therapeutic plan (Royal College of Physicians and Surgeons of Canada, 2011).

The theoretical framework for this study is drawn from the literature on narrative medicine, cultural and communication competency, and therapeutic nurse-patient relations. A narrative inquiry approach was used to explore physicians', nurses', and medical receptionists' everyday experiences of dealing with patients.

This study provides a robust description of the experiences of, and influences on, physicians and nurses in diagnostic and therapeutic encounters and the medical receptionists in intake protocols.

The supporting questions that guided the study are as follows:

1. a) What are physicians' and nurses' perceptions of the role of diagnostic and therapeutic encounters in patient care? Related to this, what constitutes diagnostic encounters from the perspectives of physicians and nurses?

b) What are medical receptionists' perceptions of the role of intake protocols in patient care?

Subquestions relating to a) and b) include:

- i. What interactive competencies do physicians and nurses believe are required/expected in diagnostic encounters?
- ii. What interactive competencies do medical receptionists believe are required and expected of them in intake protocols?
- iii. How might physicians, nurses and medical receptionists view these competencies' influence on the overall healing process?

2. For physicians

- i. What interactive competencies are physicians expected to have?
- ii. What are Canadian patients' expectations from physicians trained in Canada?
- iii. What are Canadian patients' expectations from internationally trained physicians?
- iv. How are physicians expected to behave during diagnostic encounters?
- v. What assumptions undergird these expectations?

3. For nurses and healthcare facility medical receptionists

- i. What interactive competencies are nurses and healthcare medical receptionists supposed to have?
- ii. What are some expectations of nurses and medical receptionists from the patients?
- iii. What assumptions undergird these expectations?

- iv. What kind of interactive training do the nurses and the medical receptionists receive?

Goal Statement

The overarching goal of this study was to shed light on physicians', nurses', and medical receptionists' interactive competencies in diagnostic and therapeutic encounters and intake protocols and to contribute to the literature on clinical encounters and therapeutic relationships. In applying a narrative inquiry lens, a further goal was to understand how physicians', nurses', and medical receptionists' experiences of everyday clinical encounters are shaped and influenced by narrative elements and professional/disciplinary discourses.

Summary

The purpose of this qualitative narrative inquiry was to explore the diagnostic and interactive experiences of physicians, nurses, and medical receptionists in everyday clinical encounters. A narrative inquiry method will be used to explore the experiences of the study participants. Narrative medicine concepts, therapeutic relationships, communication and cultural competency, and literature on the lived body will be used as theoretical frameworks.

Chapter Two contains a review of the relevant literature including the literature on narrative medicine, cultural competency, different approaches, and views on therapeutic relationships. Chapter Two briefly outlines the ways these ideas are used, defined, and conceptualized in the literature. The reason for including the specific literature on narrative medicine, communication and cultural competency, and therapeutic nurse-patient relationships was due to the intertwined nature of these concepts. Narrative medicine helped in exploring the participants' experiences of the everyday clinic, whereas cultural competency was used to explore potential cultural challenges experienced by the participants.

Chapter Three provides an overview of the research methodology and procedures. Included in Chapter Three is a description of narrative inquiry, the method used to explore the experiences of physicians, nurses and medical receptionists. Chapter Three also contains a description of the approaches to data collection and data analysis. Finally, a discussion of the ethical considerations pertaining to this study and a discussion on reflexivity and trustworthiness are included in Chapter Three. Findings are presented in Chapter Four, Discussion and Recommendations are presented in Chapter Five.

CHAPTER TWO: REVIEW OF RELATED RESEARCH LITERATURE

This chapter reviews the body of literature on clinician-patient encounters, therapeutic relationships, and narrative medicine as the main concepts related to this study. The first part of Chapter Two focuses on literature related to physicians', nurses', and medical receptionists' experiences in clinical encounters. To explore interactive competencies in diagnostic and therapeutic encounters and intake protocols, it is important to understand a clinician's approach to patients in clinical encounters. Medical training is primarily concerned with developing technical and scientific skills and, as well, emphasizing a view of the person as a client or patient rather than a whole person (Mishler, 1984). In this perspective, medical interviewing is less emphasized in medical schools.

Review of the literature contributed from Toombs' (2001) edited collection, *Phenomenology and Medicine* (Cassell, 2001; Connolly, 2001; Frank, 2001; Komesaroff, 2001; Madjar, 2001; Mazis, 2001; McWhinney, 2001; Rudebeck, 2001; Toombs, 2001; Walton, 2001), *The Rejected Body* by Wendell (1996), *Non-Western Perspectives on Human Communication* by Min-sun Kim (2002), and therapeutic relationships mainly by Stein-Parbury (2005) helped to outline the complexity involved in clinical encounters involving physician, nurse, and patient.

The theoretical framework provided a broader picture of clinical encounters based on multidisciplinary perspectives from areas of medical sociology, communication, education, and cultural studies. Further, it provided diverse and interrelated perspectives on practitioner-patient encounters. The multidisciplinary approach in understanding patients' experiences of illness including medical perspectives, philosophical perspectives, medical educational model, and cultural competency assisted understanding of the existing trends in interrelated literature. The theoretical framework helped clarify the preference of medical practitioners in their focus mostly

on biomedical explanations of human body (Mishler, 1984; McWhinney, 2001; Toombs, 2001). The assumptions in a biomedical model undermine a patient's lived experience of illness and, thus, result in challenges and variations in opinion between physician and patient in clinical practice (Connolly, 2001; Komesaroff, 2001; McWhinney, 2001; Mishler, 1984; Toombs, 2001). These variations are discussed further throughout the theoretical framework of the study. Developing cultural sensitivity is crucial for professionals in dealing with clients from diverse cultural groups. Therefore, a discussion of cultural sensitivity among professionals is included in the theoretical framework for broader understanding of clinical encounters with patients from non-Western cultures. Further, the theoretical frameworks informed the strategies I used to analyze the data sets and sensitized me to the possibilities within the various data sets. I was also aware of being sensitized for the UN-expected in the data sets.

First, I intend to provide a discussion about differences in views of medical professionals and embodiment based researchers about the body and illness and disease by including literature from the book *Phenomenology and Medicine* (Toombs, 2001) and other related literature. The authors in this review are physicians and other healthcare professionals who work phenomenologically. This review includes a brief discussion of the following topics: (a) the differences in views of the medical body and "the lived body," (b) differences between illness and disease, embodiment and challenges in clinical encounters, mental health issues and medical authority in clinical encounters, and (c) a brief historic review of clinical methods and the patient-centeredness approach in medicine. Therapeutic relationship is another review that is included in the theoretical framework. Chapter Two ends with a brief discussion of narrative inquiry.

The Differences in Views of Medical Body and “The Lived Body”

Medical science alone cannot answer all the questions in clinical practice (Mishler, 1984; Svenaeus, 2001); phenomenology, however, complements medical sciences by focusing on the lived body based on an individuals' lived experience (Toombs, 2001). In addition, phenomenology provides a broader focus on individuals' embodied experiences as well as an evaluation of their experiences and not only a biological exploration of the body. Further, phenomenology enriches the biomedical understanding of experiences of illness and answers the broader question of how it is to live with an illness (Svenaeus, 2001).

Medical professionals' view of illness is that it is deviation from normal organism and/or physiological functions (Sundstrom, 2001). Medical professionals hold the power to assign people with labels (disease; Sundstrom, 2001; Wendell, 1996). Labeling patients with diseases is the cement of the physician's world. Diseases are always influenced by the cognitive authority of medical professionals and few diseases exist independent of medical professionals' interventions (Sundstrom, 2001; Wendell 1996). Medical professionals also hold the power of having medical vocabulary (Mishler, 1984; Sundstrom, 2001). Disease often means a new state of being in the world. This new state of being often affects not only the person who is experiencing the illness but also his family as well as those involved in providing care for him such as physicians, nurses, social workers, etc. Disease can be detected using advanced technology not just externally but also microscopically, internally and, in some cases, surgically by using a knife (Sundstrom, 2001). Phenomenology focuses on a wider range of experience of physician and patient and their shared experience in clinical encounter (Sundstrom, 2001; Svenaeus, 2001). In addition to having updated knowledge of the medical sciences and evidence based medicine, it is critical for physicians to have empathy towards their patients (McWhinney, 2001; Sundstrom, 2001; Toombs, 2001). Therefore, it is important for clinical practice to include both scientific

experience and each individual's unique experience to supplement and complement clinical practice (Charon, 2006a; Sundstrom, 2001). Diseases are a double-sided reality that involve both physician and patient. Physician-patient interaction involves actions, reactions, emotions and events that require a broader and complex dialogue between the two parties (Charon, 2006a; Mishler, 1984; Sundstrom, 2001).

If not recognized by medical professionals, illness can remain illness without any medical labels (disease). Similarly, when a person believes that he feels well and is perfectly fine but the biomedical examinations found physiological, anatomical, chemical changes in his immune system, the person can be labeled diseased without experiencing any illnesses (Sundstrom, 2001). In almost all medical encounters, illness and disease both exist and rely on a physician and patient productive relationship (Aho & Aho, 2008; Sundstrom, 2001).

When bodies fail to meet the standards of normalcy, they are frequently categorized as other (Connolly, 2001). This is especially true in cases of female bodies due to the frequent deviation from prediction, explanation, and control. Therefore, female bodies hold a relatively stronger threat to social authority of medicine. In the medical encounter, a physician's explanation of a patient's experience of illness is more valuable than a patient's subjective explanation of her condition. Further, the lived body is considered a weak source of information about one's illness (Connolly, 2001). In the biomedical model "bodies are the problems and medicine is the solution" (Connolly, 2001, p. 181). Dysfunctional bodies also pose a threat to all institutions whose success depends on "production, predication and control;" therefore, these bodies should be returned to normal bodies. To grasp a logical view of the lived body it needs to be viewed through a combination of body, experience, and culture and the meaning of the embodied experience. Connolly (2001) emphasizes that it is not always the experience of illness

that makes an individual “othered” but also individuals who do not exhibit body ideals and do not meet the norms of the Western cultures “appearance and behaviour (p. 185). This may also include the healthy body that goes awry of the expected norms. This categorization often solely relies on a physician’s reductionist perspective that questions, invalidates, and doubts patients’ real embodied experiences when they do not fit with the preconceived disease. Physicians tend to keep the medical knowledge and understanding of the body mystified and make a patient’s embodied experience a less valid source of information as it cannot be quantified. Because female embodied experience is more difficult to translate in medical discourse than male, it is no surprise that female embodied experience is often devalued and prone to receive diagnosis of mental health conditions and less described “unreal” medical conditions (Connolly, 2001). A patient’s embodied condition is in need of medical confirmation and, if not, it may result in invalidation of the lived body (Connolly, 2001; Wendell, 1996). Females with no medically describable felt sense of their embodiment are prone to be denied, mistrusted, and invalidated from their lived body by medical professionals (Connolly, 2001). To get an insight into the complexities of medical encounters, physicians need to focus beyond evidence-based medicine to a patient’s felt embodied experience and validate it as an equal source of information (Charon, 2006a; Connolly, 2001), and admit to biomedical limitations in clinical encounters (Connolly, 2001). Further, Charon (2006a), Connolly (2001), and Wendell (1996) emphasize listening to patients’ embodied experiences and stories as a valid and effective tool in healing.

The biomedical model of the body fails to facilitate the process of healing in patients because of its lack of focus on the body as whole (e.g., ignoring the emotional changes in embodiment; Mazis, 2001; Mishler, 1984). The main focus in the biomedical model is on physiological and biochemical changes in an individual’s body and this model assumes that

emotional and mental healing in an individual is the focus of other professionals and the patient's family (Mazis, 2001; Mishler, 1984). In addition, this model focuses on the patient's world independent of his/her environment. Unlike the medical model, phenomenology is concerned with everything that is involved in a patient's world (Mazis, 2001). In brief the biomedical model fails to recognize the importance of the emotional sense of an individual's embodiment. Clinical encounters happen in a larger context of a patient's lifeworld which should not be limited to the objective map often sought by medical professionals (Mazis, 2001; Mishler, 1984; Timmermans & Angell, 2012). The body is partially mechanical but the ways patients structure their world, food choices they make, activities they choose, moments of excitement they share with people, sexual options, and many more have emotional significance that are strictly related to patients' embodiment. Therefore, it is important for physicians and other healthcare providers to also explore the larger embodied dimensions of their patients. The body and the emotions are inseparable and physicians focus strictly on physiological and mechanical aspects of the body can increase tension between physician and patient (Mazis, 2001). In addition, the narrowed focus of medicine on biotechnical machinery ignores the subjective and emotional world of a patient's experience of illness or makes it less important in achieving physical health. The emotional insignificance of the patient's embodied experience by medical professionals can also leave the patient's family and friends in doubt about the patient's felt embodied experience (Mazis, 2001; Wendell, 1996). According to Merleau-Ponty (1962), the body and one's emotional reserves are closely associated and interweaved; embodiment is not separate from the body but is "dispersed throughout its lived context" (p. 248). When medical professionals treat the patient's body as an independent physiological object, the larger context of the patient's relational embodiment, motivation, and sense are missing. Medical professionals may not be able

to find a “true” experience of patient experience of illness which is often through pain, unless in addition to the mechanical dimensions of the body they focus on the patient’s lived body experience that also includes the patient’s world and emotions (Mazis, 2001).

The focus of medicine on the body as an isolated mechanism further challenges a patient’s healing process as emotion plays a central role in patient recovery (Mazis, 2001). When physicians examine the body as a separate mechanism, it is only one part of the body that they examine and only a certain sense of the patient’s larger world in a confined medical facility. As Merleau-Ponty (1968) states, an individual is never in separation from the environment and his world. Therefore, clinicians need to explore the broader embodied experience of individual in association with their world(s) and take into consideration the healing power of emotions in their well-being (Mazis, 2001). Phenomenology is concerned with exploring first person accounts of experience of illness through narratives (Connolly, 2001; Mazis, 2001). Patients with severe illness and depressed emotions often find themselves in separation and isolation from their everyday world. Exploring the patient’s emotional world may be complicated and challenging but if medicine wants to bring about positive changes and increase the process of healing in a patient’s life, it is vital to change its narrowed focus from the body as a mechanism to the body as a lived body (Mazis, 2001; Mishler, 1984). These concerns are also relevant in therapeutic relationships.

The experience of illness may mean loss of control over the body and telling stories about the experience of illness may bring a sense of gaining control over one’s body and life (Frank, 2001). Talking about the embodied experience of illness is more than just being conscious of illness (Frank, 2001). Illnesses that results in mobility loss change an individual’s experience of space as they find themselves in a changed world different from the world they lived in when the

body was functional (Toombs, 2001). Loss of mobility in physically disabling illnesses also means reorganization of the functional space accompanied by emotional changes and adjustments as well as change in temporal experience. Physically disabling illnesses are also accompanied by shame, frustration, limitation, and a feeling of dependency on others. Using mechanical supports for help, such as wheelchair or a cane, become part of embodiment (Toombs, 2001).

Unfortunately, clinicians are less interested in patients' embodied experiences of illness and it is assumed that they already know enough about it (Connolly, 2001; Walton, 2001).

In the medical model, changes in the body mean changes in one's physiological, anatomical, and biochemical structure (Mishler, 1984; Komesaroff, 2001; Sundstrom, 2001). Physician-patient interaction involves several different discourses, such as of scientific medicine, (e.g., talking about symptoms and causes) and the experiential descriptions of the impacts of these changes. There is also a discourse of psychological indication, metaphorical explanation, philosophical considerations, and reflection of the past experience (Komesaroff, 2001). Patients using these different discourses in clinical encounters are not simply deploying a language but rather are expressing a patient's world of meaning of bodily experience and value and who the patient really is (Charon, 2006a; Komesaroff, 2001). Similar to the patient, the clinician also uses different discourses in the clinical settings. The discourse of science is, as they talk about diagnosis and treatment, the language about psychological indications, interpretation, and reflection as they translate the patient's experience of illness into the language of medicine (Komesaroff, 2001; Mishler, 1984). The interaction between physician-patient is not simply "an abstract linguistic exchange" but rather a phenomenology of self-other relationship. A general trend in patients' visits to a physician office is so that physicians will hear and listen to their

stories (Charon, 2006a; Komesaroff, 2001; Mishler, 1984). The patient as a survivor of illness and the one who lived through it and gained understanding and knowledge about it is an insider who has lived, experienced, and witnessed his suffering (Komesaroff, 2001). The physician, on the other hand, is an outsider, who as an observer listens, records, and translates patient's embodied experience into discourse of medicine. This translation of patient's embodied experience ought not be limited to the collection of facts, signs and symptoms, time and biomedical results (Mishler, 1984; Komesaroff, 2001) but should also be about the patient's lived body experience (Komesaroff, 2001).

The embodiment literature supports the idea that in every illness, the human organism is involved as a whole, from a small cell at the molecular level to the cognitive and affective level (McWhinney, 2001). In addition, an individual's environment, including social and physical, plays a major role in experiencing illness and the process of healing (Mazis, 2001; McWhinney, 2001). McWhinney refers to three knowledge expectations from the Hippocratic based medical practice after the 5th century B.C.; first, what the illness is; second, what the treatment is; and last, why certain treatments are effective in controlling one disease and not effective in others. For physicians, medical practice was based on developing a friendly relationship with their patients and being passionate about the art of healing. In other words, have respect and care for both patients and medicine (McWhinney, 2001). Several differences exist in the way the body is viewed today and the way it was viewed up to the 17th century.

After the French Revolution, foundations for modern clinical methods were laid by French clinician-pathologists. The invention of the Laennec stethoscope and Koch and Pasteur writing about causality factors and disease resulted into a major shift from natural to conventional (academic) diagnostic methods (McWhinney, 2001). Because of having a higher

predictive value, the “new” clinical method was considered promising and gradually developed during the 19th century. However, it was not until later that great success of the modern clinical methods based on reasons (analytical and impersonal value) was questioned by a patient’s lived experience and feelings (McWhinney, 2001). The focus in clinical methods was on diagnosing rather than care for the patient. In the mid-20th century, criticism of modern clinical methods increased after Michael Balint (1957) introduced the idea of “patient-centered medicine” and the idea that a physician needs to pay attention to his own emotions while paying attention to the patient’s appeared a great success at the time. Another criticism of the modern clinical method was from Engel (1977) who criticized physicians’ unrealistic judgment in clinical encounters that was strictly based on already described rules and the observed pathological changes in the body. Balint and Engel’s criticisms of the modern clinical method because of its focus mostly on qualitative values were less acceptable and scientific. Balint’s work of patient-centered medicine helped establish another concept of “physician centeredness.” Foss and Rothenberg’s (1987) criticism of modern clinical methods suggested replacing the biomedical approaches to the body with “infomedical” approaches that incorporated the lived body changes. The recent critique of the modern clinical method came from the narrative of illness model focused on embodied experiences of illness (McWhinney, 2001). Critiques of the modern clinical method have largely increased in the past 3 decades (from 1980s to present) as physicians, philosophers, and sociologists focused on the embodied experience of illness that was being largely ignored by the clinical methods (McWhinney, 2001). Kay Toombs (1992a), a philosopher who was diagnosed with multiples sclerosis, states that no physician ever asked her how it was for her to experience multiple sclerosis and how her life was affected by it. Instead, they were all interested in paying attention to physiological and anatomical changes in her body. The modern clinical method has

been criticized for ignoring patients' embodied experiences of illness as it strictly focuses on abstraction which is distant from the individual's experience and results in patients' alienation from their own bodies and lived experience (McWhinney, 2001; Wendell, 1996).

The patient-centered clinical method purportedly allows physicians to effectively provide diagnosis and treatment to the patients by listening to patients' stories and exploring a patient's experience of illness, entering into a patient's lifeworld, grasping the uniqueness in a patient's experience of illness, and understanding what illness means for the patient (i.e., emotions, feelings, and beliefs, expectations). In some clinical cases, a patient knows more about his/her embodied experience of illness than a physician, particularly the bodily symptoms of emotional state. Ignoring their embodied experience of illness can jeopardize and create conflicting notions of the case. Physicians could also provide some alternative ways of describing the patient's illness without invalidating the patient's experience of illness for a better doctor-patient relationship (McWhinney, 2001). The patient-centeredness approach may take more time during diagnostic interview; however, it can save time down the road as the accurate experience of the patient's condition would be explored during the first encounter. To bring the changes in a physician's approach to patients in clinical encounters, it is important to adopt effective communication skills, but it is not sufficient and requires a change in the physician's approach which again is not limited to gaining more knowledge but rather a transformation (Charon, 2006a; McWhinney, 2001).

In an excellent patient-centered clinical method, there is a mutual understanding between physician and patient, attending to emotional aspects of illness; there is openness and honesty in sharing and confrontation about the illness, all the small and big issues in the patient's experience of illness, and, finally, the patient's trust and assurance and physician's judgment

(McWhinney, 2001). Physicians need to have some understanding and integrate themselves in the changes that illness can cause in the patient's lifeworld and not just look for objective facts and validating them (Benner, 2001). Ontological care "refers to the ways that all human existence daily depends on embodied dwelling in particular human lifeworlds" (Benner, 2001, p. 355). Clinicians' emotional connection to their patients' experience of illness gives them a broader picture of patients' embodied experiences of illness (Benner, 2001; Charon, 2006a). In both stages of illness and recovery from illness, sense of self and the lifeworld are the important components and embodiment is a crucial part of them (Benner, 2001).

The Rejected Body

In this section of Chapter Two, I will provide a discussion of the book *The Rejected Body* by Susan Wendell (1996) and consolidate some of the themes around physician-patient interaction identified by the author and provide a summary of areas of improvements and recommendations suggested by the author.

The tendency in scientific medicine is the belief in the myth of control (Wendell, 1996). Physicians and medical professionals often remain secretive about the gaps in scientific medicine and understanding of the human body, and most physicians' training is focused on controlling the body. People with chronic illness and disabilities and individuals who are dying of incurable disease are symbols of a failure to control for medical professionals (Wendell, 1996). The process of healing in both Western medicine and non-Western medicine may involve controlling of the body and the potential for victim blaming. When no medical explanation is provided and attempts at treatments fail, patients' conditions are classified in terms of mental illness in which patients' embodied experiences are due to their imagination (Wendell, 1996). In diagnosing challenging chronic conditions, patients may be told that their physicians are not sure about the

changes in their bodies rather than telling them that their illness is psychosomatic. If patients with known, well-described physical symptoms are told that the changes in their bodies are psychological, then people with less known or not well-known conditions are more likely to be told that their symptoms are solely psychological (Wendell, 1996). Patients with little-known and unknown physical conditions are often referred to psychiatric specialists for help because of lack of positive evidence of their physical symptoms. Patients with known medical and physical conditions who receive psychosomatic diagnoses are in other ways told that there is no physical condition that cannot be diagnosed by medical professionals (Wendell, 1996).

Key themes identified by Wendell (1996) as consequences of the social and cognitive authority of medicine include: alienation, epistemic invalidation, social abandonment, and failure in communication and gaps in knowledge. Indications are that patients' objectification of and ignoring of their embodied experiences of chronic illness alienate them from their real life experiences and their bodies, and, indeed, challenge and prolong the process of healing. Wendell does not disparage the cognitive and social authority of medicine but rather cautions medical practitioners about the impacts of making decisions about patients' chronic conditions and the importance of the recognition of patients' embodied experiences in producing definite diagnosis and enhancing the physician-patient relationship.

Moreover, the cognitive and social authority of medicine is entitled to prove and disprove individuals' experiences of their bodies. It can make individuals' most immediate experiences of their bodies invalid unless validated and confirmed by medical authorities. Invalidation of embodied experience often occurs when it cannot be described and confirmed medically (observable causes). The explanatory medical model which is often based on laboratory findings only validates the subjective experiences of patients if these accounts are found to be medically

truthful. Patients' embodied experiences can be invalidated and patients may be told that their experiences are not real and that they are imagining them unless found real in relation to any causal or objective observation.

When patients are told that the experiences of changes in their bodies are not real, it alienates patients from their bodies and leaves them with doubt of their embodied experiences. When patients' physical problems are truthfully described by medicine and a label (diagnosis) is given to their chronic condition by the physician, it gives the patients a sense of relief and happiness as their embodied experiences are proven to be right. The process of reaching a definite diagnosis is often prolonged, and throughout the process patients with rare conditions which are not very well described by medicine can have their embodied experience invalidated. When a diagnosis is difficult and not forthcoming, particularly in people with no visible signs, a conclusion of psychological condition may be given to these individuals and they may be blamed for their disabilities and illness. This may result in patients with serious conditions losing their jobs, homes, and, in some cases, even their lives while waiting for a definite diagnosis. The beginning of the process of healing in the lives of individuals with chronic illnesses after diagnosis of their condition is not limited to physical improvements in their bodies but also to their entitlement for service from social support services. Individuals who are ill and disabled without a medical diagnosis are not entitled to receive support from social programs. Until being diagnosed, one cannot be eligible for any social support services one needs even if one is physically, emotionally, and financially feeling really ill and is not even able to work. However when patients have a definite diagnosis of their embodied condition, they can confidently express themselves and tell their stories without any epistemic invalidation from their families and others in the community.

The review of Wendell's (1996) *Rejected Body* demonstrates that diagnosis is a powerful tool which can work for and against the patient. Hence, the need for clinical encounters and diagnostic interviews to be given the attention and emphasis they deserve in practitioner preparation and ongoing accountability.

Non-Western Perspectives on Human Communication

Communication together with professionalism is identified as a top competency expected of physicians by CanMEDS 2005 (Royal College of Physicians and Surgeons of Canada, 2011). In this part of the document, I discuss some cultural views important for physician-patient interaction with details about Western culture and Eastern culture discussed by Kim (2002) in her book *Non-Western Perspectives on Human Communication*. I also discuss related literature.

Individualism and collectivism are two known different cultural views in cultural behaviour. The concept of self is constructed into an independent cultural self and an interdependent cultural self. In Western culture, the focus is on an independent cultural self of individual uniqueness, abilities, characteristics, and goals, while in Eastern cultures, it is the opposite with the focus on collectivist interdependence of a group where the individual's self is related to others, and their uniqueness, and abilities are influenced by their social relationship (Kim, 2002).

The goal of existence in the concept of independence is to "objectify the self" (Kim, 2002, p. 17) and disconnect an individual from the context. In contrast, the goal in interdependence is "not to objectify the self but to submerge the self and gain freedom from the self" (Kim, 2002, p. 17) while not refuting individual uniqueness. In individualistic views, the self is central and emphasized. Unlike individualism, collectivism is focused on the group. North American Western culture is influenced by individualistic views. An individual's

communication behaviour in general is influenced by his/her cultural views. However, individuals' personal choices also play a major role in their communication style. Individuals from diverse cultural backgrounds may adopt different communication styles based on their beliefs and behavior (Kim, 2002). Instead of adopting general Western theories of communication in order to have a balanced productive communication, one may also adopt effective Eastern communication theories based on collectivist views. For example, while confrontation is encouraged over avoidance by individualistic views of Western culture, it might result in anxiety and stress among individuals with collectivist Eastern cultural views. Cultural communication training may also vary according to the beliefs and behaviour of individuals from different cultural groups (Kim, 2002). Verbal assertiveness is also a preferred way of communication style in individualistic beliefs and is positively received in Western culture, particularly in the United States. On the other hand, it is poorly received by individuals with Eastern cultural beliefs (Kim, 2002).

While research in the mainstream American culture seems to indicate increased amounts of communication in developing positive interpersonal relationships, generalizability of this style across different cultures may require further research. Avoidance of verbal expressions similar to sending silent messages can be received differently (positive and/or negative) among members of different cultural groups. Gaining knowledge of an individual's cultural behaviour and preferred ways of verbal communication can result into productive and effective communication. Professionals' knowledge of individuals' preferred way of verbal communication can also facilitate the complexity involved in communication with individuals from various cultures (Kim, 2002). Because of the increased cultural integration in today's society, complex communication can benefit from gaining knowledge about individuals from diverse cultural

backgrounds. An individual's social competence in being assertive is positively viewed in the United States culture; therefore, individuals with a high level of assertiveness are considered competent. Comparative studies in assertiveness support a huge gap between the level of assertiveness in individuals from Western and Eastern cultures (Kim, 2002). While the level of assertiveness is comparatively high among individuals from Western cultures, it is relatively low among individuals from Eastern cultures. In general, people with individualistic cultural beliefs are more assertive as compared to those with collectivistic beliefs. While assertive individuals may have the advantage of being more competent in expressing their feelings, thoughts, and beliefs openly, nonassertive individuals are at risk of being defensive, self-protecting, and anxious (Kim, 2002).

Similar to assertiveness, argumentativeness is differently perceived among individuals from different cultural groups. While it is positively valued in North American cultures, it is hardly valued among individuals from Eastern cultural groups (Kim, 2002). For example, in American Western culture, it is positively viewed as it can resolve a conflict situation constructively. In Japanese culture, being less assertive, less responsive, and less argumentative are considered positive communication qualities in conflict resolution. Research on verbal communication approaches among individuals from non-Western cultures needs to be further explored (Kim, 2002).

The current available literature on communication in North America is strongly based on dominant Anglo-Saxon participants. Therefore, developing cultural sensitivity is crucial among professionals in dealing with clients from diverse cultural groups. A lack of cultural sensitivity among professionals can lead to interpersonal conflict, misinterpretation, and frustration among clients from diverse cultural backgrounds (Kim, 2002).

Social and private self are viewed differently by members of diverse cultures. For example, in American culture, one would be called a hypocrite if there is a lack of consistency between the two selves. While, in Japanese culture, expectations are the opposite where one's social self expects him/her to remain polite and maintain accord in public, and his/her feelings about the action are less important. Therefore, social bounds are preferred over private and the private self should be regulated according to social expectations. For example, social influence from majorities would result in an individual's acceptance of majority views in public, while they will still retain to their private lives individually. A successful intercultural interaction is always in need of understanding situational conformity to avoid misunderstanding and misinterpretation (Kim, 2002).

The patient-centered clinical method allows physicians to listen to a patient's stories and explore a patient's experience of illness. Physicians enter the patient's world and grasp the uniqueness of the patient's experience of illness, and understanding of what illness means for the patient (i.e., emotions, feelings, and beliefs, expectations) in order to effectively provide diagnosis and treatment for patients (Charon, 2006a; McWhinney, 2001). Patient-centeredness strongly supports individualistic Western cultural views where patients actively participate in a diagnostic interview by enhancing a good relationship with their physician and making joint decisions, both of which can be well-adopted. This approach does not seem to be equally effective in communicating with patients from non-Western cultures. Studies (such as Kim, Smith, & Yuego, 1999) support a decision-making process based on a patient's preference as a preferred method for physician interaction with patients from non-Western cultures (Kim et al., 2000).

A small number of studies support a positive relationship between cultural competency training and effective patient outcomes (Lie et al., 2010). This could be due to limited knowledge on cultural competency among physicians and improved physician-patient interpersonal outcomes (Paez et al., 2009). However, authors in other studies (e.g., Betancourt & Green, 2010; Hickling, 2012; Paez et al., 2009) believe that providing and understanding cultural sensitive care can, indeed, increase quality of care among patients. Healthcare professionals are required to receive training in cultural competence to effectively address racial disparities in healthcare (Hickling, 2012). Lack of understanding in acknowledging, understanding, and managing sociocultural variations in their patients' beliefs and behaviours may challenge effective physician-patient interaction, and threaten patient satisfaction (Betancourt & Green, 2010; Hickling, 2012).

With the growing challenges and emerging chronic illnesses and emphasis on improved quality of services for patients, healthcare professionals are expected to deliver the best possible services for their patients (Huff & Yasharpour, 2008). Therefore, there is a need to focus on the importance of interaction between practitioner-patient rather than only on the diagnosis and treatment of disease. An individual's culture is affected by his/her health beliefs, which often includes the individual's family community and other factors that play a role in cause and effect of illness.

Similarly, Helman (2007) emphasizes the importance of exploring patient care from diverse cultural groups' perspectives; for example, an individual's views of illness, definition, display, and treatment of illness from traditional perspectives. Helman adds that a patient's experience is more than merely signs and symptoms of illness as it also has cultural and symbolic meanings for them. According to the same author, there are four different theories of

illness: (a) the individual, (b) the natural, (c) social and (d) the super-natural world. In general, in a patient's experience of illness one or more than one of these theories might be involved based on their beliefs and understanding.

In conclusion, it is vital for all medical practitioners to explore and reflect upon their encounters with individuals from diverse cultural groups, and, in particular, their explanatory models of their illness and health.

Physician-Patient Interaction in Clinical Encounters

In this part of the document I provide a review of themes identified by Mishler (1984) and Charon (2006a) on physician-patient interaction in clinical encounters.

According to Mishler (1984) medical training is primarily concerned with developing technical scientific skills that help physicians in diagnosing diseases. In this perspective, medical training emphasizes viewing the patient as a client or patient rather than a whole person. Training in medical interviewing is less emphasized in medical schools. A patient's experience of illness is often translated into the language of medicine by physicians, a technical language; physicians then move toward a diagnosis and treatment. This approach emphasizes a biomedical explanation of the body and overshadows patients' real life experiences. Spending more time with patients and listening to patients' experiences of illness are often evaluated as negative qualities of a physicians' competence.

Mishler (1984) further notes that medical literature is focused on biomedical explanations of the human body. The assumptions in the biomedical model undermine patients' lived experience of illness and, thus, result in challenges and variations in opinion between physician and patient in clinical practice. A patient's medical record is often filled with a physician's understanding and interpretation of his/her experience of illness. There have been few or no

records filled with patients' reflections and feedback about physicians' understanding of their experiences of illness. To consider patients' experiences of illness as truthful, they have to be objectified and confirmed by biomedical exams (Mishler, 1984).

To gain more control over the interview process, physicians will ask more close ended questions rather than open-ended questions. This also allows the dominance of biomedical explanations of a patient's experience of illness over that patient's real life experience. Physicians also tend to control the medical interviewing process by opening and closing each series of questions. Physicians also gain control through selecting the discussed contents during the interview and also being selective in listening to the quantity of details provided by the patient (Mishler, 1984).

One of the problems with the physician's control of the interview is the patient's inability to provide details about how the illness affects her/his daily life. Further, in controlled interviews, patients get fewer chances to explain their experience of illness. Rather, the focus is on providing answers to the physician's request for elaboration which makes patients anxious about answering the next unexpected series of questions. "Physicians create a sense that their interaction is relatively impersonal, restricted in meaning and distant from what they might otherwise share for a serious concern about health and illness" (Mishler, p. 80). A physician's control of the interview and selective focus on parts of a patient's experience of illness and relativity of information depends on what the physician thinks is important. Medical interviews secure the physician's dominance and control of the clinical practice, and, therefore, often ignore a patient's lifeworld or lived experience, focusing solely on the voice of medicine without questioning assumptions made by the voice of medicine. For better medical practice, the controlling role should shift from the voice of medicine towards the voice of the lifeworld.

Mishler (1984) argues that a medical interview does not have the features of daily face to face interaction; rather, it has the characteristics of a face-to-mask interaction. Medical practitioners translate the meaning of the patient's lifeworld into the technical language of medicine. Further, Mishler (1984) argues that physician attempts to dominate and impose the language of medicine on a patient not only controls the process of interviewing but also fail to reach a mutual understanding between physician and patient. This dominance impairs interaction in ordinary language by reconstructing the lifeworld information into a technical language of medicine, and, in sum, leads to the objectification of the patient, and misrepresentation of the lifeworld experiences of illness. Furthermore, physician domination of medical interviews has been reported consistently in physician-patient interaction (Mishler, 1984). Mishler (1984) identifies two different aspects of diagnostic interviews: (a) the physician's voice to attempt to control the interview by emphasizing mechanical and biomedical explanations of the human body; and (b) the patient's voice, reflecting on his/her lived body experience focused on his/her unique experience of illness. Physicians' preference for biomedical approaches to the body put patients in a restricted position to explain their experience of illness such that it makes sense medically or in a way that can fit into the physician's biomedical explanation (Mishler, 1992). The emphasis in medical interviews is on the objectification, abstracting and decontextualization of patients' experience of illness. This is often achieved by:

- Not acknowledging the parts of a patient's experiences of illness that fall outside the boundaries of medical explanation of the body.
- Improper translation into medical language of a patient's nontechnical description of an experience

- Physician attempts to bring the patient constantly to predetermined standard questions by interrupting their conversation or cases of patients providing details beyond the question asked.

Similar to Mishler (1984), Charon (2006a) also offers some challenges involved in clinical encounters between physicians and patients. Patients' experience of illness cannot be merely found in numbers but in language and narratives. Patients' experiences of illness are often perceived in isolation from their family and their healthy bodies. By active and thorough listening to patients' stories, physicians help reconnect and heed the isolation (Charon, 2006a; Jagosh et al., 2011; Morgan, 2008).

Patient-centeredness is described as providing care that is responsive and respectful to the individual patient's preferences and values, ensuring that the patient is involved in the entire process of decision making. In some medical models of physician-patient relationship, the physician is placed in an active more professional, powerful position whereas the patient is placed in a more passive "sick role" (Goyal et al., 2008). In Parsons' (1951) model, for example, the patient's vulnerability to the physician's governing position and following the physician's advice and seeking the physician's expertise has been reported. Unlike Parsons' model, Engle's (1977) bio-psychosocial model was focused on the patient's centrality in physician-patient relations and the influence of different factors, such as cultural, emotional, and socioeconomical, as important factors in patient care. It has been advocated that physician communication training can result in better communication skills, patient satisfaction, and improved health outcomes (Goyal et al., 2008).

According to Charon (2006b), there is a bigger gap in physician and patient relations than in the relationship between nurses and social workers and their clients. This gap in part may be

due to the issues of power, gender, class, and clinical training. Charon (2006b) identified four different dissociations between physician and patient.

Physician-Patient Understanding of Mortality

There is a different understanding of mortality for physician and patient. For a physician, it is the natural process which emphasizes that all humans will die as they are mortal. For patients, however, the realization of death due to their embodied experience of illness is not immediate. For physicians, mortality is a technical defeat but patients may view it as unpredictable and incongruous. If the results of treatment are not productive and the patient's health is declining faster, the physician may worry about the patient's suspicions and about his/her own competence and lack of attention in care. Death not only separates physician from patient but also patients from people who are in good health. Therefore, patients also carry the burden to fight their illness to be able to become part of a "well person" community.

The Context of Illness

For physicians, illness is a biological fact which is in need of medical interventions. For patients, however, illness is seen in the scope of their whole lives. Therefore, there is a gap between patient and physician understanding of illness. Medical professionals are still reductionist in their approach and are focused on the biological aspects of sickness in their patients' experiences of illness.

Beliefs about Disease Causality

There are differences in physician-patient beliefs about causes of diseases and thinking about these causes. The patient's belief of unusual changes in his/her body may also be linked to his/her culture, religion, and family; therefore, describing a patient experience of illness by only the physician's causal ideas might not be sufficient for the patient's mediation. Meanings

of illness for patients are often interpreted by physicians via the aetiology of diseases and reproducible scientific evidence, while for the patients it involves more than scientific explanation and may include factors such as faith, culture, family, and the magical notion of human biology. Physician belief based on scientific knowledge may change when new research generates new knowledge.

The Emotions of Shame, Blame, and Fear

The experience of illness and suffering may also put a physician and patient on two opposite ends of the rope. Patients are often not comfortable describing their experiences of illness if it involves embarrassment (i.e., abuse related issues, bowel habits, sexual practices, etc.) for them; in particular, this is the case with patients visiting opposite gender physicians. Similar to patients, physicians also fear humiliating their patients and may avoid asking questions that may put patients in uncomfortable situations. For the sake of fruitful treatment, there is a need for openness in physician-patient relationships.

Physicians being blamed by their patients due to unfruitful outcomes of treatment and perhaps suing them contributes to physicians practicing on and treating patients with suspicion. In addition, patients may be blamed for causing their own disease. Physicians blaming patients for causing their own diseases help them shift the responsibility from their sides to their patients and give them an excuse for failing to heal their patients' illnesses. Fear is another important factor that separates physician and patient and further increases the complexity of a good relationship. Physicians who have experienced illness and have witnessed their close family members' experiences of illness are more attuned to patients' fear compared to physicians who have not had these experiences.

Successful Clinical Encounters from the Literature

Several authors suggested broader approaches in diagnostic interviews that can address the gaps between physician-patient interactions. For example, Charon (2006a) suggests five narrative features including temporality, singularity, causality/contingency, intersubjectivity, and ethicality that fill the gaps between physician and patient in clinical encounters and lead to effective treatment (see Table 1).

The author further adds that it is important to improve and connect physician and patient through shared ways of understanding of illness and mutual ways of knowing about disease. According to Charon (2006a), the decision-making process about a patient's illness is the most challenging aspect of the physician's job in everyday clinical practice. Integration of narrative medicine methods with evidence based medicine can result in fruitful patient care. Charon (2005, 2006a) described three movements within narrative medicine that include attention, representation, and affiliation. There are usually two people involved in clinical encounters, the teller of a story (often a patient) and the listener (often a physician). In order for the physician to grasp a thorough experience of the patients' illness, he/she needs to have the most crucial skill in clinical encounter which is listening (Charon, 2005, 2006a; Jagosh et al., 2011; Morgan, 2008). It is important for physicians to listen to their patients' stories by suspending any prior assumptions, distractions, and goals to grasp a broader picture of the patient's experience of illness. Despite the emphasis on good listening skills (Charon, 2005, 2006a; Jagosh et al., 2011), the typical approach in the clinical encounter is still one of a more positivistic view of reductionism. Good listening requires physicians to change their routine clinical practice. In routine clinical practice, physicians often ask a series of questions which begins with the current illness and all its symptoms and manifestations and is followed by the patient's medical history, surgeries, allergies, medications, family health history and occupational history, followed by a

Table 1

Five Narrative Features

<i>Temporality</i>	<i>Singularity</i>	<i>Causality/ contingency</i>	<i>Inter-subjectivity</i>	<i>Ethicality</i>
The quality or state of being connected with time or the world.	Individual's uniqueness in the sharing of their narratives.	Narratives attempt to make sense of why things happen, connect thoughts through motive or cause.	"The subject is the self-who-knows, the self-who-acts, and the self who observes" (p. 51)	By sharing narratives, the receiver owes something to the teller by virtue of knowing it.

(Charon, 2006a)

list of questions in “Review of Systems” beginning from the head down, to identify any disorders. Charon (2005, 2006a) takes a different approach in her routine clinical practice as she describes “I’m going to be your doctor. I need to know a lot about your body and your health and your life. Please tell me what you think I should know about your situation” (p. 264). Charon (2005, 2006a) emphasizes how this approach really changes the process of the diagnostic interview from a physician’s controlled interview and a biomedical explanation of the patient’s experience of illness to the patient having the opportunity to describe his/her real life experience. Attention is followed by representation in which physicians write the patient’s description of their embodied experience in a reflective way representing a patient’s voice and sharing their notes with the patient for a member check (Charon, 2005, 2006a). A good reflection of patient experience of illness can create a better medical practice that will encourage patients to follow physicians’ recommendations and gain their trust. Unlike narrative medicine in which notes are created in ordinary language, in everyday medical practice, the act of reflection is followed privately by the clinician and notes are reflective of the physician’s thoughts, feelings, and perceptions filled with the language of medicine. Reflective writing helps clinicians discover aspects of experience that were not clear to them until the writing (Charon, 2005, 2006a; Silva, Charon, & Wyer, 2010). Close attention to the patient’s narrative improves the representation of the patient’s condition and the physician’s representation skills and together loop toward affiliation with patients, other healthcare professionals, and colleagues. Similar to Charon’s (2005, 2006a) description of attention, representation and affiliation, a physician’s role as a communicator, collaborator, manager, health advocate, scholar, and professional have been emphasized as important qualities of physician competency on the Royal College of Physicians and Surgeons of Canada website (2007). In recent years, communication has become a central

topic in healthcare. The importance of good communication as a prerequisite for optimum care and treatment for good intercollegial collaboration is well-documented (Norgaard, Kofoed, Kyvik, & Ammentorp, 2012). (See Table 2)

McWhinney (2001) suggests a patient-centeredness approach as an effective way of addressing the challenges of patients' embodied experiences in diagnostic interviews. Patient-centeredness is described as providing care that is responsive and respectful to the individual patient's preference, needs, and values. Patients in this approach are often part of the decision-making process. The emphasis in this approach is based on five qualities for care including safe, effective, timely, efficient, and equitable practice. By including more open-ended questions, and being attentive to the voice of the lifeworld, physicians can obtain more details about the patient's experience of illness. Open-ended questions also require physicians' increased attentiveness to patients' accounts. Further, it is important to provide a summary of physician understanding of the lifeworld experience back to patients for approval and/or disapproval.

For Mishler (1984), an effective approach in physician-patient interaction is through cohesiveness. To achieve cohesiveness, there should be minimal interruption when patients are describing their stories of illness. The patient's concerns should be acknowledged, attentiveness should be applied during listening to the patient's stories, open-ended questions should be included, patient's experience of illness should be connected to the language of medicine, and a feedback of understanding the patient's conditions should be provided. Finally, medical implications should be shared with patients to achieve productive physician-patient interaction. Attentiveness to the voice of the lifeworld does not necessarily mean physicians should be inauthentically friendly, but rather should promote humanness and effectiveness of care. As the medical interview is a significant part of healthcare, the social perspective of the patient's

Table 2

The Three Movements Within Narrative Medicine

Attention	Representation	Affiliation
<p>Attentive and careful listening to patients, which includes remaining responsive to patients' spoken and unspoken words. Caregiver's knowledge and experience play a key role in gaining potentially valuable information and making the patient feel more cared for.</p>	<p>Creating notes with primary language and using writing to reflect on patient interactions helps caregivers value both their own feelings and those of their patients. This process helps discover different perspectives of patient and practitioner. Once reflective notes are created based on patients' experiences of illness they can then be followed by notes that are reflective of physicians' thoughts, feelings and perceptions of patients' situation. Physician shares consideration of therapeutic and diagnostic interventions as well as prognostic outcomes with patient</p>	<p>The process of attending carefully to patients and reflecting on patients' stories helps caregivers become more informed and more passionate patient advocates. Physicians become closely engaged in their patients' care and gaining patients' trust. This is a stage of junction and perspectives.</p>

(Charon, 2005, 2006a; Silva et al., 2010)

experience of illness is important and needs to be explored within the family, work, and community levels. The focus of Mishler's (1984) work is to draw the attention away from the biomedical model to the lifeworld experience grounded in everyday meaning of illness.

In almost all illnesses, bringing changes in health behaviour among individuals will considerably improve their health. Rollnick et al. (2008) introduced the motivational interviewing technique as an effective tool for clinical encounters.

Motivational interviewing focuses on three perspectives including collaborations, evocation, and honouring the patient's self-determination.

Collaborative

Collaboration is established through supportive and coalition relationships between physician-patient in which the focus is mainly to change patients' unhealthy behaviour.

Evocative

The focus in this approach is to encourage patients to use their available resources to achieve positive changes in their health and not on what patients are lacking such as medication, expert knowledge, skills, etc.

Honouring Patient Autonomy

The clinician may encourage, motivate, warn, and convince patients to bring changes in their behaviour; however, it is still patients' choice, freedom, and decision what they want to do.

There are four guiding principles in motivational interviewing that include: resisting the righting reflex, learning about the patient's inspirations, listening empathetically and, finally, empowering patients. According to Rollnick et al. (2008), it is important for the clinicians to learn about their patients' concerns, values, and motivations rather than merely asking them to follow their recommendations. The authors further emphasize that the focus of medical

encounters is to bring improvements in patients' health. Further, listening is emphasized as a vital clinical skill that can empower clinicians' good reflexive skills and translating patients' experience into appropriate and helpful medical language. Rollnick et al. (2008) describe these three effective communication styles for clinicians: Good listening is about paying full attention to understanding patients' experience of illness and directing and instructing them. In directing, clinicians need to take an active role in physician-patient communication as patients often depend on clinicians' advice, action, and recommendations. In guiding, clinicians need to identify the available resources within their patients' lives and with their expertise and knowledge guide patients effectively to use their available resource to make the change. Asking, listening, and informing are also important communication styles. Some practitioners feel comfortable in asking style only (asking) and tend to keep practicing relying largely on asking (Rollnick, et al., 2008). Despite the commonly adapted standardized questionnaires by clinicians in diagnostic interviews, clinicians can be creative and add open-ended questions and probes to their routine questionnaires to get details about patients' experiences of illness (Rollnick et al., 2008).

There is no universal intervention that will always be effective in changing clinicians' behaviour in clinical interaction (Cosby, Francis, & Butler, 2007). However, as suggested by Charon (2001), a close reading of literature and developing reflective writing skills will enable clinicians to effectively examine and clarify four essential narrative medicine situations including: physician and patient encounter, physician and self, physician and social group, and physician and society. Similarly, giving patients a chance to talk about their experience of illness can ensure valuable information about the patient's lifeworld and their everyday experience of illness rather than gathering facts in a request-response manner (Mishler, 1984). Patients often

remember clinicians who allowed them to describe their experiences of illness and who listened to them (Charon, 2006a; Rollnick et al., 2008). Unlike careful listening, a common criticism of patients' consultation is when they were not allowed to explain their stories of illness.

Physicians' considerations of allowing patients to explain their embodied experience can increase the patient's healing experience even during the medical interview and also provide clinicians options for alternative conclusions.

In addition to listening and including more open-ended questions, it is important to reflect on patients' narratives while listening as it helps patients confirm or refute clinician understandings of their stories. Providing a reflective summary of the main themes found in patients' narratives help clinicians write good reflective notes about each patient's experience of illness and also shows clinicians how powerful listening skills can strengthen the physician-patient relationship (Charon, 2006a; Mishler, 1984; Rollnick et al., 2008).

In the next section of Chapter Two, I discuss the therapeutic relationship between nurse-patient.

Therapeutic Nurse-Patient Relationship

The main components of nurse-client therapeutic relationship include the following:

1. Trust: a very critical aspect of nurse-patient relationship is establishing trust
2. Respect: similar to trust, giving recognition to each individual's uniqueness and health problems is important
3. Professional intimacy: addressing physical, social, psychological, and spiritual aspects of the patient's care.
4. Empathy: understanding and validating the patient's experience of illness as an individual being. (Arnold & Boggs, 2003; Stein-Parbury, 2005)

Emotional distance is also important in providing professional response in care. The issues of power are also central in nursing as the nurse holds more power in the nurse-client relationship for being part of the healthcare system (Stein-Parbury, 2005). Regardless of time, the following components have to be present in patient care: trust, respect, professional intimacy, and empathy (Arnold & Boggs, 2003; Nursing Best Practice Guideline, 2002; Stein-Parbury, 2005; Watt-Watson, Garfinkel, Gallop, & Stevens, 2002).

Understanding anatomy, physiology, pharmacology, and physical pathology are equally important as understanding an individual patient's experience of illness in a clinical situation (Benner, 2001; Stein-Parbury, 2005). An interpersonal relationship between patient and nurse humanizes healthcare. In addition to do more effective work, one's interpersonal relation should be effective and deep (Peplau, 1988).

In holistic care, a nurse reflects on the patient's unique and personal experience of illness. Clinicians, who move from patient to patient in their rounds without asking patients how their night went, often fail to understand the needs of their patients through supportive communication (Benner, 2001). For a surgeon performing a surgical procedure on a patient is just another procedure; for the patient, however, it is a lifelong experience. In clinical and therapeutic relationships patients should not be seen as another number, case, or object. The nurse functions as a source of support in this relationship. Social interaction is important for both patient and nurse in order for them to know each other. Therapeutic communication is essential in all phases of therapeutic relationships. Effective communication between a clinician and client helps to provide a safe place for the client where the client is comfortable to disclose his/her experience of illness and the meanings of his/her experience to the clinician (Arnold & Boggs,

2003). In addition, effective communication helps clinicians provide better information and emotional support which the client needs in order to achieve maximum health and well-being.

A good clinician has to be equipped with excellent interactive skills. For establishing a sound nurse-client relationship, the following components of care are central including trust, accepting, and understanding client's feeling, openness, trustworthiness, empowerment, time, clients' full rights and responsibilities in the process of decision making (Arnold & Boggs, 2003).

Listening is a dynamic and interactive process which plays a key role in the development of rapport. It is important in gaining the client's trust and establishing an interpersonal connection. Listening is an interpersonal process that occurs between the clinician and the client and is a purposeful, goal directed relationship that is focused on advancing the best interest and outcome of the client (Arnold & Boggs 2003). Caring is central to the essence of nursing. It sets up what matters, enabling connection and concern. It creates possibility for mutual helpfulness (Benner, 2001). Caring creates possibilities of connecting with and concern for others, possibilities for giving and receiving help (Benner, 2001). Healing is promoted through assisting the patient in maintaining the human ties and concerns. Human connection plays a key role in recovery from illness. To heal both the body and the person, clinicians need to combine both technological and existential skills in their unique practice (Benner, 2001). Caring is what one might call an existential skill (Benner, 2001). Nurses must stay connected to patients and assure that patients get what they need, focusing on patients' verbal and nonverbal expressions of need and their own reactions to patients' behaviour to alleviate distress. In biomedical approaches to the body, the focus is on physical aspects of body, in particular diseases that can be treated in separation from the patient's personal and social world. Ontological care "refers to the ways that

all human existence daily depends on embodied dwelling in particular human lifeworlds” (Stein-Parbury, 2005 p. 355). Clinicians’ emotional connection to their patients’ experience of illness puts them in a bigger picture of patients’ embodied experiences of illness.

Well-informed patients are able to participate in the decision-making process. In clinical relationships, a nurse following the technical protocol does not mean the patient is treated as a number (Stein-Parbury, 2005). In clinical encounters, it is important for nurses to paraphrase patient’s message to ensure their understanding is correct (Stein-Parbury, 2005). This could be done with both subjective experience of patient’s illness and objective view of the situation. Further, understanding illness is not merely knowing about the disease but also knowing about the person who experiences the illness. Similar to understanding experiences of illness, understanding cultural diversity is crucial in therapeutic relationships in general and for developing rapport and gaining the patient’s trust in particular (Stein-Parbury, 2005). Establishing a therapeutic relationship is crucial in clinician-client relationships. During the initial interview with the clients, engaging them in small talk before delving into their concerns can be helpful in facilitating a therapeutic relationship. Similarly, proper assessment of the patient’s experience of illness, applying adequate time to explore and to finish the communication in timely fashion are critical to the success of establishing therapeutic relationship (Arnold & Boggs 2003; Russell & Potter, 2002).

Responding empathically to client concerns is a necessary set of skills for clinicians to learn in order to enhance the quality and effectiveness of the therapeutic relationship (Johnston et al., 1998; Miller & Rollnick, 2002). Empathy in a therapeutic relationship is described as the ability to understand people from their frame of reference rather than one’s own. Empathy can be gained by building rapport and a working alliance with clients; by encouraging client exploration

of feelings, thoughts, and behaviours; by allowing the client to explore ambivalence toward change; by providing methods to clarify client responses in session; and by providing the foundation for later interventions (Johnston, Van Hasselt, & Heslen, 1998; Miller & Rollnick, 2002).

Peplau's (1988) interpersonal relations model includes four phases of therapeutic relationships. Peplau's (1988) model sees nursing in two ways, educative and therapeutic. According to Peplau (1992), "the goals of nursing are currently in transition; its major concerns fifty years ago had to do with getting sick people well; today, nursing is more concerned with ways for helping people to stay well" (p. 6). There are four different phases in Peplau's (1992) interpersonal relationship model between nurse and client including orientation, identification, exploitation and resolution. There is a close connection between these phases. During the orientation phase the nurse as a technical expert, mother, father, sibling, etc, listens to the patient's concerns, identifies and assesses the problem, recognizes and plans the use of the needed resources, and encourages the client's participation in managing and accepting (establishing rapport and trust). Further, a nurse assists patients to recognize and understand the changes in their bodies and informs patients about the professional help/service that is available (Peplau, 1988, 1992). The second phase for the relationship is the identification phase. During this phase, attempts are made to get to know the client, build trust, and validate the client's perceptions and expectations. The nurse works in partnership with the client and identifies problems that require working on within the relationship. Both the nurse and the client have to elucidate each other's perceptions and expectations as well as identify problems and the necessary solutions. This phase ends by facilitating the client's movement onward and creating an environment for interdependency. At the end of this phase, the patient knows what kind of

help can be offered by clinicians. In exploitation, the third phase of a therapeutic relationship, patients are enabled full use of the resources available (developing independence). During this phase, the client as an integral part of the helping environment is taking control of the situation. The patient develops responsibility and becomes more independent. Finally, during this phase the needs of the client have been met, the relationship passes to closure or the phase of resolution. In the resolution, or last stage of the therapeutic relationship, the therapeutic goals have been achieved and the client's needs have been met (Peplua, 1988, 1992). In Peplau's (1988, 1992) theory, autonomy and advocacy are central and the model examines both client and nurse (self-reflection) in the context of the ongoing relationship. Nurses can have the following different roles in therapeutic nurse-client relationship including the role of a stranger, a resource person, a teaching person, a surrogate, and a counsellor (Stein-Parbury, 2005). Acute care patients are more dependent on their clinicians for accurate diagnosis, effective treatment, and careful monitoring. Patients need to trust their clinicians to use all the scientific measures available and to believe that the clinicians are working in their best interests (Beauchamp & McCullough 1984). In the Intensive Care Unit, the therapeutic relationship may be more in the background. Therefore, the critical care nurse must maintain a balance between the science of curing and the art of caring (Canadian Association of Critical Care Nurses, 2006). Further, in acute care, the nurse is involved with the patient's family and has to advocate and communicate relevant data and the plan of care to the patient's family. Similarly, the nurse has to facilitate access to resources and maximize the patient/family's participation in decision making (Canadian Association of Critical Care Nurses, 2004, 2006).

Stein-Parbury (2005) describes differences in physician-patient and nurse-patient relationships. According to the author, a nurse often gives more total body care to the patient

than a physician, often helping with intimacy and closeness. Further, the nurse relates more meaningfully to the reaction of the patient to his/her illness including the physiological and social changes that are forced on the patient because of their illness (Stein-Parbury, 2005). Effective listening is connected with nurse care and helps the patient see genuine interest, promotes trust, conveys respect, and acceptance, and the patient feels worthwhile and valued. It also helps with taking note of nonverbal aspects.

Similar to Charon (2006a), Stein-Parbury (2005) also emphasizes that narrative is the patient's meaning of illness. The author, in agreement with Min-Sum Kim (2002), further describes that culture provides the framework for a particular society's way of life. Cultural competency helps nurses to be more clinically competent.

In summary, effective use of interpersonal skills, such as empathy, offering comfort and concern, using appropriate humour, and using oneself as a therapeutic agent through deliberate self-disclosure, are among the easiest ways to build a trusting and working relationship with a client. The relationship can be developed if the client's trust has been obtained and continuity is enhanced. Increased client satisfaction is more likely to be ensured in a caring nurse-client relationship. Diagnostic encounters based on establishing a therapeutic relationship with the client in the formulation of meaningful diagnostic care are more likely to be successful. Active listening, trust, respect, genuineness, empathy, and responding to client concerns are among the essential components of the therapeutic nurse-client relationship (Gallop, & Stevens, 2002; Nursing Best Practice Guideline, 2002; Watt-Watson et al., 2002).

Medical Receptionists and Patient Encounters

The role of a physician is not limited to diagnosis, treatment, or operations but is also more complex focused on ethical and organizational complexity (Royal College of Physicians

and Surgeons of Canada, 2007). The increasing size of general practice requires the involvement of nurse, health visitors, and other parties involved in provision of primary care (Morgan, 2008). Therefore, provision of individual patient care requires achieving good interpersonal and communication skills among all members involved in the patient's care. The goal of improving patients' outcomes is not limited to physicians but to a large group of healthcare workers, such as nurses, technicians, and particularly the medical receptionists. Patients' care can be affected by conflict between physicians and medical receptionists (Ahuja & Marshall, 2003). Patients' care involves more than physicians' competency in everyday encounters. Professional medical receptionists can help physicians in resolving conflict situations in patients' care and reducing emotional and financial anxiety involved in clinical encounters (Ahuja & Marshall, 2003). Having different approaches and goals between physicians and medical receptionists can jeopardize the common goal of improving patient outcomes (Mayer, 2000). Diverse opinions in achieving improved health outcomes for patients can also raise disagreement among healthcare professionals and medical receptionists (Canadian Medical Association, 1999). The importance of the medical receptionist role in patient care was reported in some studies (Arber & Sawyer, 1981; Eisner & Britten, 1999; Hewitt, McCloughan, & McKinstry, 2009). Despite medical receptionists' key role in general practice as the first point of contact for patients, there is limited literature detailing the extent to which medical receptionists are undertaking direct patient care activities in healthcare settings. Medical receptionists do make triage decisions which have the potential to affect outcomes for patients in general practice settings which involve the allocation of appointments and basic triage and telephone assessment. Little existing research on evaluation strategies in primary care and measuring medical receptionists important role in therapeutic relationships in general practice could be found in the literature (Patterson, Forrester, Price, &

Hegney, 2005). Because having common views, values, and preference among healthcare professionals and medical receptionists are vital issues in patients' everyday care (Canadian Medical Association, 1999), exploring a broader picture of patients' care in addition to physicians, from perspectives of nurses and medical receptionists is equally important.

Paradigms Influencing Clinical Practice

The provision of high quality patient-centred and clinically effective care is the expectation from healthcare professionals (Meza & Passerman, 2011; Morgan, 2008). A successful clinical encounter does not just evolve around healthcare professionals' knowledge and technical skills but also on the nature of the social relationship between clinician and patient (Morgan, 2008). The patient-centeredness paradigm focuses on two basic principles: First, the importance of patient's subjective experience of illness; second, clinician and patient work as collaborators who share mutual understanding about goals, responsibilities, joint decision making, and treatment plans that meet the patient's expectations (McWhinney, 2001). The approach is also called "biopsychosocial" care and was introduced by Balint (1957) and pioneered by McWhinney (2001). An understanding of patient centeredness cannot be complete without understanding the concepts of Evidence Based Medicine/Practice (EBM/EBP) and cultural competency.

Unlike patient centered care that is patient oriented, the focus of EBM is pathology oriented (Edwards & Elwyn, 2001). However, some authors (e.g., Broom & Adams, 2012) argue that patient centered medicine attempts to reconfigure the principles of EBM by engaging patient and patient perspectives after evidence is identified. Therefore, both approaches are positivistic in nature and the focus is mostly on the condition and health issues as opposed to a person and the meaning of illness to a person. The philosophy of EBM is not new in medicine; however, it

has developed more in the past 2 decades based on changes in philosophy of healthcare systematization (Broom & Adams, 2012). EBM was shortly followed by the Evidence Based Practice (EBP) concept: both are rooted in epidemiological and experimental designs (Broom & Adams, 2012). EBM is the careful, overt, and judicious use of the current best evidence, primarily from randomized controlled trials and other clinical trials, in making decisions about individual patient care (Sackett et al., 1996; Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). EBM helps in improving the quality of care by the standardization of medical care as well as changing medical practice based on clinical trials (Sackett et al., 1999; Sackett et al., 2000). EBM encourages integration of individual circumstances and preferences into the EBM protocol broadly based on population based research (Cluett, 2006). This approach encourages healthcare professionals to justify their clinical actions based on science, effectiveness, and quantification (Cluett, 2006; Edwards & Elwyn, 2001; Trinder, 2000). The purpose of EBP is to provide best quality care in a timely manner to the clients, thereby reducing morbidity and mortality rates (Cluett, 2006; Morgan, 2008). EBM is well-adopted in the problem-based learning approach first described by McMaster University researchers in Canada (Cluett, 2006; Sackett et al., 2000). The philosophy of EBP mainly evolved around partnerships with clients in order to provide services responsive to the client's needs (Cluett, 2006). According to Sackett et al. (2000), EBP is not limited to consideration of best evidence but also high in the quality of clinical skills. Achieving EBP is a challenging task for clinicians in light of new research, new technologies, and new methods that also include communication and assessment skills (Cluett, 2006; Sackett et al., 1999; Sackett et al., 2000). EBP recommends clinicians ask questions that are mostly quantified in nature. However, in practice for best patients' outcomes, there is a need for a more holistic approach that includes and considers different aspects of a patient's experience of illness

that cannot be quantified (Cluett, 2006). EBM is criticised for encouraging generalized care (cookbook medicine) as opposed to individualized patient care. The approach also relies on population based conclusions which may not be applicable to every individual (Scalise, 2004). However, according to Sackett et al. (1996), EBM is not “cookbook medicine” but rather a bottom-up approach that emphasizes the integration of best external evidence coupled with practitioners’ expertise and patient choice. The authors add that EBM is focused on patient choice as well as clinical discretion that encourages effective physician-patient relationship. Researchers argue that EBM is based on quantitative studies which undermine the value of descriptive and interpretative data; therefore, it cannot adequately explore and address the complexities of human life (Broom & Adams, 2012; Cluett, 2006; Robson, 2002). Sackett et al. (2000) acknowledge this limitation and add that the focus of EBP is only on quantitative data and recommend dialogue and debate between clinicians and proponents in qualitative research. For example, Randomized Controlled Trials (RCTs) are mainly focused on quantitative data and are “disease-centered” rather than patient-centered (Broom & Tovey, 2012) and their application to all topics in health is not possible (Cluett, 2006). Therefore, developing a basic understanding of the patient’s condition is very important for clinicians as it helps clinicians confirm their original suspicion about their patients. Sensitivity and specificity help clinicians interpret patients’ results based on probabilities; they are not the absolute confirmation of either presence or absence of disease (Meza & Passerman, 2011). Clinicians need to learn the likelihood ratio in addition to sensitivity and specificity in order to provide better patient care (Meza & Passerman, 2011). Clinicians’ familiarity with likelihood ratios also facilitates decision making on ordering the appropriate tests for patients’ best results.

Despite a broader definition of EBP (Sackett et al., 1996; Sackett et al., 2000), the focus mainly remains on generalization and undermines the individual client's choices and needs. Due to reliance on population based trends in EBM and EBP, some particular subjective features of health and well-being, such as belief, spirituality, hope, intentionality, and personhood, are often undermined and ignored (Broom & Adams, 2012). Therefore, relying broadly on EBP not only limits a patient's choice but also limits professionals' creativity in meeting the needs of highly diverse individuals (Broom & Adams, 2012; Cluett, 2006; Dew, 2012). Similarly, EBP guidelines are helpful in evaluating the standard of care provided by practitioners, but no guidelines are both perfect and responsive. Therefore, in addition to the use of EBP guidelines, there is a need for a combination of good professional judgement based on an individual's specific encounters and stories with clinical evidence (Cluett, 2006).

Further, there is increased tension and dissatisfaction from patients with chronic conditions about lack of recognition of their felt experience due to clinicians' reliance largely on biomedical interventions (Broom & Adams, 2012; Dew, 2012; Goldenberg, 2006). EBM refers to medical practice in which clinical decision making is based on the professional's expertise and less on the patient's important role (Edwards & Elwyn, 2001). Patients in this approach are placed in a passive role and the practitioner in a rather active role. Evidence based medicine follows and supports a realist epistemology in which the objective of knowledge is to predict and control (Edwards & Elwyn, 2001).

Another approach in patient care that is more inclusive in consideration of the patient's needs and expectations is cultural competence patient care. Healthcare professionals in this approach are expected to establish effective interpersonal working relationships with their clients that supersede cultural differences (Cooper & Roter, 2003). Within the cultural competence

patient care approach, the delivery of health services is based on acknowledgement and understanding of individuals' cultural diversity, health beliefs, values, and behaviours in the clinical setting (Betancourt, 2004; Betancourt & Green, 2010; Hickling, 2012; Paez et al., 2009). This starts with the attempts to inform healthcare professionals about cultural norms and cultural peculiarities regarding health and healthcare among patients. According to Betancourt (2004) cultural competency is an essential component of patient-centred care. Cultural competence is closely linked to narrative medicine epistemology in patient care (Betancourt, 2004). Unlike EBM the focus of cultural competency is to improve the quality of clinical interaction by individualizing, rather than standardizing. However, cultural competency is criticised for encouraging the risks of cultural stereotyping.

Researchers documented improved outcomes for both paradigms of EBM/EBP and patient-centered medicine in patient care. However, the outcomes of patient centered medicine show greater patient satisfaction and patient compliance, comparing to EBP (Cluett, 2006). Supporters of EBM claim it is based on certainty and rigorous science; however, this is not true for practitioners in their daily clinical experiences (Dew, 2012). For example, many practitioners struggle with uncertainties in diagnosis and treatment of patients with chronic illness and cancer.

Despite the attempts in standardization of medical practice and care, EBM was not able to reduce clinical uncertainties and the importance of experience in individual decision making. Rather, it increased uncertainties and posed difficulties for clinicians in terms of individual autonomy (Broom & Adams, 2012). For example, clinicians may have different opinions in applying clinical guidelines, protocols, and standards to specific patients; therefore, clinical decision making and implementation of EBM will vary among clinicians as they react to uncertainties in different ways (Flynn et al., 2012; Timmermans & Angell, 2012). Broom and

Adams recommend the integration of social sciences methodology with EBM which can enrich and provide better patient care. Similarly, other recent studies on the clinician-patient relationship recommend a narrative medicine approach rooted in patient centered care and the patient's embodied experience of illness, integrated with EBP that can promise best clinical practice and improved health outcomes (Meza & Passerman, 2011; Silva et al., 2010). Meza and Passerman suggest six "As" for integrating narrative medicine and evidence based medicine (See Table 3).

Chapter Summary

Clinicians often treat patients according to generalized standards of treatment, rather than standards that are focused on a patient's uniqueness;

1. The focus in medicine is on mechanical and objective changes in the body rather than on an individual's embodied experience.
2. Medical practice is often conducted with little or no empathy to the patient's emotional changes attached to their embodied experience.
3. The endorsement of medical authority is dominant in medical interviewing.
4. Lack of emphasis on communication skills in medical interviewing are issues identified in clinical encounters. (Meza & Passerman, 2011, pp. 114-115)

Western medicine views the body as "corpse" instead of viewing it as "lived experience." The impacts of Western medicine's view of the human body may leave the patients with the ideas that their everyday experiences of their own bodies are wrong. Many practitioners view illness as a process that can only be measured and understood through clinical observations and laboratory tests. Medical literature is focused on a biomedical explanation of the human body (Mishler, 1984; McWhinney, 2001; Toombs, 2001). The assumptions in the biomedical model undermine

Table 3

Integrating Narrative Medicine and Evidence-Based Medicine Features

Acquire	Ask	Access	Assess	Apply	Assist
enough information to understand the patient's concern	a clinically relevant question	information to answer the clinically relevant question	the quality of the information	the information to the clinical question	and assist the patient to make a decision

patients' lived experience of illness and thus result in challenges and variations in opinion between physician and patient in clinical practice (Connolly, 2001; Komesaroff, 2001; McWhinney, 2001; Mishler, 1984; Toombs, 2001). A patient's medical record is often filled with a physician's understanding and interpretations of the patient's experience of illness. There have been few or no records filled with patients' reflection and feedback about physician understanding of their experience of illness (Charon, 2006a; Mishler, 1984). In order to consider a patient's experience of illness as truthful it has to be objectified and confirmed by biomedical exams (Mishler, 1984; Wendell, 1996). Physician domination of medical interviews has been reported consistently in physician-patient interaction (Byrne & Long, 1976; Hauser, 1981; Mishler, 1984).

Clinicians relying strictly on an objective scientific description of the body and patients relying strictly on a subjective experience of the body may jeopardize productive physician-patient interaction (Connolly, 2001; Mishler, 1984; Sundstrom, 2001) and further challenge the authority of medical professionals (Connolly, 2001). In particular, practitioners cannot rely on a one dimensional (objective) description of the body (Connolly, 2001; Sundstrom, 2001). To get insight into the complexities of medical encounters, clinicians need to focus beyond evidence-based medicine to patients' embodied experience and validate it as an equal source of information (Charon, 2006a; Connolly, 2001) and admit to biomedical limitations in clinical encounters (Connolly, 2001). Therefore, it is important for the clinicians, in addition to exploring the physiological and mechanical aspects of the body, to explore the larger embodied dimensions of their patients. The body and the emotions are inseparable and clinicians focusing strictly on physiology and mechanical aspects of the body can increase tension between physician and patient (Mazis, 2001). Paying close attention to the patient's emotions does not mean that the

patient requires psychotherapy but rather it calls on physicians and other practitioners to enter into the patient's world and to explore what experiencing illness really means for him/her (Mazis, 2001). Unlike phenomenology that is mainly concerned with the emotional aspect of healing, medicine is often concerned with the mechanical aspects of healing. Patients with severe illness and depressed emotions often find themselves alienated and in isolation from their everyday world. Exploring the patient's emotional world may be complicated and challenging but if medicine wants to bring about positive changes and increase the process of healing in the patient's life, it is vital to change its narrowed focus from the body as a mechanism to the body as a lived body (Mazis, 2001; Mishler, 1984). The patient as a survivor of illness and the one who lived through it has gained understanding and knowledge about it is an insider who has lived, experienced, and witnessed his suffering (Komesaroff, 2001). A clinician, on the other hand, is an outsider who observes, listens, records, and translates a patient's embodied experience into the language of medicine. This translation of a patient's embodied experience is not limited to the collection of facts, signs and symptoms, and biomedical results (Mishler, 1984; Komesaroff, 2001) but is also about the patient's real lived body experience (Komesaroff, 2001).

The patient-centered clinical method allows physicians to effectively provide diagnosis and treatment for patients by listening to the patient's stories and exploring the patient's experience of illness, by entering into the patient's lifeworld, grasping the uniqueness in the patient's experience of illness, and understanding what illness means for the patient (i.e., emotions, feelings, and beliefs, expectations).

In some clinical cases a patient knows more about his/her embodied experience of illness than a physician particularly the bodily symptoms of their emotional state. Ignoring these embodied experiences of illness can jeopardize and create conflicting notions of the case.

Physicians could also provide some alternative ways of describing the patient's illness without invalidating the patient's experience of illness for a better doctor-patient relationship (McWhinney, 2001).

In an excellent patient-centered clinical method, there is a mutual understanding between physician and patient, attending to emotional aspects of illness, there is openness and honesty in sharing and confrontation about the illness, all the small and big issues in the patient's experience of illness are equally important, and the patient trusts the physician's judgment (McWhinney, 2001). Physicians need to have some understanding and integrate themselves in changes that illness can cause in the patient's lifeworld and not just look for objective facts and validating them (Benner, 2001).

The impacts from the cognitive and social authority of medicine are not just limited to individuals with chronic illness but also to their families and people in the community (Wendell, 1996). A careful examination of the cognitive and social authority of medicine and recognition of the phenomenological descriptions of patients' embodied experience will improve quality of care and/increase patient's trust in their care providers. Phenomenological descriptions of the embodied experience need to be accepted and recognized as an equally evident truth as the medical scientific descriptions (Wendell, 1996). Disapproval of the patient's embodied experiences of illness prevents patients from describing their embodied experience to physicians and leads to vague understanding of patients' conditions. Even though patients' information about their condition contributes a great deal to the biomedical explanatory models, there are little or limited resources available within physicians' training to listen, elicit, and respect patients embodied experiences. Exploring patients' embodied experiences can contribute to the diagnosis and treatment of patients' illness (Wendell, 1996). Understanding the presentations of

patients' embodied experiences is also challenged by the limited vocabulary of the scientific descriptions of patients' conditions available for clinicians. Therefore, in addition to biomedical conceptualization, clinicians also need to be aware of the phenomenological orientation to, and philosophical deconstructions of, the human body (Toombs, 2001). Giving recognition to patients' embodied experiences and listening to their experiences of chronic conditions cannot only result in improvements in patients' psychological conditions but also have a significant impact on the reduction of morbidity and mortality. Physicians' view of patients' bodies as a whole instead of objectifying as parts can establish a renaissance for better practice and shorten the mysterious embodied experiences of chronic conditions (Wendell, 1996). Understanding patients' bodies as a whole, exploring their embodied experiences as unique individuals, and exploring their conditions through their embodied experiences can, indeed, speed up the diagnosis of their chronic conditions (Charon, 2006a; Connolly, 2001; Wendell, 1996). Active listening, trust, respect, genuineness, empathy, and responding to client concern are among the essential components of the therapeutic nurse-client relationship (Gallop, & Stevens, 2002; Nursing Best Practice Guideline, 2002; Watt-Watson et al., 2002).

A positive relationship between cultural competency training and effective patient outcomes has been reported. Providing and understanding culturally effective care can, indeed, increase quality of care among patients. Healthcare professionals are required to receive training in cultural competence to effectively address racial disparities in healthcare. Lack of healthcare professionals' understanding in acknowledging and managing sociocultural variations in their patients' beliefs and behaviours may challenge effective physician-patient interaction, and threaten patient satisfaction (Betancourt & Green, 2010).

A wide variety of lesser and more complex roles played by the medical receptionists is reported in the literature. A patient's visit to a clinician's office is not limited to their interaction with a physician and/or a nurse only but also with medical receptionists. The medical receptionist often books patients' appointments, attends to the phone calls from patients and other doctors' offices, provides some medical information to patients on the phone, greets patients at their arrival, books follow-up appointments for patients, and provides reassurance to the patients at the beginning and ending of sessions. These are some of the important roles they play in a patient's journey and through their interacting competency they can make patients' visits smoother and more effective.

In summary, some of the areas that need to be further explored are the following (a) the current approach in clinician-patient encounters ; (b) the connection between physicians' and nurses' competency in diagnostic and therapeutic encounters, as well as healthcare facility medical receptionists' competence in intake protocol and patient care; (c) differences between scientific conceptualizations and embodied experiences as a significant part of health disparities ; and (d) the relation between physicians', nurses', and medical receptionists communication and cultural competence and its effect on patient outcomes beyond the individual organism, potentially influencing their lives, families, work places, and societies.

CHAPTER THREE: METHODOLOGY

It was through qualitative social science, particularly sociolinguistics, that medicine came into narrative realms as a means to represent and understand physician-patient interaction (Mishler, 1984). This research employed a qualitative research design. One reason for using a qualitative research design was because of a lack of empirical literature on clinician-patient interaction in diagnostic and therapeutic encounters. The exploratory nature of qualitative research allowed me to describe broader perspectives and experiences from participants in everyday clinical encounters and the meaning of their experiences, which could not be captured by quantitative techniques. The inductive nature of qualitative design allowed me to document participants' experiences, priorities, and current knowledge in diagnostic encounters and intake protocols. Qualitative research is helpful in gaining detailed and in-depth understanding of any phenomenon about which little is known (Strauss & Corbin, 1990). Further, qualitative data are helpful in describing a phenomenon from both the researchers' and participants' perspectives (Lincoln & Guba, 1985).

Qualitative research helped to gain a deeper understanding of the issues in clinician-patient interaction and the involved challenges. As suggested by Goyal et al. (2008), adopting an interpretive approach is best for evaluating and studying practitioner-patient encounters. Qualitative designs typically include thick description data sets that are then analysed via a variety of interpretive approaches. However, the main difference between quantitative and qualitative approaches is not in the type of data collected nor the forms of analysis used but in the foundational assumptions, beliefs, and givens that are thought to be the organizing principles (Willis, 2007). The traditional views in quantitative research rely on positivist or postpositivist paradigms. Qualitative research gained its position in the late 19th and early 20th centuries in an

academic era that allowed for studying subjective aspects of human existence also known as the constructivist paradigm (Creswell, 2003). In a constructivist paradigm, qualitative data are used and the emphasis is on the importance or relevance of the results to real life. Further, in a constructivist paradigm it is recognized that individuals develop subjective meanings of their experience and create subjective understandings of their everyday world (Creswell, 2003).

Unlike quantitative postpositivist methods which employ deductive methods to reduce ideas to a small set of testable variables that constitute a hypothesis, in a constructivist paradigm the goal is to look for patterns of complexity to generate new ideas (Creswell, 2003). Willis describes ontology and epistemology as follows: "Ontology is about what can exist and what is real, and epistemology is about knowledge" (p. 10). In a constructivist paradigm, the researcher's goal is in finding multiple realities, each contingent on social and experiential situations, rather than a single reality. Realities can be varied in their form and contents, but are still valid as they are based on an expression of individuals' thoughts, feelings, and indications on personal experiences. In the constructivist paradigm, the use of subjective epistemology and relativist ontology are adopted (Denzin & Lincoln, 2005). I engaged in interacting with the study participants and interpreting their views, signifying a willingness to engage with multiple constructions of reality (Guba & Lincoln, 1994). As suggested by Patton (2002), as a researcher one should be attentive and conscious of intellectual, political, communal, linguistic, and ideological origins of one's own view and voice as well as the perceptions and voices of those who are being interviewed and those the researcher reports to. Therefore, through my engagement in reflexivity I provided details about my role as a professional and my personal interests in the research which added to the trustworthiness of the study.

The research method has to be in agreement with the research question and the topic chosen (Holloway & Wheeler, 2010). My research questions were focused on exploring interactive competencies in diagnostic encounters and intake protocols. To obtain a deeper understanding of the experiences of physicians in diagnostic encounters, nurses in therapeutic encounters and medical receptionists in intake protocols, a narrative inquiry helped explore differences between scientific conceptualizations and embodied experiences as a significant part of health disparities. Researchers use a research question to examine the focused issues and gain new information (Holloway & Wheeler, 2010). The research questions were mostly focused on the participants' experiences of everyday life including feelings, hopes, aesthetic reactions, and moral dispositions. I hoped to capture a holistic aspect of participants' perspectives and experiences.

In narrative structure, individuals' accounts are used as a valued way of knowing and understanding for a wide range of social and behavioural phenomena. Narrative and self-identity are intimately related, and, therefore, stories represent the core of our identities that are a universally human way of giving meaning to experience (Charon, 2006a). A narrative approach can be used to understand the meaning and significance of stories through cognitive, representative, and sentimental means (Charon, 2006a).

I used the three features suggested by Mishler (1995) for narrative studies. First, the relationship between the orders in which events happened and the order in which they are told in narration refers to order of reference and temporal orders. In this stage, transcripts were read numerous times, considering participants' interaction based on past, present, and future structure. Second, textual consistency and structure concerns the linguistic and narrative strategies on which the story is constructed. Third, is the importance of narrative with the broader place of the

story within the greater society or culture. In the last two stages, I looked at participants' experiences based on narrative and discourse elements and larger "master" narratives. Further, participants' existential conditions in the environment with other people and their intentions, purposes, assumptions, and points of view were explored.

I was interested in physicians', nurses', and healthcare medical receptionists' accounts of their encounters with patients. The potential participants' reflection on self, their engagements with patients, other practitioners and colleagues were explored. In addition, participants' perceptions and everyday accounts of dealing with patients with chronic illness who require more than typical biomedical treatment were explored.

In addition to issues suggested by Mishler (1995) for narrative research, some of the areas suggested by Engel et al. (2008), such as listening skills, expressing empathy during medical encounters, interpretation of patients' experience of illness into medical language, writing reflective notes, and engaging in medical ethics, were also explored.

Narrative structure helped to develop and increase the existing knowledge about physicians, nurses, and medical receptionists in patient care. In addition, through exploring accounts of the participants, I as a researcher gained access to their experiences and the meaning they give to their experiences. Further, it helped record a holistic view and perspectives of the participant's experience in medical encounters. Exploring some phenomenological aspects of the participants' experiences helped explore the context of lived experiences, embodied experiences, the self-interpretation, and understanding of participants of the study.

The focus in narrative inquiry is in the construction of reality and is interpretive in approach. Narrative inquiry helped provide a more robust description and analysis of

physicians', nurses', and medical receptionists' perceptions and experiences of dealing with patients.

Narrative Inquiry

Often people tell stories about their life experiences that help other people understand these individuals' thinking, actions, and reactions (Ricoeur, 1990). Narrative inquiry is a way to make sense of our surroundings and our actions, to ourselves and to others, as well as the narrative framework that is used (Fulford, 1999). Narrative inquiry has gained popularity in the fields of nursing, medicine, and law as well as organizational studies such as therapy in health fields, social work, and psychotherapy (Clandinin, 2007). Narrative inquiry is used to gain a deeper understanding of an individual's unique life experience. The term narrative refers to a more comprehensive unit of actions that include not only the story telling of individuals' experiences, but also the participants' evaluation of the reported events (Ochs, 1997). Murray (2003) defines narrative inquiry as an organized interpretation of a sequence of events. Similarly, it is a type of qualitative research that captures story as both its raw data and its product (Bleakley, 2005). Bruner (1991) argues that scientific and narrative ways of knowing are fundamentally different. While science concerns itself with the establishment of truth, narrative's concern is to endow experience with meaning. Narrative means to know, and storytelling engages in the production of knowledge as well as the shaping of experience (Chambers, 1999). According to Polkinghorne (1995), narrative inquiry includes three different kinds of research data: numerical, short form, and narrative. In addition, it is an appropriate methodology for researching experiences through time, such as chronic illness (Bleakley, 2005). Chase (2005) sees narrative inquiry as an "amalgam of interdisciplinary lenses, diverse disciplinary approaches, and both traditional and innovative methods—all revolving around an interest in

biographical particulars as narrated by the one who lives them” (p. 651). Lieblich et al (1998) suggest two dimensions for narrative inquiry that include holistic vs. categorical and content vs. form. In a holistic approach, a story is taken as a whole and contextualized in a culture and history, and attempts to cover the general pattern or leading descriptions. While in a categorical approach, particular episodes are selected that may be drawn inductively from the raw narratives to provide manageable data for further investigation. The content is how events happen in a narrative and the form is the way events happen (Lieblich et al., 1998). In addition, Denzin and Lincoln (2005) indicate that “narratives are socially constrained forms of action, socially situated performances, ways of acting in and making sense of the world” (p. 641). The authors further add that narrative inquiry can be used to develop a social change agenda, which can encourage individuals with similar experience to tell their stories. The narrative inquiry approach helps individuals to create a public space for them to be heard as valued citizens (Denzin & Lincoln, 2005). This approach not only explores the participants’ experiences in clinical encounters but also the meaningfulness of these experiences (Fulford, 1999). A narrative inquiry methodology can help to retell the stories of the individuals in rich thick descriptive information which Clandinin and Connelly (2000) call the four directions of inquiry. The first direction (inward) reflects on feelings, hopes, aesthetic, and moral reaction. The second direction (outward) includes existing conditions and environment. The third and fourth direction (backward/forward) include past, present, and future.

The rationale of narrative research is to study personal experience and meaning making in an orderly manner. Narrative research can offer helpful arguments for how events have been constructed by active subjects. Narrative inquiry is used to gain a deeper understanding of an individual’s unique life experience. Narrative inquiry focuses on the experiences of a small

number of people as opposed to a large group and frequently involves giving voice to those whose stories have not been heard before (Clandinin & Connelly, 2007). In narrative inquiry, life experience is described and analysed in the form of a story. In narrative research, the data can be collected in the form of a life story, interview or a literary work. The data can be used to identify differences among individuals and learn about social phenomena and historical periods and to explore personality (Lieblich et al., 1998). Mishler (1995) identified three types of central research issues in narrative studies. First, the relationship between the order in which events happened (order of temporality) and the order in which they are told in narration (order of reference). Second, textual consistency and structure concerns the linguistic and narrative strategies on which the story is constructed; and third, the importance of narrative with the broader place of the story within the greater society or culture. In 1938, Henry Murray, a trained physician, described the use of individual narrative case studies, which had been central in the history of medical science (as cited in White, 1963). He emphasized that living beings must be studied as living wholes.

In narrative inquiry, a detailed story or detailed life experiences of one person or a small number of people is obtained. In narrative research, individuals' stories are explored based on their personal experiences (e.g., work, home), their social experiences (e.g., community, culture) as well as their historical contexts (e.g., time and place) (Connelly & Clandinin, 2006). Three areas specific to narrative inquiry including temporality, sociality, and place make this methodology different from other qualitative methodologies. Connelly and Clandinin (2006) call these three areas "commonplaces." By attending to the commonplaces, researchers are able to gain an in-depth version of participants' experiences inside and outside the inquiry. In temporality, the quality of experience through time is explored based on past, present, and future

structure. In addition, attention is paid to temporality of places, events, and things. In sociality attention is paid to both the person and the social conditions. Personal conditions include individuals' hopes, feelings, desires, and moral disposition. Social conditions refer to the unfolding of participants' experiences and events in their context and present conditions, as well as the involved environmental factors such as community, administrative, and institutional narratives. Place is defined as a setting or series of places where events take place as all events happen in some places and individuals connect their experiences and stories in relation to a place.

Stories matter to patients, families, physicians, nurses, and everyone who is involved in clinical and therapeutic relationships. The results of a clinical encounter are often fruitful when careful attention is paid to the participant's accounts. However, if a patient's stories and accounts are not taken seriously, the results of a clinical encounter are usually much more problematic (Engel et al., 2008).

Narrative Research Background and Context

In his third edition of *Qualitative Inquiry and Research Design, Choosing Among Five Approaches*, John Creswell (2013) summarizes several key features of narrative approaches to inquiry from the works of noted researchers in the field (i.e., Clandinin & Connelly, 2000; Chase, 2005; Josselson & Lieblich, 1993; Pinnegar & Daynes, 2007). Narrative approaches typically involve stories which can come from interviews, third party reports, documents, and conversations; involve collections of individual experiences that shed light on the identities of those involved; may be individual (i.e., a single individual) or may be phenomenal (i.e., about a particular experience) or may be institutional or cultural; may be gathered through various forms of data; may be shaped into a chronology or rendition by the researcher that need not be in

keeping with the order of telling; are analyzed in numerous ways, but typically enable the eventual reader to understand the “story” of the experience, person, or phenomenon under study; and narratives can occur in particular places and situations and often contain tensions, contradictions, interruptions, and turning points or salient experiences.

One of the most distinctive features of narrative inquiry is its reliance on narrative as an overarching existential and epistemological structure (Ricoeur, 1990) for humans in interpersonal, sociopolitical, and cultural experiences. That is, humans are constantly working within and between varying kinds, degrees and levels of narrative as they live, work, play, and learn. Familiar narrative structures of progression through a trajectory, unfolding and intertwining storylines, roles, plots, conflict and resolution, subtexts and successions of “beginnings-middles-endings” are frequently lived or enacted in interpersonal, familial, professional, institutional, societal, and cultural contexts, albeit in often unconscious or invisible fashion. Further, since many cultures have their own idiosyncratic narrative forms and traditions, it is not uncommon to see these patterns threaded through the intra-cultural layers of family, profession, organization/institution, and society. The trick in narrative inquiry, especially narrative inquiry that is concerned with phenomenon or experience more so than singular or individual stories, as in this study of narratives of clinical encounters, is to uncover the narrative structures at work beneath the surface that even the tellers of the tales may not be aware of.

Charon (2005, 2006a) and Mishler (1995) have taken narrative structures to the context of medicine and have re-oriented the narrative tools at their disposal so that narratives within various medical encounters might be analyzed in ways that reveal what is at work beneath the surface of taken for granted encounters. Indeed, the more taken for granted or familiar the encounter, the more likely the internal workings of narrative will be invisible in their familiarity.

Charon (2006a) uses the process metaphors of attention, representation, and affiliation to allow for an analysis of typical encounters which illuminate and crystalize how various levels and types of narratives might be operating simultaneously and/or at odds with each other. Mishler (1995) uses more formal tropes of language structures, order of reference or order of temporality, and figure/ground against a larger cultural narrative to allow aspects of taken for granted retelling to be analyzed in more particular and unsparing fashion, most especially when specialized discourses are used and when power differentials are enacted, either consciously or otherwise.

This study takes up many of the features outlined by Creswell (2007); yet, is also more closely aligned to the overarching structural approach and utilizes the particular application of narrative to medical contexts as proposed by Charon (2005, 2006a) and Mishler (1995). Narrative elements are present in the stories, documents, and website. Inductively, Mishler (1995) allows for an articulation not of an individual physician's story or narrative account of an experience, but rather a superordinate template of the narrative elements operating within the interview accounts of clinical encounters, policy documents of physicians, nurses and medical receptionists, and the CCC website. Deliberately using Charon (2006a) allows the data sets to be recast in terms of narrative medicine themes that are present across types and levels of clinical encounters.

Site and Sampling

Depending on the research question and focus, decisions about targeting a sample for a study are made by the researcher during the initial phase of the research (Holloway & Wheeler, 2010). The site in which the data were collected is Niagara Region which is populated by over 410,000 people (Information Niagara, 2006). The Region includes: St Catharines, Niagara Falls,

Welland, Fort Erie, Port Colborne, Grimsby, Thorold, Niagara-on-the-Lake, Lincoln, Pelham, West Lincoln, and Wainfleet (Information Niagara, 2006).

Having a small sample size is not an issue of concern as the goal is to gain in-depth understanding of the participants' experiences using qualitative research. However, it is important to provide details on the richness of data collected and its sufficiency. The study participants were selected based on specific characteristics (Patton, 2002). A criterion sampling (select cases that meet the set criteria) with reasonable coverage of the phenomenon considering the purpose of the study was used (Patton, 2002). In recruiting the study participants the focus was not to select a representative sample, but rather to recruit information rich participants and explore their perceptions and experiences on diagnostic encounters and intake protocols. Information rich participants were selected because of their uniqueness. Data were collected from purposefully selected participants to show a different perspective of the issues (Yin, 2003).

The researcher worked in a related healthcare profession and had access to an experienced physician who helped in recruitment of physicians from Niagara Region based on the established criteria. In addition to five physicians, four nurses and four medical receptionists were identified and a copy of the letter of introduction was provided to them. Each participant took part in an interview that lasted approximately 45-60 minutes. The interviews were conducted in different locations within Niagara Region. The study has been reviewed and received ethics clearance by the Brock University Research Ethics Board (File # 10-065 - CONNOLLY).

A purposeful sampling method was utilized, which involves selecting subjects to complement the goals of the study (Schloss & Smith, 1999). Purposeful sampling uses special knowledge and expertise about a group to select participants who represent that population

(Berg, 2004). According to Patton (1990), purposeful sampling selects information rich cases for in-depth study. A criterion sampling which involved the selection of participants who met some criteria was used. Participants were selected based on the following criteria:

- licensed physicians
- practiced medicine for 5 plus years or in specialty training
- living in Niagara Region.
- between 25 and 65 years of age
- male or female

for nurses and healthcare medical receptionists

- worked in healthcare field for 1-5 years
- worked in Niagara Region
- between 19 and 65 years of age
- male or female

Data Collection

Data collection can be achieved through interviews, observation, and reviewing documents such as diaries, oral history, and letters. Interviewing has established its place as a common method of data collection by qualitative health researchers in the last 2 decades (Holloway & Wheeler, 2010). Multiple sources of data including interviews, policy documents, and a website (triangulation) were used (Merriam, 2009). Triangulation as a primary strategy can ensure validity and reliability of the study. Furthermore, triangulation can ensure consistency of findings, different sources of data, and the use of multiple theories or frameworks in interpretation of data (Patton, 2002). Data were collected through interviews and the researcher engaged in interacting with the study participants and interpreting their views, signifying a

willingness to engage with multiple constructions of reality (Guba & Lincoln, 1994). Policy document analysis provided a historical and formal view of the larger medical system requirements (Holloway & Wheeler, 2010). In addition to interviews with physicians, nurses, and medical receptionists, a third source of information that was invaluable to this research was analysis of content and process available on websites from The College of Surgeons and Physicians of Ontario and University of Toronto (communication and cultural competency program).

For the purpose of this study, a total of 13 participants took part in the standardized open-ended interviews. Participants included five physicians in active practice, four nurses, and four medical receptionists from a HR department that provided healthcare services in different healthcare settings such as hospitals, complex medical services, walk-in-clinics, family medicine, and sleep medicine. The interviews lasted 45-60 minutes and the participants had a chance to describe their feelings, thoughts, and experiences in their own unique way in response to questions and further prompts when necessary (Patton, 2002).

Through triangulation of the policy documents, website review, and interviews, I hoped to make a contribution to the scholarly knowledge in the two particular areas (a) the current literature on clinician-patient interaction, and (b) the perceptions of physicians, nurses and medical receptionists regarding patient care in everyday clinical encounters and its importance for future practices. Ultimately, I hoped to learn more about how these issues might be effectively integrated into the framework of narrative medicine. Details were provided on the researcher's own knowledge and understanding of the assumptions that might have been brought to the study.

In addition to construction of meanings in the context of a particular interview or study, I provided details on excision of any previous theory or knowledge, or socially constructed meaning that might have shaped or limited the results in the study.

Interviews

In qualitative research, the purpose is to understand some part of the human experience, and one of the most common methods of qualitative data collection is through interviewing (Donalek, 2005). According to Patton (2002), qualitative interviewing begins with the assumption that the perspective of others is important, understandable, and able to be made clear. Consistency in interview structure is helpful in ensuring that information within the same area is being collected from all the participants of the study. Despite a more focused approach than in guided interview, standardized open-ended format still allowed for flexibility; for example, follow-up questions and probes were added depending on the responses. The questions were open ended and this approach facilitated information within a shorter period of time compared to an unstructured, conversational approach (Kvale, 1996). I formulated the questions using Quinn Patton's six types of interview questions guideline (demographic, experience/knowledge, behaviour, emotion, sensory-based, and opinion/value) and a past-present-future prompting strategy. I also drew from the literature and the background documents to provide familiar discourse and examples for each group of informants. A standardized open-ended interviewing method was used to interview the participants and represent their perceptions, opinions and facts about their life experiences (see Appendices A, B, and C). All interviews were tape-recorded and later transcribed verbatim.

Policy Documents

Policy document analysis can provide a historical and formal view of the system requirements (Holloway & Wheeler, 2010). Policy documents regarding intake protocols and diagnostic interviews, and standards of practice/curricula applicable to practitioners in Ontario, Canada were reviewed. These documents were accessed from the following websites: Council of Ontario Faculties of Medicine (COFM), The Canadian Association Schools of Nursing (CASN) and Academy of Learning College Ontario.

The Website

In addition to interviews with physicians, nurses, and medical receptionists and review of policy documents, a third source of information that was invaluable to this research was analysis of documents available on the websites called Communication and Cultural Competency (CCC) by the Royal College of Physicians and Surgeons of Ontario (2007). The website helped understand the embedded assumptions regarding interactive competences and comportment of Canadian physicians. Attention was paid to identification of narrative elements through manifest and latent content analysis.

The College of Physicians and Surgeons of Ontario and The Medical Council of Canada (2007) has developed the (CCC) website for physicians practicing in Ontario. However, the focus of the program was mainly for physicians trained outside North America, often referred to as International Medical Graduates (IMGs). The program is intended to help IMGs to gain familiarity with medical competencies expected of physicians in Canada. In addition, the website aims to help IMGs understand the objectives (called the CLEO -2s or C2-LEOs) of the Medical Council of Canada. According to the website communication, ethical and professional behaviours were recently added to the revised Medical Council Objectives. The need for adding

these topics to the revised Medical Council Objectives was because of a lack of availability of these topics in textbooks and other sources of information used in medical schools. The website is mainly intended to improve cultural and communication competency among IMGs.

The reason for including analysis of this website was to help clarify competence expected of IMGs in Canada and the assumptions undergirding these expectations. Further, the website became a third source of data and contributed to credibility and dependability in the context of data triangulation.

Ethical Considerations

Participation in the study was voluntary without any monetary incentives. To improve the credibility of the interview (Lincoln & Guba, 1985) an audit of the transcripts was conducted. To ensure confidentiality, pseudonyms were assigned. In the letter of introduction for the recruitment of participants, the idea of confidentiality was clearly discussed. It ensured that the participants were fully aware of the purpose of the study and confidentiality. Confidentiality was maintained during the primary data collection phase. The written transcripts were labelled by the interviewer using pseudonyms. A master list of the participants' names with related pseudonyms was stored in a secure location in a locked drawer in the office of Dr. Connolly, Brock University. All paper records that linked participants' actual names to pseudonyms were destroyed upon completion of the study. Anonymity cannot be guaranteed as the researcher conducting face-to-face interviews with the participants. The assigned pseudonyms were used in reporting the findings. All identifiers (i.e., references to specific individuals) were stripped from the transcripts and verbatim quotes used in the reporting of the study. Participants' names do not appear in the written and oral dissemination of the study. Where necessary (i.e., in the use of direct quotes) pseudonyms were used. The direct quotes were scrutinized to ensure that the

participants were not identified. The study has been reviewed and received ethics clearance by the Brock University Research Ethics Board (File # 10-065 - CONNOLLY).

Qualitative Data Analysis

Data analysis is the process of systematically organizing data, bringing meaning to patterns and themes so that they tell a coherent story, and communicating that story to others (Glesne, 1999). In this process of data analysis, I took the role of an active learner. As Connelly and Clandinin (1990) describe, a researcher in a narrative inquiry focuses on learning about both the personal experience and social experience of the participants. According to Creswell (1998) acquaintance with data should be ensured in the process of data analysis. I began data analysis by familiarizing myself with interview transcripts, and read each transcript thoroughly numerous times to ensure familiarity with the data. Numerous reading of transcripts helped bring new insights and consideration of multiple meanings intrinsic in the data (Hatch, 2002; Patton, 2002).

An overall approach to inductive analysis starts with specifics and proceeds to general elements (Hatch, 2002). Particular pieces of information collected from the participants were developed into a meaningful whole (Hatch, 2002). Data analysis began from the time I engaged in data collection. Once familiarity was achieved with the collected data, I started with open coding and broke the data into units of meaning to explore the important categories. Through overall levels of inductive analysis, I discovered how the participants made sense of their personal and social world.

Then I developed strategies for reducing the large data sets into more manageable, yet representative, categories. The categories developed helped examine each transcript for complexities, richness, and depth. Categories were drawn together to tell a story. According to Patton (2002), the first step in data analysis is classifying the data into a manageable scheme or

coding. Open coding was used to label and summarize data into meaningful units. Specific segments of information were identified in each transcript. Each participant's account was examined for similarities and differences during the process of coding (across case and within case analysis; Patton, 2002). Open coding involves familiarization of the researcher with the data and identifying large units of data that relate to an idea. I started open coding by reading the data line-by-line and assigned terms that best represented the idea that was expressed. Open coding helped to explore the data in a detailed way by identifying and conceptualizing the data. Then I used axial coding that helped to connect different open codes into clusters and categories and includes situations and phenomena in discovering the relationships between different statements. I divided the codes into different categories and examined the transcripts for similarities and differences across the participants within and across groups. The coded transcripts were then sorted based on interconnected patterns and salience. Selective coding was then used to confirm the relationships between different categories (Patton, 2002). The selective coding was informed by literature driven typologies. Data were examined thoroughly to reduce redundancy among different categories. Inductive analysis steps suggested by Hatch (2002) helped to connect different categories and include situations and phenomena in discovering the relationships between different statements. Big units of information were reduced which became the basis for defining different categories that developed from the data sets. Relationships between different categories were confirmed (Patton, 2002). The most important categories were used as the main headings in the findings section. Mishler's (1995) narrative strategies were deployed in "retelling" the narrative elements and in the construction of a composite, consolidated narrative.

For the purpose of reviewing the website on communication and cultural competency as well as human resource documents, the features suggested by Mishler (1995) and Charon (2005,

2006a) as well as manifest and latent analysis allowed for a holistic lens on the experiences, ideas, and views that were offered. Berg (1995) defines manifest and latent contents as follow: “manifest content is comparable to the surface structure present in a message” whereas latent content refers to “the deep structural meaning conveyed by messages” (p. 176). Manifest content focus takes seriously Quinn Patton’s (2002) suggestion to “make the obvious, obvious,” while the latent content analysis takes up Quinn Patton’s further steps of making the obvious, dubious, and making the hidden obvious.

Inductive methods were used that supported the trustworthiness of the results of the study (Bryant & Charmaz, 2010; Charmaz, 2006; Holton, 2010; Lincoln & Guba, 2000). An explanation of the process, action or interaction shaped by data analysis as suggested by Creswell (2007, 2013) was provided. I adopted a critical reflexivity in the process of data analysis (please see the reflexivity section). I included all data collected in the process of inductive data analysis. I started with reading and coding and moved to theoretical frameworks and gradually brought the focus to the research questions. The research findings developed from the frequent, significant patterns and saliences grounded in raw data, without imposing any restraints. A clear link between research goals and summary of findings was established to ensure the transparency of the process.

The theoretical framework for the study helped in representing the accounts of the participants in a descriptive way that reflected their experiences and perceptions of care in clinical encounters and intake protocols. (See Table 4)

Table 4

*Summary Chart Chapter Three***Sampling and Site**

Sampling strategy	Number of participants	Site
Criterion	5 physicians	Niagara Region
Heterogeneous	4 nurses	Niagara Region
Purposeful	4 medical receptionists	Niagara Region

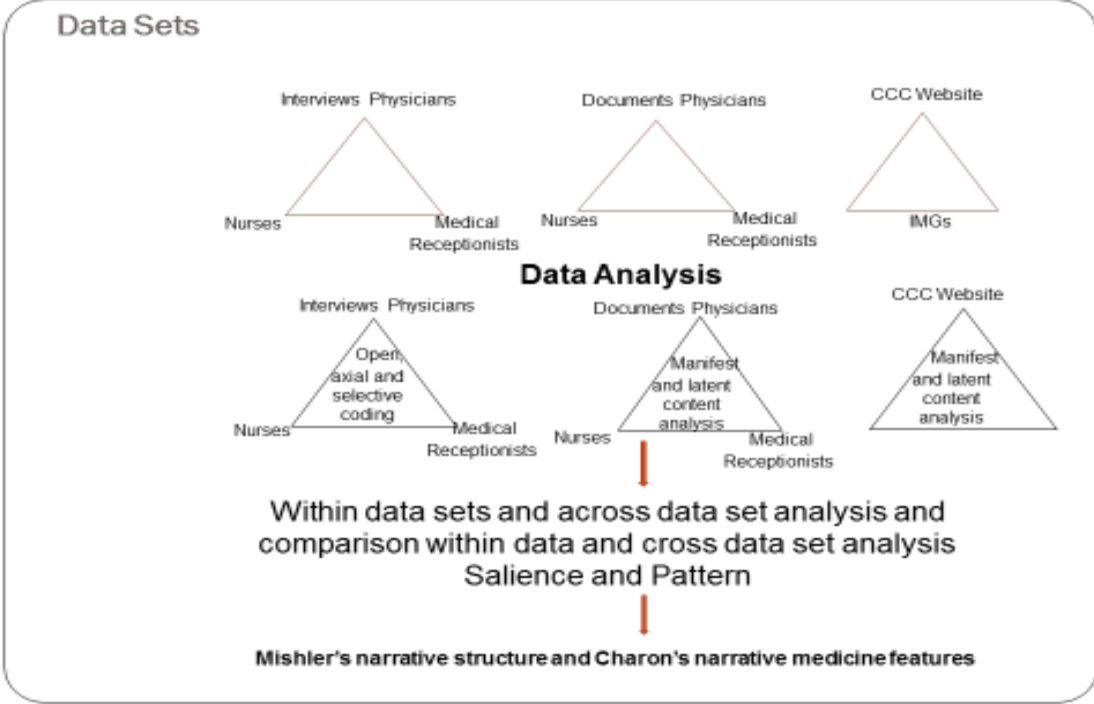
Data Collection

Interviewing	Human Resource Policy Document	Website	Site
Physicians	The logistic and technical experience related to diagnostic encounters and staff members	Communication & Cultural Competency (CCC)	Ontario
Nurses			
Medical receptionists			

Note: The reason for including the CCC website is to explore the embedded assumptions regarding interactive competencies of Canadian physicians.

Data Analysis (Using NVivo10)

Interviewing	Human Resource Policy Document	Website
Open, axial and selective coding, within case and cross case analysis. Narrative features and structure based on Mishler (1995) Charon (2006a).	Manifest and latent content analysis, as well as Mishler and Charon's narrative structures.	Manifest and latent content analysis. Mishler and Charon's narrative structures.



Reflexivity

According to Hertz (1996), the concept of reflexivity arose from a modification in the consideration of data and its gathering. A reflexive study does not just report facts or truths but actively constructs interpretations of the researcher's experience in the field. Reflexivity is also the reaction of participants resulting from being studied or observed (Howard, 1985). Other qualitative researchers define reflexivity as the process by which researchers review and challenge the bases for their thought and decision making throughout data gathering and theory building (Hertz, 1996). While reflecting on the data, researchers also reflect upon the ways they create the assumptive framework upon which they construct their understandings of the data (Berg & Smith, 1985). Furthermore, reflexivity can be defined as an awareness of the impact of the research process on the participants of the research investigation (Calhoun, 2002). According to Patton (2002), as a researcher one should be attentive to and conscious of, intellectual, political, communal, linguistic, and ideological origins of one's own view and voice as well as the perceptions and voices of those who are being interviewed and those to whom the researcher reports.

A responsive sense of awareness was maintained when adding contextual data and also when writing journal entries. A journal was kept to note memos and field notes throughout the research. Following Holloway and Wheeler (2002), to ensure the credibility and dependability of the study, as a main tool of research I reflected on my role, feelings, and experiences as a researcher during the study. Further, I reflected on my own learning process, emerging themes, and potential connections. A journal with wide margins on the left-hand side was used to enable me to highlight particular events of interest and create specific notes. The journal helped to remind me to investigate events in more depth (Berg, 2004). It also helped note participants' thoughts and responses about their experiences.

I am a graduate of Kabul Medical University with an MD degree in medicine. After completing medical school and my residency in surgery, as well as completing 1-year training in general surgery, I started working in a reconstructive (maxillofacial) surgery ward in the Academy of Medical Science hospital in Kabul and continued my work until July 2001. Working under the tight military environment as a civilian doctor was the main reason for quitting my job as a surgeon and joining an International Non-Governmental organization (NGO) as a health program officer in July 2001. My interest in and appreciation of qualitative research started from my work in the NGO. I have participated in over 20 need assessment surveys and participatory rural appraisals and always found deep meaning in the stakeholders' stories and one-on-one interviews.

My passion for conducting qualitative research increased in 2005. I conducted a qualitative research study of a community organization *Design for a New Tomorrow*. The mentioned organization provides support for women who have experienced abuse related trauma. It was this experience that encouraged me to undertake Master's level research and further explore the experience of trauma among women and find out more about their experiences of social exclusion in the mainstream society. The flexible nature of qualitative research allowed me to use a narrative inquiry to re-tell the life stories of eight women who experienced trauma and used the data analysis software Nvivo 7 to analyze the data using open, axial, and selective coding. I was able to gain more in-depth knowledge of qualitative research and therefore intended to take the research to a more advanced level in my doctoral studies.

In 2007, I also started working as a Sleep Technician for the Greater Niagara's Sleep Disorder Clinic, where I am currently working as a Team Leader and Sleep Technician. Despite my background in medicine, I have always had an appreciation and interest in social science.

However, I was not aware of the different perspectives and approaches to the body other than the dominant biomedical approaches.

My theoretical interest in exploring the clinician-patient interaction in diagnostic encounters and nurses and medical receptionists in intake protocols is partly because of the results of my previous research on women who have experienced trauma and their access to community supports. Part of the results indicated that women's experience of social exclusion, isolation, and lack of access to the social determinants of health was due to their social workers' incompetence and reductionist approach, their inability in understanding the impacts of trauma in the personal and social life of the participants, and what it was like for the participants to cope with experiences of trauma in a broader embodied and environmental experience. Community support workers' reductionist approach in participants' intake protocol raised several questions about intake protocols in general and in clinical encounters in particular. My interest in exploring interactive competence among clinicians gradually developed after hearing a large number of patients' narratives and dilemmas concerning interaction with their clinicians. Another source that contributed largely to this interest was through a review of phenomenological literature on lived experience and embodied experience of illness.

My interest in using narrative inquiry is out of my interest as I make meaning in my life through narrative and make sense of my personal actions and my social interactions through narrative. I construct my realities through narratives. The more I focus on my stories the more I know about my life and the lives of other people.

After reviewing the books *Phenomenology of Medicine*, *The Rejected Body*, and other related literature, I became more attuned and aware of the unconscious understanding of the body through a broader lens of "the lived body." Understanding and studying the body through

an individual's emotions and experience of illness and what it really means for someone to be ill is more than just learning about mechanical changes in the body. Phenomenology taught me how significant and vital understanding of an individual's experience of illness through emotions and meaning of illness is and how it is equally as important as physiological and anatomical changes in the body, since emotions can play an important role in the process of healing. Correcting, repairing, and treating mechanical changes in the body cannot restore patients' emotional disconnect from their world after experiencing illness, and focusing only on physiological and anatomical changes can only correct the mechanical aspects of the body and can never guarantee an accelerated healing process.

I intended to provide a summary of my medical encounters in my previous job as a surgeon and my current job as a Team Leader/Sleep Technician. I possess a friendly demeanor and the kinds of communication skills which make it less likely that I would irritate or offend patients. As a committed professional trained in medicine with a research background in Applied Health Sciences, I understand scientific methodology and appreciate the ideologies of clinicians that make it easier for me to understand the logic of clinical reasoning. I have witnessed the medical authority of clinicians in everyday life through my own background as a surgeon and sleep medicine practitioner, and through my visits as a patient to my family physician and other specialists' offices. My initial existential anxiety was reinforced when I first started working as a sleep technician. My work solely involved technical and procedural work with some interaction with patients. Finding myself in a different role in the medical field and prolonged engagement with patients made me more sympathetic towards patients' experience of illness and I started reflecting on my understanding of patients' visit to the sleep clinic and providing a brief history of patients' concerns and emotions that were not included in my job description, on the patient's

monitoring sheet. After writing my reflective notes on patients' monitoring sheets, I started to receive appreciatory notes from the director of the sleep clinic about my notes and how it provided him with a word picture of the patient that helped him in making accurate diagnosis. After a year, taking a patient's history of sleep became part of all technicians' job description in my work place.

I will provide a summary of my life as a maxillo-facial surgeon from 1999 to 2001. The main focus in this branch of surgery, similar to other branches, is to maintain the physiological function and aesthetic appearance. Reconstructive maxillofacial surgery includes correction of deformities in different anatomical regions particularly in the maxilla, mandible, face, cranium, and throat. After a successful surgical procedure confirmed by the laboratory results, it was expected that the patients would immediately, after the expected postsurgical recovery period, acknowledge the positive changes in his/her body by affirming a complete physiological and mechanical well-being in the damaged anatomical region. But if the results were otherwise then most of the surgeons in the team would assume that the patients might be in denial of the positive changes. The patient was not acting "normal" after mechanical repair to his/her body as if there were some universal rules for normalcy. The emotional side of the patient's reembodiment was not our concern and none of us had known what it really was that was taken away from this patient before the injury, or that having the deformity corrected was more than just aesthetic correction for the patients. Our expectations after postsurgical recovery from patients' bodies were solely in mechanical corrections. Perhaps to find themselves in the world and validating the emotional impact of their embodied experiences had more healing power than the surgery. Listening to patients' narratives and what it was like for them to live with illness and deformities would have definitely helped in finding common grounds in our interaction with patients and

also getting the patients' sense of control over their bodies by listening to their embodied experiences. Exploring the emotional register of the patients' situation might have helped patients to repair their emotionally devastated relationship to the world and facilitated the emotional process of healing in addition to physiological and mechanical repair.

I have been working in sleep medicine for the past 5 years and through this position have worked very closely with patients with different sleep disorders particularly those with sleep apnea. My current research topic has a lot to do with my earlier view of patients as subjects and their bodies as mechanisms, which could be solely understood through physiological and biomechanical consideration of the body.

I will now reflect on my several years of experience of working in sleep medicine. I frequently deal with patients with severe obstructive sleep apnea and the treatment of it by using the gold standard treatment Continue Positive Air Pressure (CPAP Titration). Obstructive sleep apnea is a serious sleep disorder in which breathing frequently stops and starts during sleep. Obstructive sleep apnea is the most common type of sleep apnea, which occurs when your throat muscles sporadically relax and obstruct your airway during sleep and snoring is its most noticeable sign. The CPAP includes a small machine that supplies a constant and steady air pressure, a hose, and a mask or nose piece. The main focus in CPAP treatment as in most medical models in evidence-based medicine is to correct the pathological respiratory changes in patients that disturb the normal breathing pattern and, thus, cause sleep fragmentation and interruption and often leave patients with nonrestorative sleep. What this treatment really means for patients and how this new way of being in the world is experienced by the patient are not fully explored. For those patients with a belief in the medical model and view of the body as solely mechanical, it is easy to find themselves after using the CPAP mask for their one night

stay at the sleep disorders clinic very positive by acknowledging a dramatic improvement in their sleep. However, one would never understand through assessment of the patients' questionnaires, the embodied experience of patients who despite correction of their severe apnea would end up saying "I had a horrible night." Maybe this group of people includes those in denial of their embodied conditions as when they sleep they are not aware of what happens to them and feedback from partners and family members and friends is not credible. There is still the question in my mind why some patients diagnosed with severe sleep apnea are resistant to the use of the CPAP treatment despite it being the most effective treatment. Perhaps this category of patients are those who are thinking of the treatment beyond correction of their breathing and perhaps it means being in a different world, a world unknown to their bodies. Getting used to using the CPAP mask would mean adapting to a new space as they picture themselves in a changed world different from the world they lived in when they thought the body was still functional without any external help. Perhaps this group of patients is more aware of their embodied experiences and the meaning of these experiences they may see themselves in a different world with a disconnect from their world in a uniquely different way, and correcting the mechanical aspect of breathing and gaining restorative self cannot provide a logical enough explanation. After a successful CPAP titration that corrects severe pauses in breathing, getting rid of the horrible snoring and severe desaturations (decrease in oxygenation of the blood), patients still believe that they did not have a good night's sleep. I used to get upset at patients' "dishonesty" about their feedback about their sleep and especially after putting a lot of effort into doing a successful titration, being sleep deprived myself because of not being able to get enough sleep some days would increase the expectation of positive feedback from patients. It would also mean that being sleep deprived, and looking at a perfect breathing effort and witnessing patients' deep restorative

sleep would make me wish to have slept with a CPAP mask myself and gained the refreshing feelings of a restorative sleep. But perhaps I somehow was also thinking about my success and achievement as it was about me (as assumed in clinical encounters) and might have ignored that correcting the mechanical aspect of breathing cannot immediately change a patient's view of his/her sleep. A larger meaning of a good night's sleep is not just to experience no respiratory events, snoring, and desaturations but also the meaning a patient attaches to a good night's sleep. Perhaps their own bed and sleeping environment is a familiar environment to the body, where the lived body finds a sense of comfort, meaning, and relaxation. Then it is not just the sleep they had the morning after their study that the patient is talking about; it also is the entire environment and how they attach their environment to the meaning of a good night's sleep. Having less control of a certain way of sleeping (i.e., sleeping on stomach) and being unable to do that because of the CPAP mask could also restrict the patient's bodily freedom and the level of control he/she has. Patients perhaps feel having less or no control of the way they sleep being unable to move freely and as much as they want would be a factor as well. This might not be true for all patients as sleep hygiene and patients' bedding could also play a major role in how they feel after their sleep. I often hear patients say "You are a nice guy, I hope to see you again but not here, it was a horrible night."

In conclusion, it is important to understand and explore patients' experiences of illness and their narratives in addition to biomedical explanations. It is also important to explore the adverse health outcomes associated with the experience of illness. For clinicians, developing skills to establish a safe clinical environment and gain patients' trust can increase both clinicians' and patients' comfort and improve outcomes in everyday clinical encounters. Maybe one of the reasons why clinicians do not ask patients about their experiences of illness is that they often do

not find that their instructors or senior clinicians do that. Young clinicians often find their ideal model in the everyday clinic and try to follow them as their role models. For individual clinicians to employ excellent clinical skills, such as narrative medicine, it is important to have a high level of expertise in communication, cultural competence, clinical decision making, and professionalism that are mostly defined under physician's competence in the Royal College of Physicians and Surgeons of Canada (2007).

Trustworthiness

According to Glaser and Strauss (1967), trustworthiness is the extent to which one can believe in the research findings. According to Lincoln and Guba (1985), a researcher needs to bring together into temporary categories those pieces of data that actually relate to the same content. It is then important to “devise rules that describe category properties and that can, ultimately, be used to justify the inclusion of each data bit that remains assigned to the category as well as to provide a basis for later tests of replicability” (Lincoln & Guba, 1985, p. 347).

In addition, Lincoln and Guba (1985) illustrate that in qualitative research methods, the terms credibility, confirmability (neutrality), dependability, and transferability are the essential criteria for quality. According to Patton (2002), a detailed and truthful report and document of the process of data analysis and research findings adds to the credibility of the research.

Since all qualitative research studies are unique, they demand unique strategies for analysis (Patton, 2002). Memos were written during the analyzing process (Glesne, 1999) as this helped in understanding participants' experiences. Memos helped in linking emerging categories and recording emerging reflections. Analyzing the data (i.e., transcripts, documents, and website) required more than description and thematic development of the data (Ollerenshaw & Creswell, 2002), the central focus was to understand the participants' perceptions and experiences in

medical encounters. Further, memos helped me document my experiences, thoughts, and feelings throughout the research process and helped establish context and meaning.

To address the issue of trustworthiness of analytical interpretations, the following points were considered as suggested by Hollway and Jefferson (2000). There is a need for reflecting on my subjectivity in terms of observing, listening, and engaging in reflexivity. I thought of the research process as a whole and I tried to maintain a responsive sense of awareness of personal knowledge of the topic.

Credibility

According to Lincoln and Guba (1985), one of the criteria for assessing trustworthiness is credibility, which is the assessment of whether or not the research findings represent a credible theoretical interpretation of the data drawn from the participants' original data. The authors further add that ensuring credibility is one of the most important factors in establishing trustworthiness in qualitative research. Credibility promotes researchers' confidence that they have accurately covered the phenomena under investigation. In addition, the changing conditions of the phenomenon under study can be ensured through dependability. According to Lincoln and Guba (1985), the basic question addressed by the idea of trustworthiness, is simple: "How can an inquirer persuade his or her audiences (including self) that the research findings of an inquiry are worth paying attention to, worth taking account of?" (p. 290). A key issue for qualitative research is developing a shared understanding of the appropriate procedures for assessing its credibility or trustworthiness that refers to the truth or believability of the findings recognized by the researchers (Morse, 1994). Improving the credibility of the study involves the use of multiple comparison groups, and sharing with each participant the verbatim transcript of the individual interviews and drafts of the emerging concepts and categories (Glaser & Strauss, 1967).

Similarly, Patton (2002) adds that participants' reflections, conveyed in their own words (verbatim quotes) strengthen the credibility and validity of the research.

In addition to deploying these strategies, I also strictly adhered to the rules of a good design and norms of correct interpretation to avoid any overt or deliberate biases.

Transferability

Transferability is the degree to which the findings of an inquiry can pertain or transfer beyond the boundaries of the project. It involves collecting enough data so that external judgments may be made about the data (Guba & Lincoln, 1989). Lincoln and Guba (1985) suggest thick description as an important aspect for transferability of a qualitative study. The transferability of the data is a practical question which cannot be answered only by the researcher (Lincoln & Guba, 1985). The focus of my study is not to generalize findings, but rather to understand and describe the perceptions and experiences of the study participants from an interpretivist stance. The context of interest should be compared to the research context to identify similarities. The degree of transferability depends on the similarities found between the two contexts. It is also called "fittingness" which is the degree of similarity between sending and receiving contexts (Lincoln & Guba, 1985). In addition, the degree of transferability depends on similarities between the two contexts being studied; the researcher collects rich information with detailed description of data in context and presents them with sufficient detail and accuracy that can allow the judgment of readers on transferability. The readers can then apply the research findings when they find sufficient similarities between the two contexts (Holloway & Wheeler, 2002). The degree of transferability of the results of the study will depend on the readers' determination on how far they can be confident in transferring the results to other situations.

Dependability

Dependability can be established through the development of an audit trail (Lincoln & Guba, 1985). To address the dependability, the processes and steps taken within the study should be reported in detail, thus enabling other researchers to repeat the work. I reported a detailed coverage of the steps taken during the study that allowed the readers to develop a thorough understanding of the methods and their effectiveness. To check dependability, the study was carefully audited using NVivo that enabled researchers to verify different steps in the process of data analysis/interpretation as well as the logic and chronology of the research process. By utilizing NVivo 10, analysis was supported through an audit trail which explicitly showed the steps taken during data analysis (Richards, 2000). The use of software, such as NVivo, can help with establishing an audit trail and enhancing the trustworthiness of research (Sinkovics, Penz, & Ghauri, 2008; Yin, 2003, 2009). The use of NVivo 10 enabled the researcher to demonstrate the integrity, robustness, and therefore, trustworthiness of the study. Further, it helped the research process become more transparent and open to closer scrutiny (Sinkovics & Alfoldi, 2012). The rigorous quest of dialoguing between theory and data, as stored on the computer, encourages qualitative researchers not only to formally articulate their crucial research rationality and underlying assumptions, but also to engage in greater self-reflexivity and responsiveness (Sinkovics & Alfoldi, 2012). NVivo facilitated the creation of the audit trail, for example, by automatically tracking the day and time that nodes were created, as well as keeping the records of the research methods, analysis, and findings. In addition, I kept detailed notes on decisions made throughout the process and added to the research auditability and, therefore, reliability (Holloway & Wheeler, 2002). The NVivo qualitative software can enhance the reliability of data by applying the rules built into the program (e.g., the line by line numbering of interview

transcripts) as well as keeping a record of coding and writing (Richards, 2000). The logic used for selecting participants to interview and include in the study should be clearly presented in order to make the results more dependable (Lincoln & Guba, 1985). The context of the study was described in detail, and the findings of the study were reported consistently and accurately to achieve some measure of dependability (Holloway & Wheeler, 2002).

Confirmability

Confirmability is a measure of how well the inquiry's results are supported by the data collected (Lincoln & Guba, 1985). To reinforce the confirmability of themes, verbatim quotes were included in the report. Confirmability may be ensured by using the NVivo software as the research findings can be matched to the data by having another researcher review the research notes, transcripts, the codes, and the decision trails so that the research process can be clearly followed.

To strengthen the confirmability of the study, I referenced the results of the study to literature and findings by other authors in order to support the interpretations (Guba & Lincoln, 1989). In addition, I reflected on my background and feelings to comprehend the details of constructed themes and their interpretations. Further, to show confirmability, a record of the inquiry process was provided (Lincoln & Guba, 1985). The methods used in the study were described as concisely as possible to provide an audit trail. All the successive steps in the study were clearly stated and undertaken with conscientious concentration to detail.

Table 5

Summary of the Dominant Themes from Theoretical Frameworks which Informed the Selective Coding Process

	Phenomenology and Medicine	Patient Centeredness	Positivist/Post positivistic Approach	Evidence Based Medicine	Cultural Competency Training	Narrative Medicine	Therapeutic Relationships
Focus and features	<ul style="list-style-type: none"> • Pioneered by Zaner (1995) and Toombs, (2001) • lived body approach based on individual’s lived experience (Toombs, 2001) • exploring individual’s experience of illness through emotions and feelings (Komesaroff, 2001; Mazis, 2001) • enriches the bio medical understanding of experiences of illness and answers the broader 	<ul style="list-style-type: none"> • Introduced by Balint (1957), pioneered by McWhinney (2001) • a consumerist relationship in which patient takes an active role and clinician adopts a fairly passive role (Cluett, 2006; Morgan, 2008) • Less controlled interviewing style, with more open ended questions (Cluett, 2006) 	<ul style="list-style-type: none"> • Introduced by Parsons (1951) • Exploring physical aspects of patients’ experiences of illness (Mishler, 1984) • Physician is in an authoritative position and often decides and informs patient on initiation of interventions (Parson, 1951; Mishler, 1984; Morgan, 2008). • Physician acts as patient’s guardian (Morgan, 2008) • Patient is expected to 	<ul style="list-style-type: none"> • Pioneered by Sackett et al (1996) • EBM is the careful, overt and judicious use of the current best evidence mainly from population based studies (Sackett et al, 1996; Sackett et al, 2000) • Focuses on generalization rather than uniqueness of individual health needs (Meza & Passermans, 2011) Recommendation based on clinical evidence (Passerman, 2011; 	<ul style="list-style-type: none"> • A strategy for improving knowledge, attitudes, and skills of healthcare professionals (Betancourt, 2004; Betancourt & Green, 2010) • delivery of health services is based on acknowledgement and understanding of individuals’ cultural diversity (Betancourt & Green, 2010; Hickling, 2012; Paez et al., 2009) • cultural competency is an essential component of patient-centred care (Betancourt, 2004; 	<ul style="list-style-type: none"> • Described by Mishler (1984), pioneered by Charon (2005, 2006a) • a combination of theories, from narrative studies, literary studies, aesthetic theory, and qualitative research methods in social science (Charon, 2006a) • understanding an individual’s worldview and values through his or her use of language (Mishler, 1984; Zaner, 1995) • effective clinician patient interaction and fruitful results through 	<ul style="list-style-type: none"> • Peplau introduced the interpersonal relationship model between nurse and client including orientation, identification, exploitation and resolution. • Main components that need to be present in patient care include : trust, respect, professional intimacy and empathy (Arnold & Boggs, 2003; Gallop, & Stevens, 2002; Nursing Best Practice Guideline, 2002; Stein-Parbury, 2005; Watt-Watson et al., 2002). • Nurse expresses concern and care about and commitment to

<p>question of what it is like to live with an illness (Svenaesus, 2001; Toombs, 2001)</p> <ul style="list-style-type: none"> • focuses on a wider range of experience of physician and patient and their shared experience in clinical encounter (Svenaesus, 2001; Sundstrom, 2001) • phenomenology is concerned with everything that is involved in a patient's world (Mazis, 2001) • Phenomenology is concerned with exploring first person accounts of experience of illness through narratives (Connolly, 2001; Mazis, 2001) 	<ul style="list-style-type: none"> • Encourage patient participation, sharing information and mutual decision making (McWhinney, 2001) • More time spent on listening to the patients (Cluett, 2006; Morgan, 2008) • Understanding patient's perspective is explored and valid (McWhinney, 2001). • Subjective experience and meanings of illness to patients are explored (McWhinney, 2001; Charon, 2006a) 	<p>cooperate with advice and treatment (Mishler, 1984; Morgan, 2008)</p> <ul style="list-style-type: none"> • Controlled interviewing (Mishler, 1984; Morgan, 2008) • Closed ended questions • Explanation of illness based on biomedical model (Mishler, 1984; Morgan, 2008; Parson, 1951) • Few opportunities for exploring patient's beliefs and concerns (Mishler, 1984; Morgan, 2008) • Less or no emphasis on communication skills (Cluett, 2008; Morgan, 2008) 	<p>Edwards & Elwyn , 2001; Cluett, 2006)</p> <ul style="list-style-type: none"> • Maximize the value of clinical research in light of patient care (Sackett et al, 1996) • Helps in curing disease and preventing suffering caused by disease (Sackett et al; Cluett, 2006). • Ignores the interpersonal aspects of clinical expertise (Morgan, 2008; Edwards & Edwyn, 2001) 	<p>Betancourt & Green, 2010)</p> <ul style="list-style-type: none"> • linked to narrative medicine epistemology in patient care (Betancourt, 2004) • Cultural competence can ensure clinicians preparedness in providing a quality care to diverse populations (Betancourt, 2004; Betancourt & Green, 2010) • A lack of cultural competence among professionals can lead to interpersonal conflict, misinterpretation and frustration among clients from diverse cultural backgrounds (Kim, 2002). 	<p>attention, representation and affiliation (Charon, 2005, 2006a; Meza & Passerman, 2011)</p> <ul style="list-style-type: none"> • Emphasis on listening to patient's stories by suspending any prior assumptions, distraction and goals to grasp a broader picture of patient's experience of illness (Charon, 2005, 2006a). • changes the process of diagnostic interview from physician controlled to the patient having the opportunity to describe his/her real life experience (Charon, 2005, 2006; Zaner, 1995) 	<p>viewing patients as whole people rather than objects (Benner, 2001; Stein-Parbury, 2005).</p> <ul style="list-style-type: none"> • Responding empathically to client concerns is a necessary set of skills for clinicians to learn in order to enhance the quality and effectiveness of the therapeutic relationship (Johnston et al., 1998; Miller & Rollnick, 2002). • Nurse can have the following different roles in therapeutic relationship: a stranger, a resource person, a teaching person, a surrogate and a counsellor (Stein-Parbury, 2005).
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Epistemology	Constructivist	Constructivism (co-construction of reality)	Empiricism (seeing is believing), positivistic (single truth that can be discovered by science)	Realist epistemology in which the object of knowledge is to predict and control	Relativism (finding multiple realities) hermeneutics, interpretive (Betancourt, 2004)	Relativism (finding multiple realities) (Charon, 2006a; Meza & Passerman, 2012)	Relativism (finding multiple realities) (Charon, 2006a; Meza & Passerman, 2012)
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CHAPTER FOUR: FINDINGS

This chapter provides excerpts of the 13 participants including five physicians, four nurses, and four medical receptionists. Qualitative data analysis software Nvivo10 was used to analyze the data using open, axial, and selective coding. Open coding was used to label and summarize data into meaningful units. Data were coded into categories and each category was given a name. Open coding helped to explore the data in a detailed way by identifying and conceptualizing the data. Axial coding helped to connect different categories and include situations and phenomena in discovering the relationships between different statements. The emergent patterns and salience were then divided into different categories and examined for similarities and differences between and across the study participants. Selective coding based on literature driven typologies was used to confirm the relationships between different categories (Patton, 2002).

This chapter begins with a brief history and background of the study participants, including age, education, work experience, communication skills, experience of dealing with clients (positive and negative), and the challenges experienced. Within the subsequent sections, the participants of the study shed light on the research questions that guided this study, in addition to explicating the narrative elements.

The accounts provided important insight into experiences of physicians, nurses, and medical receptionists in diagnostic and therapeutic encounters as well as intake protocols. In each of the following sections, the analysis and subsequent findings reflect the uniqueness of participants' lives and their personal journeys. Verbatim quotes are used to enable the participants to speak in their own voices. Pseudonyms are used throughout the findings to ensure confidentiality.

About the Participants in the Study

The physicians, nurses, and medical receptionists who participated in this study (13) all live in the Niagara Region. Physician participants' work experiences varied from family medicine, sleep medicine, internal medicine, psychiatry, the intensive care unit, and community hospital settings.

Almost all physician participants had over 2 years of clinical experiences of dealing with patients. The physician participants included two females and three males in active practice, and were between the ages of 37 and 60. Except one physician who was trained in family medicine, all other physician participants had obtained specialty training. Years of practice for physician participants of the study varied from 2 years to over 20 years of practice. Despite some similarities among the physicians in their experiences of dealing with patients, each physician had his/her unique way and approach in their practice. The physician participants' beliefs in evidence-based medicine and narrative medicine varied. The participants' current field of practice played a major role in their approaches with their clients. Each physician participant in the study had a unique opinion about diagnostic encounters. For two participants, the goal of diagnostic encounters was to diagnose and treat complex medical conditions. For the other two, however, diagnostic encounters meant establishing rapport, empathy, and patient satisfaction. For one physician, most of the patient encounters were just about triaging and referral and rarely focused on diagnostic and therapeutic issues. Approaches with patients from diverse cultures were also different among the physician participants of the study. For the most experienced participant in the study, cultural diversity and encounters with patients from diverse cultures meant exposure to individuals from diverse racial groups. For one participant, it meant individuals from different religious backgrounds with different beliefs. For another participant, individuals from diverse cultures referred to people who are not native English speakers and

speak English as a second language. For one participant, everyone was the same, and the only difference between people is differences in their levels of understanding and education, rather than cultural differences.

Consequently, almost all participants described experiencing some challenges in their everyday patient care. Listening to patients in almost all physician and nurse participants' cases meant listening to patients' clinical stories of signs and symptoms including the onset of illness rather than patients' life stories. From the physician and the nurse participants' narratives, their relationships with patients seemed to be advocated because of improved therapeutic interventions. A common factor affecting physician and nurse participants' relationships with their clients was limitation of time including (a) limited time to listen, (b) limited time to come up with a proper diagnosis, (c) limited time for making decisions in critical life threatening conditions, and (d) limited time for patients' visits.

The nurse participants in the study also lived and practiced in different areas within the Niagara Region. Their areas of practice varied from community nursing, public health nursing, walk in-clinics, and intensive care units. The nurse participants' ages were between 32 and 58 years. All the participants had 10+ years of work experience and almost all the nurse participants of the study had previous work experience in a hospital setting. Despite experiencing similar challenges, each nurse participant of the study had a different approach in establishing therapeutic relationships with their clients. For most of the nurse participants of the study, establishing therapeutic relationships meant being compassionate and empathetic. Despite giving some recognition to the importance of narrative medicine, both the physician and nurse participants of the study focused mostly on the use of evidence-based medicine in their decision making and clinical encounters with patients. The nurse participants also talked about the

importance of effective communication in their encounters with patients. Attentive listening and using simple everyday language were some positive skills described by the nurse participants.

The medical receptionist participants in the study ages were between 37 and 60 years old. Their work experience varied from 7 years to over 30 years. They worked in different locations in Niagara Region. Each participant worked in a different medical office setting, for example, walk in-clinic, family physician office, and a complex medical facility. Being empathetic to patients, being an attentive listener, developing rapport, and being conventionally polite to patients were some positive qualities described by the medical receptionist participants.

Some challenges experienced by the medical receptionist participants of the study included dealing with (a) upset clients, (b) clients with mental health and addiction issues, and (c) new immigrants with language barriers. In addition to doing clerical tasks, the medical receptionist participants also were involved in patient assessment, monitoring, therapeutic interventions, as well as, in one receptionist's case, assisting with minor surgical procedures. Educational background was different for the medical receptionist participants of the study. Two medical receptionists had undertaken medical receptionist training programs, while two others were trained in other medical fields such as nursing and retail pharmacy assistant. Almost all medical receptionists emphasized the importance of listening as a key to success in patient and medical receptionists' interactions.

Findings Phase I, a) Within Group and Cross Group Analysis by Interview Questions

Combined with Open, Axial, and Selective Coding

Findings, Summary Phase I a).

Sequence of Analysis

Transcripts	CCC website	Human Resource Policy Document
Open, axial coding within case and cross case analysis selective coding cross case analysis Mishler and Charon's narrative structure	manifest and latent content analysis Charon's attention representation and affiliation Mishler's narrative structure	manifest and latent content analysis Charon's attention, representation and affiliation Mishler's narrative structure

Table 6

List of Themes and Subthemes from Open, Axial, and Selective Coding

Main Themes	Subthemes
Typical Day	
Therapeutic Relationship	
Challenges	Time Dealing with upset patients and difficult clients Lack of resources Increased client expectations Patients' visits (single versus multiple) Dealing with patients from diverse cultures Lack of adequate training
Evidence based versus Narrative Medicine	Preferred method during interview
Communication Skills	<ul style="list-style-type: none"> • The ups and downs of communication with patients • Dealing with patients from diverse culture • Accomplishments and interactive competencies • Accomplishment during interview and intake protocol
Hopes and desired changes	Desired change Likes and dislikes Career choices Plans for further training
Qualities for successful physicians, nurses, medical receptionists	
Therapeutic Relationship Diagnostic Interview	Preferred method during interview

Table 7

Open, Axial, and Selective Coding on Transcripts Example

Coding	Physicians	Nurses	Medical receptionist
<i>Open coding</i>	<ul style="list-style-type: none"> • <i>I can get them to open up getting people to understand what they need to do</i> 	<ul style="list-style-type: none"> • <i>by their look, their facial expression is that is okay</i> 	<ul style="list-style-type: none"> • <i>I am really good at interacting with old people</i>
<i>Axial coding</i>	<ul style="list-style-type: none"> • <i>I do practice Western medicine because I am Western trained</i> • <i>I am open and empathetic with patients</i> • <i>...they actually leave and they listen to you and they take your advice and they come back and they say 'thank you,</i> • <i>most people will appreciate that you just talked to them like a human</i> 	<ul style="list-style-type: none"> • <i>Protocol says if you are using the \$10 dressing with anti microbial etcetera that dressing shouldn't be changed for three days...</i> • <i>someone that is coming in and they are not showing you their bits and pieces, they don't have anything to show you except their stories</i> • <i>you have to allow them to know that they have some choice.</i> • <i>you have to have good communication skills, and you have to be caring</i> 	<ul style="list-style-type: none"> • <i>think we have to remember to listen before you actually say</i> • <i>Sometimes patients just need someone to talk to, they just need someone to say 'just be calm I want to help you so please let me know what your concern is</i> • <i>The calmer you are, it makes them feel pretty stupid by yelling at you</i> • <i>they come with a whole list of aches, and pains and the doctor does not have the time to listen to 20 different things ...</i>
<i>Selective Coding</i>	<ul style="list-style-type: none"> • <i>if they {patients} say something that we were unable to prove then I have to go back and consider if our test was a false negative</i> • <i>it is gonna be some standardized test, or some standardized questions that you are seeking and varies things that lead to the diagnostic criteria</i> • <i>I think it depends, part of it depends on speciality and subject, some physicians go faster than others and some areas just require more discussion with the patients</i> • <i>I will talk to them in terms of evidence ... I also caution people in general about alternative treatments.</i> 	<ul style="list-style-type: none"> • <i>even for a surgical patient you only have three visits. If you need three more, then you need to get an authorized order</i> • <i>... in hospitals you are the authority who have control, "you will be doing what I say" whereas in community in someone's home, it is more of a negotiation</i> • <i>if you make a mistake" just say "I am sorry" so acknowledge your own shortcoming.</i> • <i>I come from a clinical point of view, I have all the information and I know more than you do and therefore you need to listen to me.</i> • <i>for me the patient centered really need the focus on the clients making decision</i> 	<ul style="list-style-type: none"> • <i>I think courteousness, greeting the patient with a smile and you will get a better reception and by asking 'yeah, what do you need?</i> • <i>they are in distress and so you try to do everything as quick as possible and make them happy</i> • <i>basically just listening to what they have to say, and advocating on their behalf cause a lot of don't know how to do that.</i> • <i>people don't wanna discuss their medical problems in front of the other people in line. So keep it very brief, and if they say it is personal then just write it down</i>

From within and cross group analysis by interview questions a number of common themes and subthemes that arose are presented in this section of the findings.

Challenges

All participants of the study talked about experiencing challenges in interacting with their clients. The challenges included: time limitation, dealing with difficult patients, lack of available resources, inability to meet clients' expectations, lack of adequate training, and dealing with patients from diverse cultures.

Challenges (Medical Receptionists)

Challenges experienced by medical receptionists included dealing with "aggressive clients," clients who were "angry" and "abusive." Another challenge that most of the medical receptionists experienced was having unsuccessful encounters with their clients. For Becky, the challenge of dealing with aggressive clients is a difficult aspect of her job. Becky describes that dealing with aggressive clients is a challenge for her but she learned a lot from it and she is being sympathetic to patients and describes that patients are acting aggressively because of their medical conditions and she does not take patients' aggressiveness personally as she further describes:

It is absolutely challenging because your first instinct as a mother is comfort the child and you do what you can and you hope that you are saying the right thing that you really don't know this person and you don't know if you can hang on to their arm or if, are they gonna find that intrusive so you have to be careful... And you can't come across being aggressive to them and you know because there is something going on and that is causing them to do this.

Glenda describes challenges of dealing with clients with behavioural issues, clients who are difficult, as well as those who are frustrated and upset. Glenda talked about one particular client with a behavioral issue who was being aggressive towards her “trying to be calm with her and not yelling.” Glenda also describes that some patients she had unsuccessful encounters with were because of their mental health issues. She describes dealing with good and bad patients, as she adds “you have to deal with the good and the bad”. One way of dealing with aggressive clients, according to Glenda, is trying to be calm and attentive with them, as being understanding and sympathetic towards patients makes the situations easier to control and more successful. Glenda talked about one particular client who had experienced unsuccessful encounters with several other receptionists at the front desk as she adds “so one person that I could think was someone who came and had dealt with several people at the front desk and was very frustrated and did not understand what we did and why we did it.” Glenda took her time in listening to her and dealt with her with a much calmer and more sympathetic manner and made this client’s experience positive and successful.

She was very calm because she knew I listened to her, I had taken some actions, I had investigated the situation and I had got back to her so she was really happy about that.

Whereas she had dealt with several people who had said that there was nothing they could do and that just made her more frustrated.

Glenda also talked about how most of the challenges experienced at her clinic were because of lack of a policy procedure manual. But after developing a policy procedure manual most of the challenges not just experienced by her but also other medical receptionists have been addressed. She also talked about how having a consistent approach with patients could also help deal with some challenges “{the} biggest challenge here is developing the staff to a level that we have a

consistent approach.” Some additional challenges that were unique to Glenda included dealing with patients with multiple complaints. She described that in the walk-in-clinic setting, the nature of the business is dealing with one complaint per patient, she further adds “we deal with the complaint...sometimes the doctors don’t understand the nature of the visit...medical receptionists help physicians understand the nature of this type of business {walk in clinic}.”

One of the reasons for having unsuccessful encounters with clients, according to Glenda, is lack of adequate training and receptionists’ experience

I think we have a lot of young students which I have been trying to move away from that because I don’t believe that at the high school level particularly grade 11, 12, 13 level they have the maturity to deal with the issues they have to deal with here.

She believes job security also plays a key role in a receptionist’s approach with clients. She describes how full-time receptionists operate at a better and professional level than part-time staff. “I think that our full time staff operate at a different level than our part time staff and even our university students.”

Similar to Glenda, Grace also finds dealing with patients with multiple complaints and several health issues difficult and challenging. In addition, dealing with clients on the phone can be difficult as well. She describes how some patients on the phone often do not listen and get frustrated with medical receptionists and are less satisfied with their telephone call. A “Client, on the phone who wouldn’t listen kept saying that we are disrespecting her...we try to talk over her and she wouldn’t listen and then she was put on hold and then the supervisor talked with her.” Grace talked about the challenges of dealing with clients with multiple medical conditions in walk-in-clinic settings. She described that dealing with such patients is challenging due the

nature of their conditions. Patients with multiple medical conditions are expected to prioritize and bring only one medical issue to their visits as she adds:

So when they say “I have this issue,” then so you will say “you can come back tomorrow and see the walk-in doctor.” And or make an appointment and see a family physician and look after that issue. So if they have multiple complaints we offer them to come back.

One unique challenge that Grace talked about was dealing with new immigrants and clients who do not have OHIP coverage in addition to having language barriers. For example, some patients with a language barrier have trouble completing their medical questionnaire. Also if they come in without an interpreter then there is a challenge of addressing their health concerns as well as she adds:

There are different documents, for immigration for example, there are documents that need to be filled out and they have to sign and that is the only difference they don't have a health card and we have a document that we have to bill...we always hope that they bring somebody with them. Cause we don't, well, we have a Spanish speaking lady that works and that can help, but we always hope that they have somebody with them.

Similar to Becky and Glenda, Nancy also talked about the challenge of dealing with aggressive patients; she talked about dealing with patients with addiction and mental health issues as well. According to her, there are good and bad clients in every business; therefore, she has to be prepared for them and find a proper way of dealing with these clients. “There are some people with mental health issues that are very aggressive and you know and you just kinda, but there are some people, I guess everywhere you have to deal with the good and the bad.”

Challenges (Nurses)

The challenges experienced by nurses included lack of community resources, dealing with young clients (under 18 years old), challenges of dealing with clients with mental health issues, lack of adequate funding, and limitation of patients' visits per policy and the challenge of dealing with clients who lack medical vocabulary. Crystal talks about challenges of having limited home visits (three visits) with patients and describes that limited patient visits is an obstacle in gaining patients' trust and establishing therapeutic relationships. She further adds

Even for a surgical patient you only have three visits. If you need three more, then you need to get an authorized order...so if you need more than three visits there has to be a great deal of discussion, there is a lot more bureaucracy now.

Crystal also described the challenge of patients who withheld private information from a nurse. "People that are very private and withhold information...they don't see the value in the questions that you are asking." She further described that some patients she deals with also do not have a medical vocabulary to describe their condition. "They lack the vocabulary to tell you." For Nancy lack of patients' ability in describing their condition is a challenge as she cannot properly pass the information to other medical professionals involved in the patient's care. Crystal also talked about nurses who use different approaches than the required protocol approach in their therapeutic relationship with patients as a challenge as she adds: "having difficulties with clients who dealt with other nurses in the past due to different approaches... I have so much difficulties because I am so much different than they are and a lot more assertive." She believes in assertiveness with patients as an important strategy. Crystal describes how she is different from her colleague; she is a lot more assertive and sometimes she experiences a patient's defensiveness as she describes "patients would say 'well Suzie says I don't have to' and I am

like ‘but you really should’ (laugh) but Suzie the other nurse ‘no, no, I don’t have to do that.’” Crystal talked about experiencing challenges due to different levels of expectations and beliefs between other nurses and her supervisors. Crystal also talked about a unique challenge she experienced with her supervisor. She described that she does not get along with her supervisor because they have different approaches in patient care,

I don’t have any respect for her {supervisor} at all because I trained her, I trained her as a brand new community nurse...I have had three occasions that I brought things up to her but they have been totally addressed in an inadequate manner. So I will be very reluctant to go her.

Another unique challenge that Crystal talked about was particular to community nursing. She described how patients have different expectations and understanding about community nursing. She talked about the challenge of dealing with one particular client who wanted to socialize with her and she had a specific goal to achieve as she further describes:

So he is the one who wanted the socialization I think but it is not our job, our job is a therapeutic relationship so he was a little distressed. So some people have a misconception about who a community nurse is.

Paula talked about some challenges particular to sexual health in public health settings. One example she talked about was dealing with young clients “sixteen years old, sexually active and needs to go on birth control...we are trying to prevent the spread of disease, she’d gonorrhea, herpes, syphilis, she is homeless we can’t find her.” Paula explained how this particular challenge was often limited to clients from a poor socioeconomic background “I have to try and stop spreading the disease in the community and I can’t do that with her, so that is a major challenge.” Paula further explains:

{S}he is homeless we can't find her, if we find her to give her the medication fine but we can't stop her you need to be 7 days on medication and she can't work and if she has one partner and she tells us all these things one particular partner that she has sex with, with no condoms she makes \$1,500 a night I can't tell her that, you can't give up that money because that is the only money she makes so a big challenge for us.

Wendy talked about dealing with patients with mental health issues. She described that the interview time is an issue with these patients due to their lack of focus in answering questions. She talked about one particular patient who had schizophrenia as she describes "he had too much difficulties maintaining his focus and answering the questions and became agitated." She further talked about challenges of dealing with patients who are not aware of their nurse visit and having trouble gaining their trust "if they don't know you are coming they are quite defensive...accusatory of their neighbours, their families." Wendy finally described lack of coordination between the healthcare system and other healthcare professionals in providing healthcare services as an obstacle in establishing trusting relationships with clients "sometimes the challenge is dealing with other healthcare professionals... I took him {client} to the ER they wouldn't even look at him they wouldn't even treat him." Similar to Crystal, Wendy also talked about having limited visits with patients as a challenge. She described having limited visits with some patients as a barrier to establishing therapeutic relationships. Similar to Wendy, Barb also talked about challenges of dealing with clients with mental health issues. She described that patients with mental health issues take longer than other patients to trust their healthcare professional "I think every patient is different some of them are really forth right and other people it takes a while to break those walls." One of the challenges she experienced was with a client with mental health issues and she was concerned about the physical safety of the nurse

looking after the patient, "...one person that I may be concerned about may be the staff's physical safety with this person."

Challenges (Physicians)

Challenges experienced by physician participants of the study were in different categories including time limitation during patient's interview, patients withholding information, patients not being attentive listeners, challenges of dealing with patients with unknown or less described illnesses, and complex medical conditions. Other challenges include dealing with patients who have visited multiple specialists to find answers to their unknown medical condition, dealing with patients with no obvious medical condition, challenges of dealing with patients with poor communication skills, language barriers, new immigrants, individuals from diverse cultural groups, time constraints, challenges of dealing with patients with mental health issues, and challenges related to time constraints in emergency situations.

For Dr. Carly, lack of time during clinical encounters was a challenge. She described time constraints in getting to know the patient and their culture as a barrier in establishing trust and rapport with patients. "It would be a challenge time wise all right, too, to get that part of their story I think it would be challenging. I have to broaden my horizons a little bit and get to know more about their cultures." For Dr. Carly, other challenges include dealing with patients with multiple health issues. She describes her main and primary concern as a specialist is to deal with the issues related to her profession.

Dr. Carly also talked about patients who are disruptive and she has to see them a few times before she is able to gain their trust and patients feel comfortable providing details about their medical conditions. One particular example she talked about was clients with depression as she further adds:

I've seen lots of patients and they speak disruptive... you have to see them a few times before they admit that they are depressed and then you can start to get somewhere and they don't have sleep apnea but they don't sleep well and, um, very challenging patients I had two of them today.

Dr. Carly also talked about clients with multiple health concerns and the troubles of addressing all the concerns they have as she has to still focus on particular health concerns that have to do with her area of speciality (e.g., sleep medicine). She adds "a lot of them have physical problems, physical pain and that is not my ball of wax but you really have to listen to them." Dr. Carly also talked about dealing with patients from diverse culture, patients with a language barrier, and new immigrants and wishes that they would always come in with an interpreter. She further adds:

I had a patient who was a Muslim and he wouldn't shake my hand because I was a woman but I did not shake his hand and I just bended the same way he bended. Um, it is wonderful if they have interpreters with them because and try to encourage that, and I read a sleep study and get the idea that they might be new to Canada or the questionnaires filled out indicates that English is not their first language, so it is nice to try and have an interpreter around.

Similar to Dr. Carly, Dr. Greg also talked about dealing with patients with unknown, or less known medical conditions as a challenge as he adds "some of the biggest challenges I have had were people who have conditions that we don't understand, people with fibromyalgia and chronic fatigue, the chronic pain syndrome." He further described how these patients' complaints can be easily mixed with other medical conditions with similar symptoms and how this further challenges patients' encounters and diagnostic interviews. Dr. Greg explained that patients with

these conditions are also confused in terms of what is really going on with them due to the complexity and overflow of their medical conditions. As he describes: “those are people who always bother me because you never quite know because there is a huge flow over from mood disturbance, anxiety disturbance, depression with fatigue because all of those influence their sleep.” One of the challenges Dr. Greg talked about was dealing with patients with no clear pathology and clients with depression. He described that the challenges of dealing with these patients are that there is nothing obvious about their condition that requires treatment and it is hard to treat these patients as he adds:

We don't know people's diet with depression we certainly know that even people who eat and mix their diet is probably not that replete with certain things and I think the difficulties for those type of patients is that because they've got nothing obvious and there is nothing definable on testing either, we don't know how to treat them.

Dr. Greg further explained patients with unknown medical conditions, those with no pathological changes found in their bio-medical exams hold a challenge for medical professionals in diagnostic encounters. One particular case Dr. Greg talked about was a patient who had visited several specialists prior to visiting him and the patient had no clear pathology and a complicated medical history. Dr. Greg described that the only possible treatment for her would have been cognitive therapy but lack of community resources and the patient not having coverage for cognitive therapy made this case challenging as he describes:

That was an incredibly difficult diagnostic interview with her because no matter what I would have suggested to her she had tried it on and someone else had tried it on and you go through the treatments for people like that such as cognitive therapy which is not

covered they had no money and it has impacted her, so the resources to treat someone like that are not there so that is a very difficult one.

Dr. Bob talked about challenges of dealing with patients with mental health issues and the complexity of their condition makes it impossible to diagnose their conditions within limited clinical encounters. “The average bipolar disorder takes about 10 years to diagnoses so there is an extreme example of a condition that is almost never diagnosed.” He also talked about the challenges of accurately diagnosing during a few interviews. He further describes, “ it won’t matter how much time you spent with them that day, it is not appropriate or necessarily that you will make the diagnosis that day.” Dr. Bob also described challenges of dealing with patients who do not provide specific information about their conditions and how this makes the decision-making process rather challenging for him; for example, patients who do not provide specific information about the exact time of onset of their conditions.

It is like ‘how long have been short of breath’ they would be like ‘I have been short of breath since my grandmother’s birthday party’ and then you are like when was that (giggle) and they are like a long time so those are sometimes challenging because you have a timeframe and also patients who are angry patients who don’t want to talk to you because they have a barrier.

Dr. Jane talks about challenges of dealing with patients who are not providing good information about their conditions to the physician and it makes it rather challenging and difficult for the physician to help them. “Patients who are circumstantial talkers who won’t answer the questions, angry patients, and patients who can’t really give you a history and you have to ask everything 10 times before they can give you an answer.” Dr. Jane also explained having challenges of dealing with patients who are not good listeners and she has to repeat the

same information several times and at times she has to write the information down on a piece of paper so that the patient would remember. She adds:

I repeat things multiple times, I will write down the instructions and so if something is very important I will write down on a piece of paper or on a prescription pad I will write a list of the important things they have to do when they go home, cause I know they will forget.

One specific challenge Dr. Jane talked about was dealing with angry patients who often may be in trouble with the Ministry of Transportation due to the possibility of losing their driver's license because of having a specific medical condition. As she adds "there was a patient that walked out on me this week because we were talking about Ministry of Transportation and reporting for sleep apnea, so he was upset and he left so that can't be helped." Dr. Jane also described challenges of gaining patients' trust in physician-patient relationship due to involved obligations as they feel betrayed when the topic of reporting to the Ministry of Transportation is being brought up during clinical encounters.

So often times it is worse than being given a cancer diagnosis as soon as they hear Ministry of Transportation they stop listening and they don't want to hear the treatment options and they just get very upset and angry...so then I think, the problem with that is also the patient-doctor relationship break down a little bit cause usually it is mostly based on trust and you are there for them. In this case as soon as you tell them that you have to report them to the Ministry they feel like you betrayed them.

Similar to Dr. Carly and Dr. Greg, Dr. Adrian also talked about time being a major challenge and constraint during clinical encounters. He describes:

the biggest challenge is always about time, it is about bouncing the needs of one patient against the other patients and the needs of the family and personal needs and uh, community because there is also other patients in the office that are waiting to be seen.

Dr. Adrian explained dealing with patients in emergency situations that requires immediate medical assistance versus patients who he sees at his office with less immediate conditions. Dr. Adrian emphasized that in emergency medicine he has to decide within a shorter time period what needs to be done for the patients and describes the challenges of a patient's family members feeling pressured about making an immediate decision about the patient's condition. Dr. Adrian understands and acknowledges the importance of a patient's family being part of the final decision about that patient's condition, but believes that the time constraints make it very difficult for the medical team to have a detailed discussion with the patient's family members.

I have to be honest 10 minutes is sometimes all I have, the family certainly feels it is not sufficient but I have to hit the highlights tell the situations tell them this is what we're gonna do and this is the way it is and most accepted.

Dr. Adrian further explains how due to time constraints and the patient's critical condition there is a lot of frustration for the physician and the patient as well as their families time wise. He describes how he has to be very direct with a patient's family and a patient's family has to decide what should be done about the patient. He further adds

There is a lot of frustration because they would want more time but the realistic nature is this is not possible sometimes, in acute emergency you know sometimes I go to families and say 'no we have to make a decision now' and they might say 'I am being pressured' but it is not me pressuring you it is the situation, if we don't make a decision your family member would be dead.

Communication Skills

Communication skills were central among all the study participants as a main way of interacting with patients. These skills include attentive listening, using simple everyday language with patients, using humour, asking open ended questions, putting a smile on when greeting patients, using positive body language, being empathetic towards patients, and also gaining patients' trust. Almost all the participants emphasized effective communication skills with their patients. Some of the areas listed by the physician and nurse participants were establishing good patient professional relationships, gaining patient's trust, and empathy.

Nurse Crystal described that talking to patients and explaining things with clarity makes it easier for patients to know their rights and the choices they have, "you have to allow them to know that they have some choice." She believes that respecting a patient's choice in achieving common therapeutic goals is the key to success. She also described providing emotional support as an effective way of achieving goals. Crystal also believes that listening to patients' stories also plays a key role in the patient-nurse relationship as she describes "I think she appreciated that I just sat down and talked to her and heard her story." For nurse Paula, having good communication is central in interacting with patients. As she describes "you have to have good communication skills, absolutely have good communication skills and you have to be caring and I think um ethical, those would be I think the top training." Paula believes that no one is perfect and you learn as you go and emphasizes being honest with patients. She believes if there is anything she does not know it is okay to admit and share it with patients, rather than pretending that she knows it "I think that, you know, and I think it is about honesty and respect and I don't pretend to know about all the cultures and every religion"

Nurse Wendy talked about having endurance with her clients and advocating for them. Wendy also talked about being relaxed and patient-focused during interactions with them, especially patients with mental health issues. In addition, she believes in being knowledgeable about her profession. “Understanding that the person is ill and you know because if you have that understanding you are not gonna get your back up and you are not gonna be offended by what people say.” The most important communication skill for Wendy is being a patient advocate. She adds “being an advocate, you know, in mental health, you need to be a strong advocate and I think it is one of my strongest skills, that, just advocating.”

Nurse Barb talked about using humour as an effective interactive tool with patients. She describes how she would not use it if she noticed her patients not being in a good mood. Further, she believes that appearing reassuring about patients’ confidentiality is also an important tool in interacting with patients. She describes:

I tend to use humour a lot and I would certainly turn that down if I have somebody coming with anxiety and depression. They are not in a joking mood so I would turn that down definitely. I think it is important with someone with a mental health issue to, to um stress to them confidentiality cause they are very concerned about that.

Barb also talked about gaining a patient’s trust and described that patients are different and depending on each patient it might take longer or shorter to gain their trust as she adds:

Some people would come in and they are just (pause) they wanna vent like crazy, and then someone else, but I think they need that time to trust us or maybe feel comfortable and then talk about it and that is okay. Everyone handles those situations differently.

Barb also believes that developing a good rapport with patients is an important part of interacting with them; however, she believes that different patients might not develop a good rapport with their carer and it is okay for them to see a different healthcare professional

I always tell people that maybe if you didn't click with that physician that is okay because we don't always click with everybody and maybe next time and maybe they want to try to see a different physician and maybe they will have a better rapport with them.

Barb suggests that if a patient does not develop a good rapport with their physician or nurse, they could always see a different physician or nurse and have successful encounters with them as she states "I think some physicians and even some nurses have had even experiences with other patients and even life experiences so maybe they could be more empathetic with the patient." Barb believes her strengths in communicating with patients are her sense of humour, making patients feel comfortable, and being nonjudgmental as well as compassionate about patients as she adds:

I hope I make people feel comfortable I hope that there is atmosphere, that non-judgemental atmosphere, I hope that will be my goal. One of my strengths, I think having a sense of humour and being non-judgemental I think I rely on. And I hope that I portray compassion because I really do care about the patients.

Medical receptionist Becky talked about attentive listening to patients as an important skill in communicating with patients. She talked about the tendency of medical receptionists trying to talk more and ask too many questions and added that it is important to listen to the patient's complaint first. "I think we have to remember to listen before you actually say... we

have the tendency to start talking and you have a million questions but I think the key is to hear them out and then ask your questions.”

Similar to Becky, medical receptionist Glenda also talked about the importance of listening. Glenda describes that listening to patients’ stories is an important aspect of her job and she believes that it helps patients a lot and it also plays a key role in gaining their trust.

“Sometimes patients just need someone to talk to, they just need someone to say ‘Just be calm. I want to help you so please let me know what your concern is.’” Glenda described that a good way of dealing with clients that are upset is to be calm and relaxed with them “trying to be calm with her and not yelling. I find, the best way to deal with someone that is upset is to lower your voice. The calmer you are, it makes them feel pretty stupid by yelling at you.” She further describes that being attentive to patients’ complaints and listening to them helps in calming them down and resolving a conflict situation as she describes:

She {the patient} was very calm cause she knew I listened to her, I had taken some actions, I had investigated the situation and I had got back to her so she was really happy about that. Whereas she had dealt with several people who had said that there was nothing they could do and that just made her more frustrated.

Glenda believes that having additional skills, such as being able to multitask and having good computer skills, also helps and makes medical receptionist-patient encounters successful. “I think personality is big thing; you have to have a certain amount of computer skills, a certain amount of multitasking.” Glenda described that approaching patients with a friendly and courteous manner also helps with successful encounters “I think courteousness, greeting the patient with a smile and you will get a better reception than by asking ‘yeah, what do you need?’

you know, the approach is everything.” Further she described that being empathetic with patients also plays a key role in successful medical receptionist-patient communication

I think as far as the communication goes the most important thing is the expression on your face, the tone of your voice, um, don't be abrupt because these people are sick. They are not at their best; you need to be open and willing to listen.

For Glenda, the other important aspect of communicating with patients is making their experience more positive. She believes if a patient had a positive experience with a medical receptionist the first time they come into the clinic, they may come back again and vice versa as she adds:

The very important thing is ‘do you have a good experience the first time you were in’ so if you come in and somebody is solemn with you or ‘here is the paper work fill it out’ even if the doctor is receptive and listens and does his job this person might go somewhere else.

The last part that is important for Glenda in communicating with a patient is confidentiality and the importance of keeping questions about a patient's visit limited to the reason for his/her visit and she describes as follow:

Because people don't wanna discuss their medical problems in front of the other people in line. So keep it very brief, and if they say it is personal then just write it down because they may not say it in front of other people.

Similar to Glenda, medical receptionist Grace also talked about patients' satisfaction as an important part of interacting with patients. She explains

Satisfaction, like you want them to be happy you want them to come back. So you have to satisfy (pause) and to gain their satisfaction, just try to do whatever they want, if they

are asking for certain things, you have to try to do as much as you can for them. Say, if they need a specialist appointment but if they are just not happy with their experience, just try to admit it.

Similar to Glenda, Grace also believes in having good conversational skills in interacting with patients as she describes how having good conversational skills helps with successful medical receptionist patient relations. “Good conversational skills (laugh), you have to know how to diffuse the issue, yeah, you learn along the way actually, you really do.” Grace also talked about paying close attention to patients and making sure they get the attention they need especially patients who are distressed because of their medical condition.

If you see someone upset you usually prepare, you do (pause) you still put the smile on your face, yeah, and you try to make them happy and get them in to the doctor as quick as possible. Cause they are in distress and so you try to do everything as quick as possible and make them happy.

Grace talks about particular situations when patients are upset and do not want to talk in front of other patients in the waiting area and described that she often takes them to a different room where they feel more comfortable and tries to address why they are upset.

I think there were probably a couple of times but what we generally try to do and when someone is not happy, from as soon as they walk in, and we try to take them to another room and talk to them there and try not to raise your voice cause their voice is rising. So you just try to defuse it and but that is what we try to do and try to bring them into an isolated room and so we are not having a conversation in front of the whole reception area.

Similar to Glenda, Grace also believes in having the ability to multitask when doing the

medical receptionist job. She adds “we have to be organized and be able to multitask. Answer the phone and just do many things all at once.” One unique strategy Grace has when talking to upset patients on the phone is she often takes notes of their conditions and offers to call them back and she believes that often helps and calms the patients down.

What helps is that if they are excitable at that particular time, you would get their name, and their phone number and will call them back. Maybe in an hour maybe they cooled off a bit. So that kind of helps if they are on the phone, and you kind of say ‘right now I have many people in front of me can I call you back’ kind of thing.

Similar to Glenda, Grace also believes that being courteous with patients is one of the necessary interactive skills for medical receptionists as she adds “I think just being pleasant with them, because they are sick you know, so you have to understand when they come to the window and they may not be happy, so you still have to be pleasant with them.” For Grace, dealing with patients who are standing before her at the office has priority over someone on the phone.

They have to be first, the person in front of you not the person on the phone, so the person in front you is first, so if the phone is ringing or if you are writing something down you have drop what you are doing because there is a person in front of you.

Medical receptionist Nancy also talked about being an empathetic and careful listener to patients as an important interactive skill. Nancy indicated that she is really good at interacting with senior patients:

I am really good at interacting with old people, the elderly have a lot of problems and nobody has the time to listen to them, and they always want somebody to talk to and that is what, just basically listening is what they want.

One unique communication approach Nancy has is listening to patients with multiple complaints and helping them narrow down their concerns. She believes that sometimes these patients just need someone who listens to their stories.

I think basically just listening to what they have to say, and advocating on their behalf cause a lot don't know how to do that, um, they come with a whole list of aches and pains and the doctor does not have the time to listen to 20 different things so, you know what they have got to say and when he comes in he can just look at it and he knows what the patient is really complaining about this and so, you know that kinda thing.

One particular communication skill Nancy talked about was having patience when dealing with elderly patients "I have a lot more patience for an adult old adult patient."

Dr. Carly talked about using open-ended questions when interviewing patients, and being empathetic with them as some important interactive skills. She described these as being effective interactive skills for her during medical encounters as she adds "asking open-ended questions and being empathetic during the interview ...I think I am pretty good, and I ask them open-ended questions." Dr. Carly further explained the importance of eye contact and attentive listening to patients as additional interactive skills as she adds:

I am open and empathetic with patients and yeah so I certainly try to do that. And as you can see I am not a clear desk (giggle) you know one piece of writing paper in front of me and you better get it right the first time cause that is the only chance you are gonna have.

Dr. Bob describes that he is satisfied with his communication skills with patients and states that as long as his patients speak English he has no issue communicating with them. "My communication skills, at least if patients speak English, I think I am satisfied with my communication skills (giggle)."

Dr. Jane believes having good communication skills is one of her strengths in interviewing patients. She further described that she is a people person and is chatty in her everyday life as she explains:

I am very chatty...I have always known this is a strength from talking to other people.

Like some people really have a hard time talking to patients and explaining things, I have never really had that trouble and I, there is nothing specific that I do. And I thought everybody could do this.

For Dr. Greg, the important part of his communication with patients is when his patients listen and follow his advice. He stated that a satisfying part of his job is when he sees improvements in patients' health and gaining their trust as he adds:

sometimes getting that trust with someone where they actually leave and they listen to you and they take your advice and they come back and they say 'thank you, this has impacted my life' and obviously this is very satisfying and that is no drugs involved, no equipment involved, nothing, it is just getting them to understand.

Dr. Greg also talked about using different methods in educating his patients. One specific method he talked about was writing things down for his patient as an effective way of communicating with them.

I wrote it down for her I show it to her that one can of pop a day for you equals 6kgs of fat, and I just made it simple, so she looked it out straight and she was absolutely staggered and said 'I did not realize' she said 'I knew it had sugar in it, but I did not realize', but once it was explained to her, I explained to her the metabolism, and how quickly you metabolize things and the calorie content of food and once she understood

that took less than 3 minutes, and once she understood that she was able to deal with it but some people don't want to deal with it.

Dr. Greg also talked about the importance of listening to patients and talking to them in simple language. He further added that it speeds up the process of healing with patients and patients appreciate that their doctor takes time in talking to them and also examining them properly. He adds:

Most people will appreciate that you just talked to them like a human and most of the times they are surprised when I look at them and I talk to them and I sat next to them because a lot of doctors will sit behind their desks and don't touch them. So, and they also appreciate the fact that I examine them properly and I found a lot of thyroid cancers by examining people's neck properly, I never used to do that and all of this, it makes a difference.

Dr. Greg explained that communicating with his patients is one of his strengths in clinical encounters. He described that he treats his patients with respect and uses the everyday basic language during communication so that it is comprehensible to patients.

I treat people very respectfully and I, my language with them is often very basic, I don't speak down to them...my strengths are probably that I can communicate with them in a way that they feel comfortable, they don't feel that I am threatening, they don't feel that I am proselytizing or even you know just, uh, being arrogant towards them. I think that is one of my strengths I suppose.

Dr. Greg further described that sometimes using certain "bad" words also helps patients feel comfortable talking to him and makes him more human in their eyes as well as a friendly figure that patients feel comfortable and open sharing their concerns with, as he describes as follows:

Use the odd bad words, they quite like that. It makes you much more human in their eyes and you are not an authority that they have to try and push against. And I think that is the big problem, you know some people have a natural abrasion to authority. Part of the interview that I do, I like to engage people and let them understand very clearly and I always draw out things and write out things so they can see what I am saying, so that it makes sense to them, so when they understand they can follow it.

Dr. Adrian described that he would like to improve his communication more with his patients and believes that communication is a dynamic process that continues throughout his medical career and he learns from his experience. Dr. Adrian uses two different communication approaches when dealing with patients from different socioeconomic and educational background as he describes:

There are differences in patients I see who are socio-economically different than those who are less educated or people with different religions. And you have to kind of take a different approach with those that are more educated comparing to those who are not, so you don't have to go through some of the basics as much but then there is also the challenge of because they are more educated they are also even they might not be the expert in medicine they might see that they already have knowledge so they might be giving you a pre-set opinion that might not be necessarily correct so there is a challenge that way. And with the other group they may not have a pre-set opinion but they also have a lack of knowledge and understanding.

The Ups and Downs of Communication with Patients

The study participants talked about their strengths and weaknesses in communicating with patients. Having good communication skills was central for all the participants' successful

encounters with patients. Strengths in communication with patients for medical receptionists included being courteous, attentive, empathetic, having positive facial expression, and others. For Becky, being empathetic with clients and understanding that they are ill are some of the strengths she has. She believes that when patients are being aggressive, they do not really have anything against the receptionists but it is their condition that bothers them as she adds: “it is something that they [clients] are acting their anger towards it is not personal.” Becky described listening as an important part of her job and added that she always tries to improve on her listening skills.

Medical Receptionists

For Glenda, listening to a patient’s complaint, being polite, courteous, greeting patients with a smile, and acknowledging that their complaint is taken seriously are some of her strengths. Specific to strengths in communication she believes in positive facial expressions and attentive listening skills.

Glenda also explains that the expectations of medical receptionists is to be polite and steady with patients and she describes that she cannot tolerate a staff member being abrupt with a patient,

I think the hardest thing for me to accept is to see a staff member who is abrupt and not polite and I don’t care what the reason is, I don’t care if your husband left you last night or whatever (giggle) the reason is but ‘I am sorry but don’t bring it to work’ or don’t come to work...and also telephone manners and written reports, I talked to them you don’t write a report like you have a conversation. I want consistent facts, I don’t want long narratives.

For Grace, similar to Glenda, having a positive facial expression and being pleasant with

patients are important communication skills with patients. She believes being positive and putting a smile on can often help with defusing possible conflict situations with patients:

First greet them you have to have a smile on your face. And ‘how are you? What is the weather like out there?’ and you know try to get them into a conversation.... putting on a smile, try to defuse a difficult situation.

Grace believes when talking with upset patients on the phone, the strategy of putting them on hold and getting back to them often helps. Also, when patients are upset and they come to her window, she is always pleasant with them as she adds “I think just being pleasant with them, because they are sick you know, so you have to understand when they come to the window and they may not be happy so you still have to be pleasant with them.”

One of the weaknesses she talked about was while multitasking at work she is not sure if she can listen attentively enough to clients as she adds:

Weaknesses, uh, you really have to listen to them, so I don’t know if that is a weakness but uh, but sometimes it is hard to listen to everything that they say because we have always so many tasks going on, all at once, the phone is ringing and if you pick up the phone then you say ‘excuse me’ put phone on hold and then ask them again.

For Nancy, some of the strengths she has are interacting well with the elderly patients and listening attentively to them. Nancy described listening as a key component of her job and added that she makes patients feel comfortable during their visit.

I think basically just listening to what they have to say, and advocating on their behalf cause a lot of them don’t know how to do that...I think I am just good at talking to people and they just feel so comfortable.

Nancy explains how some patients “ don’t know how to cope with things and they get all upset and when they talk to me it is more comfortable and they are not scared, cause I am not the doctor and they just feel more comfortable.” Nancy also does calls to follow up and check up on patients. She described how some of the elderly patients that she deals with appreciate her phone calls as it shows how she and the doctor she works for really care about their patients’ health:

I think, because you know, like some of these people, like a 90 years old lady calls in and well she can’t come to the office, so when you do a house call you check on her and make sure she is okay and get the medicine and everything that they need, and then when you are all done then think, well you made this person’s day a little better.

Nancy also describes that she is good at narrowing down patients’ complaints which often helps patients with their visit to their doctor and also helps the doctor “well, people want to tell me their problems, which is listening you know so that helps and that I could pretty much pick through which helps you know and pin pointing the problems.” Nancy described that her weaknesses are being less patient with clients who go on and on about the same problem and talk in circles and also for drug addicts who, she believes, pretend that they need medications as she describes “my weakness, probably impatience, you know people go on and on and on about the same thing (laugh) and I think another weakness I think I don’t have a lot of patience with drug addicts.” Nancy showed her concerns about patients with addiction and added that there should be ways of dealing with these patients. “I think they take an awful lot of money and time and I think there should be a better way and some of those clinics they are just condoning the drug use and there is a lot of that around here.” Nancy also described having less endurance with patients with drug addiction and some parents with children as she adds “I have less patience for drug addicts. And also have less patience for mothers that let their children go crazy and carry on and

I am not too good with that either.”

Physicians

The physician participants of the study mostly reflected on positive and strong communication skills with patients. Strengths in communication included attentive listening, developing rapport, listening to patients’ stories, treating patients with respect, explaining the patient’s condition in everyday simple language, and using different strategies to educate patients.

One of the weaknesses Dr. Carly talked about was getting overinvolved with her patients.

But I think, I tend to get over involved and I try to umm, it is not appropriate to the clinic where I am and what I start to do which is really get to know them to treat them for depression and stuff like that cause I don’t have time here if I clog up all my appointments.

Dr. Carly’s strengths in communication with patients include listening well, developing rapport with patients, and making sense of their complaints as she adds:

I think my strengths are try to get to know them a little bit and then try to put their symptoms into context and I think I am pretty good at that. I am pretty good at listening to patients and what is the reason behind what they are saying.

Dr. Carly described that her background in psychiatry helps a lot in diagnosing certain conditions in sleep medicine “as a psychiatrist I think your ears just prick up when you hear something that has to do with psychiatry that might be interfering with your sleep.”

Dr. Greg talked about his strengths in communication with patients. Dr. Greg talked about being comfortable talking to patients in simple and everyday language, the ability to answer their questions and concerns, educating patients well on their health issues, and involving

patients in the decision making and treatment processes. He also talked about having good people skills and the ability to gain patients' confidence.

Dr. Greg talked about not being comfortable with patients that are aggressive and offensive as he describes:

The weaknesses will be if I get somebody who is really offensive and aggressive sometimes I don't feel comfortable with them and sometimes those interviews I am not engaged in a long interview because I feel is not really helpful.

Dr. Adrian talked about his communication skills and explained how he wishes to improve his communications skills. He described that his interaction with his patients is often positive but there are times when the interaction is also not so positive as he describes

I know that I can certainly improve upon the communication and I know that there are some positive interactions I have with families and patients and sometimes there are negative interaction when I know that the patient and families are not satisfied or happy so I think it is a dynamic process that continues throughout your career and you learn from your experiences both the positive and the negative.

Dr. Adrian also talked about communicating with patients from different educational and economic and religious backgrounds and described that his communication approaches are different with these individuals. With patients who have less medical knowledge, he has to review the basics but with more educated patients he does not have to review the basics as they already have basic knowledge and understanding.

Dr. Bob talked about patients, particularly student clients, who are comfortable discussing their health concerns with him. However, he describes that some of his clients with mental health conditions take more time than others before they open up to him and provide him

with detailed information about their conditions. Dr. Bob also explained that his female clients who may have experienced abuse related trauma from a male partner or parent may not have a productive interaction with him. He added that this does not relate to having weaknesses in communication for him as he described:

I would say people seem comfortable in doing that with me. Not necessarily in the first 5 mins but the majority do... having said that I am, I mean specially in mental health, for example, if I am faced with a female student whose father physically or sexually assaulted her and I am the same age as her father and I am a male I am not probably the best person to be dealing with her and it has nothing to do with me and my skills and I am well aware of that especially in the mental health and counseling thing, there needs to be some match that has nothing to do with me but again I am well aware of that, that I won't be able to satisfy someone a hundred percent. But I think I do satisfy most.

Dr. Jane described being empathetic towards her patients, answering their questions, educating patients about their medical conditions, having the skills to break the news about serious health issues, such as cancer, to patients as some of her strengths in communication,

I think being empathetic towards them and answering their questions and not just repeating things over and over. Because I know she forgets things as soon as I tell her.

Cause she is so nervous and upset. So that was helpful and she left calmer than when she came in and I told her she had cancer.

Dr. Jane also talked about feedback she gets from her colleagues and patients about her strengths in communicating with patients. She described that communication with clients according to her clients can be difficult as she describes:

I am not sure if I could put an exact sort of description on it, I have been told by a lot of patients and other colleagues and especially in respiratory we have a mentor that you sort of spent a whole year with, but I have always known this is a strength from talking to other people. Like some people really have a hard time talking to patients and explaining things, I have never really had that trouble.

Dr. Jane describes that one of the weaknesses she has is being mentally affected by her patients' conditions. She describes that she should not get overinvolved with patients, that their condition both bothers and affects her and makes her upset. She also talked about thinking about these patients at home and trying to figure out what could have been done differently so that she could have been more helpful to them. She further describes,

In terms of weakness I think I take things personally sometimes, for example, angry people, who I know they are angry because of the situation they are not angry at me specifically, but sometimes I think I am more affected by it than other people would be. Because I tend to think about my patients when I go home and think if I have missed anything, or if I could have done anything differently I do think about that (laugh) so I think in a way it can be a weakness and I know I shouldn't let that bother me.

Dr. Jane believes that some strengths she has are not taking offence with patients who make inappropriate comments and not being defensive towards them. As she adds:

People coming and sometimes saying inappropriate things, men make their inappropriate comments, and I am not usually offended by it and it becomes awkward and I usually finish the conversation and give advice without sort of making it awkward... so yeah, those kinda of things I am pretty good at dealing with.

Nurses

Some of the strengths in communication explained by the nurse participants of the study included patient education, gaining the patient's trust, taking a friendly approach with patients and not appearing as an authority figure, avoiding using too much medical vocabulary with patients, and being nonjudgmental. For Crystal, some of strengths she has include the ability of educating her patients within the limited visits she gets with them and also convincing them to follow the instructions and achieve therapeutic objectives. As she adds "will teach you {patient} whatever you have to learn and will increase your ability to learn, so even for a new diabetic you have three visits to teach them everything you know...you have to find a way." Another strength Crystal has in communicating with her patients is admitting to the limitations of her assistance and acknowledging her shortcomings as she adds:

If you do something that is painful or if you make a mistake" just say "I am sorry" so acknowledge your own shortcoming. And if there are some, or if you know that something is painful, just say "I am very sorry that I have to do this to you but it is necessary" and make sure they understand why. They don't have to like it but they have to understand why it is necessary.

Crystal is not sure if it is either a weakness or strength for her but she tends to attend to patients' needs and sometimes it takes more time for her and she tends to spend more time than expected with her patients.

It absolutely takes more time, when I first started doing this the company I worked for and I had a buddy and she used to always be done at 3:00...I was working till 6:00 or 7:00 at night and that last three hours were not paid and once in a while I will get mad at myself and say 'stop working for free.

One weakness Crystal talked about was getting emotional and affected by patients' medical conditions. She also talked about being less organized as one of her weaknesses as she describes:

I think sometimes I can be a little emotional...I think sometimes I take too much of myself to the job...specially with community nursing we work free with everything, we have to prepare on our own time, ordering supplies in our own time so sometimes ordering things on a personal cell phone and there are a lot of administrative stuff that are not paid, I guess the weakness could be a I could be a little more organized and when I started doing this 13 years ago it was fun but it is not fun anymore.

For Paula, some strength she has in communicating with her patients are not being an authority figure towards them and talking to them in simple everyday language as opposed to using medical terminology strange to them. As she describes:

I am not sir, I am not madam' I might be just the brown chick the chick with the brown hair that I saw last time and to talk to them at their level and speak to them with their own language. I don't use language that is different from theirs and I try to use the language that they get so I don't say intercourse, I say sex, I don't say fellatio I would say blow job, this is how they talk and that is how they are comfortable talking.

Paula believes that her strength in communicating with patients is that she is nonjudgmental, educating them in simple everyday language that is familiar to them using positive body language and making eye contact with them:

I try and if I have to use, if I have to use a medical term at all then I would say such as therapeutic abortion or D and C is the medical term, I would just say abortion. So they have to understand and that is really important and the relationship has to be one to one so my body language is really important not sitting at the desk holding a pen, with typing

on the computer and taking their history, a lot of time I don't even open their charts, I will look at their chart beforehand and give myself a reminder of where they are at and I usually walk in with nothing.

Paula believes in the importance of the patient's agenda over following a strict protocol with patients. "They don't want me to come from a prejudged point of view or an agenda; my agenda is not important their agenda is important you know what I mean, so I think that is more important than anything." In addition to being nonjudgmental, Paula also talked about being open-minded.

whether it is gay man or a straight man or a lesbian or a 79 year old woman, a woman that I saw last week had a sexual encounter, the fact that I can provide a safe place for them and to talk, I feel like have done something.

The weakness Paula talked about was talking more and listening less during interaction with patients:

I think a weakness of mine is that I talk too much and don't listen to them. ..I need to be more empathetic, instead of, and more accepting, I need to be more patient with them and their change theory, where they are at and not try to hurry them up to meet my agenda.

Wendy talked about being focused on addressing patients' health concerns and advocating for patients as her strengths in communication. She further described that she is always patient-focused and believes in the importance of the patient's agenda. Wendy also talked about working in geriatrics and mental health and added that one of the strengths she has is communicating well with patients with addiction.

For Barb, using a sense of humour during interaction and making people feel comfortable are some of the strengths she has:

One of my strengths, I think having a sense of humour and be nonjudgmental I think I rely on. And I hope that I portray compassion...I hope I make people feel comfortable I hope that that is the atmosphere, that nonjudgmental atmosphere. I hope that will be my goal.

Evidence-Based Versus Narrative Medicine (Physician and Nurse)

The physician and nurse participants of the study talked about the consideration of evidence based medicine and also, in some cases, narrative medicine in different degrees in their interaction with patients and clinical decision making in diagnostic encounters. However, the use of evidence based medicine was predominantly discussed by the participants of the study. Dr. Greg talked about using both evidence based and narrative medicine during clinical encounters. However, he describes how he has to mostly depend on objective evidence as patients are often in denial of changes in their bodies. "I use both, if it is unequivocal from our data, if it proves something that they don't know what is going on, then I need to use that evidence because obviously denial is an important part of patient management." He further adds that sometimes when bio-medical exams do not match with patients' complaints, he would request a repeat of a test as the test may have been false negative. "If they say something that we were unable to prove then I have to go back and consider if our test was a false negative." Dr. Greg described that in some cases, he would go ahead and treat his patients based on subjective data from the patient as well as symptoms. "Sometimes I will treat patients even if the test has not shown, uh the specific complaint, sometimes I will treat them even though the test did not show, based on the symptoms and responses from patients." Dr. Greg also talked about taking the evidence more

powerfully as he does not have an alternative way of justifying a patient's condition and coming up with a working diagnosis. "I usually use the evidence more powerfully because if it is unequivocal I don't have any other way of explaining it." Dr. Greg explained the use of narrative medicine more frequently in clinical cases that are less described. One of the issues that Dr. Greg finds in his encounters with patients is variation in biomedical and subjective experiences of illness. Dr. Greg talked about how the patient's subjective explanation of his/her condition does not match with the objective finding as he adds:

It is their perceptions that don't always join with what we find, some people will be complaining of chest, I suppose the analogy is a chest, is someone prevailing with a chest pain, there is a differential diagnosis and if you are 15 year old healthy individual and you have some sort of chest pain that is stabbing and is intermittent and comes out when you are anxious that type of chest pain is obviously much less malicious than a 50 year smoker who is overweight and gets chest pain on activity. They are the same symptoms but you weight them differently.

Dr. Greg further talked about some patients whose biomedical and subjective findings do not help physicians with a working diagnosis and treatment plan. "I think the difficulties for those type of patients is that because they've got nothing obvious and there is nothing definable on testing either, we don't know how to treat them." Dr. Greg talked about the importance of a patient's subjective experience of their condition specific to his field of speciality and emphasized that patients' subjective experience is very significant for successful clinical encounters. Dr. Greg finally talked about the complexity of clinical decision making in his speciality and emphasized that because he is trained in Western medicine he weighs evidence

and objective facts more powerfully but he also believes in alternative medicine and encourages patients to seek alternative treatment if medical treatment is not satisfying as he adds:

I do practice Western medicine because I am Western trained, but I often encourage people to seek acupuncture and chiropractor and some holistic type of thing that can be helpful, because there is not one side of it all... most of people with something really awful they are going to need some type of interventions that is fairly science based but when it becomes psychological based, emotional problems and things that can normally recover on its own but they take longer and even traumatic, emotionally traumatic things those are open to enormous differential things, and treatment regimens so that is not what we do, so Western medicine does not always offer everything that I know.

Dr. Adrian talked about the importance of evidence based medicine in his area of practice in the emergency department. He indicated that often patients in emergency situations are not conscious and/or are semiconscious and there is not much subjective information to be gathered from them. He added that interventions in the emergency room are often based on objective facts and at times based on the physician's clinical experience. He added that due to time limitations, a decision has to be made within a short time frame. "Unfortunately we don't have discussion time to morally, ethically to go through this because if we don't make a decision God will be making a decision and the patient will be dead and we only have 10 or 15 minutes." Dr. Adrian added that his training was focused on patient and family centered "my whole training was always around patient centered and family centered" and he does value patients' and their families' opinions in decision making. However, a patient's critical condition does not allow him to discuss the situation in detail at the time of the emergency "family suddenly have to make a very quick decision and value judgments about survival versus quality versus length of life and

what is important to them and sometimes families have not really explored these concepts.” Dr. Adrian’s practice in his office is different from the emergency department. At the office, he spends more time with patients and allows them to describe their situations in more detail. Depending on his time limitation if he is running behind, then he would be doing most of the talking but if he has more time then he allows patients to talk more.

It comes down to time pressures, so if I am behind or running late or have huge busy clinic, then I am gonna do more of the talking and direct the patient more. If I have a little more time then I would like the patient to do more of the talking.

Dr. Adrian explained that in most cases, because he has to direct the patient and make a clinical decision he has to talk more

because I have to direct the patients, I need certain information to make certain clinical decisions...the reality is I do more of the talking and I am trying to direct to get certain pieces of information so that I could make a clinical decision.

Dr. Adrian added that in his office based practice he uses both bio-medical and subjective data in his decision making whereas in emergency care he has to rely on objective data as he adds:

I think it is actually both. You need a combination of both to make a decision. I need to know how the patient feels and values and concerns about a situation but I also need some objective data because medicine is ultimately driven by, we try by reach studies and everything to put people into boxes of this group benefits from this treatment that group benefits from doing that treatment so there needs to have stratification and we have to be there for management allocation.

Dr. Adrian values and weighs Western medicine over other alternative practices and takes objective facts and evidence more robustly in his clinical encounters. However, he also respects a

patient's choice in seeking alternative treatment and intervention that are not based on scientific methods.

My personal belief is to let the patient um, it came from my training as a medical student that we have to value the patient's beliefs but I let the patient, I always tell them about the value of Western medicine and that it is rigorous, it is very scientific and we see the benefit and we can show you it objectively and in numbers but I tell them that if you want to pursue other avenues that is fine.

Dr. Bob talked about the importance of Western medicine and his belief in Western medicine compared to other holistic therapeutic approaches. However, in his clinical decision making in addition to objective data he also weighs the patient's subjective experience of illness as he adds:

I have seen times and times in medicine that 80% of your diagnosis comes from your history, not from your physical exam, so usually physical exam is to confirm or refute your diagnostic impression at the end of the history, and the history is usually composed of the complaint.

Dr. Bob adds that he always has to investigate and order further bio-medical exams before making a diagnosis. He believes that most illnesses have common signs and symptoms and it is important to further investigate and come to a concrete decision before making a final diagnosis

So even if it seems like a mental health issue, if you think it is depression, it is gonna be some standardized test, or some standardized questions that you are seeking and various things that lead to the diagnostic criteria of depression, same with anxiety, same with bipolar disorder and so on.

For Dr. Jane, the emphasis in her clinical encounters is more on the history taking part than the physical examination. She adds:

by the time you finished talking to the patient, particularly part of initial consult you usually have a good idea what this might be and also what investigation you need to do.

So out of everything that we do I think the history is the most important.

According to Dr. Jane, her clinical decision making is often based on collecting subjective information from patients as well as biomedical findings.

The physical exam because basically it just confirms what are thinking and so very rarely I picked up something in physical that I was like ‘hum’ that was kinda surprise and then I might do an extra test to find out more, but this is very infrequent.

Western medicine is central in Dr. Jane’s approach with patients “cause that is what we are trained in” and she does not believe so much in alternative medicine as she does not know much about it. She describes how traditional or alternative medical treatments don’t have a rigorous scientific basis and are not well-researched and she, therefore, cautions her patients about seeking alternative treatments.

I would caution people that in general depending on what sort of thing they are talking about, something that don’t have a lot of evidence so I will talk to them in terms of evidence it doesn’t matter what it is, is it something that you rigorously studied and what type of studies we are talking about you know and I also caution people in general about alternative treatments and that they really should do research before they sort of undertake it if there is significant cost associated.

Dr. Carly talked about consideration of the psychosocial aspect of medicine in her approach with her patients. She added that she uses the approach a lot in psychiatry, not so much

in sleep medicine but she does believe in a combination of both scientific and cultural approaches in her medical encounters.

The nurse participants of the study also described taking different approaches (evidence based and subjective) in their encounters with patients. Crystal described that the information she receives about her clients hardly has any evidence based data about the patients' conditions; therefore, she mostly relies on patients' subjective information in her encounters with patients. "Sometimes there is hardly anything so sometimes we go with a great disadvantage, and we rely quite a bit we rely on patient's information." Crystal described that she has a set protocol to follow during patient care. However, she uses her clinical experiences more often in her practice than solely following the protocol

Protocol says if you are using the \$10 dressing with anti-microbial etcetera that dressing shouldn't be changed for three days and but this lady's frustration was that it was leaking and she also was on haemodialysis... I can use different ways to monitor the results and see how effective they are and I was totally impressed with drainage.

Paula talked about using two different approaches in her practice in the emergency room at the hospital and in public health settings. She described that she is more confident in dealing with patients in the emergency room because everything she does is evidence based even if a patient's subjective information is in contrast to clinical findings. Paula believes that biomedical evidence is enough and she does not really need a patient's subjective information.

Someone that is coming in and they are not showing you their bits and pieces, they don't have anything to show you except their stories...this patient in intensive care they can tell me all the stories they want. You can tell me all your story but I have got clinical

evidence that blood test; I have got everything to tell me the story, even if that person can't talk. I know what is happening with their body.

Paula believes that in public health settings the challenge of dealing with subjective data is that patients often do not share true information with the nurse and also do not trust their nurse; therefore, clinical decision making based on the patient's subjective information is difficult but evidence-based data are a strong source of knowing the truth about patients' bodies and their conditions.

If I get a positive pregnancy test my lab results does not collaborate your story. So for me to get the correct information and try to help them with their issues it is really important that they can be honest with me and trust me. Where the ICU patient can lie and say what they want but I still have the evidence and I have to treat them based on that.

For Paula, helping patients in an emergency setting is less challenging as, according to her, changes in their bodies are often physiological changes that can be detected with biomedical exams; however, in a public health setting, changes are often emotional and depend on the patient's subjective information.

The problems in intensive care is physiological and there are emotional problems but they come secondary because it is acute care because they are sick and we need to treat what is there. In the sexual health center someone needs to come and talk to me about their pregnancy I can't help them unless they are honest with me.

Paula further adds that "the evidence speaks for itself" and she relies more on evidence than on the subjective experience of the patient's illness.

For Wendy, the emphasis in her approach with patients is on the patient's preference as opposed to scientific approaches to treatment. Even if the patient's preferences are not supported

by the empirical methods and the patient does not want to follow the treatment plan, she supports the patient's opinion, feedback, and preference:

They {clients} don't want to take the medications and so then you know we have to respect their decisions despite knowing that they may benefit from them, some sort of medication treatment and we have to look at the alternatives and how are we gonna support them. So it is really I rely a lot on clients' inputs for their care and try to support them as best as can.

Barb believes in Western medicine scientific approaches in her everyday interaction with patients and generally follows a generalized protocol with all her patients.

Hopes and Desired Changes (Physicians)

The physician participants of the study talked about desired changes, likes and dislikes about their jobs, their career choices, and plans for taking further training. Dr. Carly wished she had had the chance of doing a general internship between her medical school and career. She believes that would have given her more confidence in diagnostic encounters as she describes "I did not do a general internship between my medical school career and going in to psychiatry I think you should be made to do that because that would have given me the confidence." She further describes that the internship would have also given her the clinical experience that she needs in picking up some complex clinical cases "it hadn't come from the clinical experience, and I miss that to this day... I am sure there are things, well there are numerous things that I have a harder time picking up on." Dr. Carly suggests doing a general internship before residency training for all and believes that it helps physicians become more competent in their diagnostic skills "to do a general internship in internal medicine before you go on to do whatever residency

you are doing. I think that would be an important thing to do to sharpen your diagnostic skills.” According to Dr. Carly, medical schools are not as ‘cognisant’ today as they were 30 years ago.

I heard other places are not as cognisant as they were 30 years ago of the importance of empathy with the patients um but I think they built on most things now as in most of the medical schools it was not set up that way you know ‘there are three admissions coming in tonight’ and then you had to and study up about thyroid anatomy cause you knew that the guy was gonna ask about thyroid anatomy and did not really make you sit near the patient’s bed and try to listen a whole lot but you gotta find the balance for yourself that is how much is enough, so I think that is important that they take that into consideration.

Dr. Greg wishes he had more time for research instead of working this hard: “I think I would probably not want to work this hard, because I would have liked to have done more research, whole lots of reasons things just didn’t pan out the way I thought they would.” Dr. Greg enjoys practicing sleep medicine but because of being very busy with work he hardly finds time to write research papers. He described that he had come across several clinical cases that were new and had not been reported officially and years later came in literature as he adds:

I was making diagnosis and coming up with questions about conditions that 4or 5 years later came in the literature and I knew what those things were, and never reported them and I never formally acknowledged that I knew what they were and I should have.

Dr. Bob suggests adding training programs for physicians during medical school or residency on the business aspect of how to run a clinic. He believes new graduate physicians often do not have some important leadership and management skills, as he adds:

looking at that I don't think residents get a lot of training as far as the business aspect of running a practice. I don't think family medicine residents or even medical school residents receive any training in terms of leadership and training in management.

Dr. Jane likes her field of practice but she wishes that she did not have to train for such a long time for her speciality.

I like where I ended up, I just don't like it terms of it taking me so long and sort of having a difficult time to get here (laugh), so in retrospect I am not sure, I think I could have gone into family medicine where you do two years of training as opposed to five, or do something like four years of med school and (pause) I should have just become a teacher (laugh).

Dr. Jane also wishes she had shorter hours during residency training as she explains "I mean having shorter hours during residency; otherwise you know it is pretty good."

Dr. Adrian wishes he had more exposure to community hospitals when he was doing his residency; he believes that it would have prepared him a lot for the job he is currently doing at a community hospital.

What the medical school did not help us with is in the community setting which is very different from a tertiary care hospital ...one patient I am seeing right now might have a cardio-pulmonary problem and the next patient coming to the ICU may have a massive neurological stroke so you all of a sudden then have to pull all those different things together so in your training you are doing a lot of one thing and focus on one thing at time.

Dr. Adrian suggest all medical residents should be sent to different community hospitals to become more exposed to the diversity of medical issues they will be dealing with and also diverse people from diverse cultures.

In the community you have to do a little bit of everything so what I would recommend to residency is, in the beginning you need to teach residents that way but as they get closer, because the majority of the physicians are not going to work in big teaching hospitals and university settings, the majority are gonna go into communities like me and where they're gonna be expected to be much more flexible and dynamic. So what I would recommend to residency program is in the last six months send the residents out to the communities, to do their final set of trainings and the kinds of environments so they kind of know this is what is going to be like.

Dr. Adrian explains that as specialization in medicine becomes narrower and more focused to one particular health issue, it is good if a patient only has one issue to be dealt with. But physicians might be challenged to treat patients with multiple health issues, or one patient has to see multiple specialists to find answers to their medical condition. To him, this means lack of cohesiveness in medicine and he believes that

There is this phenomenon of hyper specialization everyone is specializing, specializing and the general skills are slowly being eroded in some ways that is okay because as people specialize we are learning more about how to treat a specific problem better and so if you have someone who really knows that problem well and they treat the patient it is amazing but the down side is if you have someone who has multiple issues or interacting issues then no doctor or even group of doctors is going to sufficiently satisfy the patient... so this is where medicine is becoming highly challenging.

Dr. Adrian also believes that specialization in one small field makes it difficult for physicians to be unified and patients often complain that physicians are not helping them and they have to see multiple specialists for each different complaint they have. He further adds

Patients say I have ten specialists and they are not really fixing me because there is no cohesiveness and the family doctors who, have to be that cohesive say ‘oh I don’t understand any of these disciplines now cause things have gone so far and so much knowledge that I am gonna just sit, I am left here kinda just taking information from people and compiling it, writing and summarizing for the patients.

Qualities for Successful Physicians, Nurses, and Medical Receptionists

Almost all the study participants agreed on listening as an important quality for their jobs. Effective communication skills were another area where all the study participants reflected on similar communication approaches in building good professional relationships. Gaining patients’ trust, making them feel comfortable, and not talking down to them were also some qualities most of the study participants talked about.

Qualities for Successful Physicians

Regarding good qualities of success, the physician participants of the study talked about diverse sets of skills, including clinical and communication skills necessary for successful encounters. For Dr. Carly, the important skills include the ability to develop rapport, being kind and empathetic with patients, being honest with patients as well as an attentive listener, asking open-ended questions, and letting patients feel that they have been heard as she adds:

I think first you have to develop a rapport with the patients because if you don’t they won’t listen to anything you say and not give you the honest truth about what is going on so that is very important. Umm, it is important to try to handle patients’ symptoms in a

sort of a form of framework and try to figure out what is the matter with him, umm, it is important to start with an open ended question and end with much more specific questions, you have to let them feel that they had been heard, umm, and sometimes that means they talk on for five minutes and then you have to sort of interrupt them and steer them towards the part that they are here to see you for.

Dr. Carly also talked about making eye contact with patients and using everyday language with patients and not so much medical vocabulary that is unknown to them. Also looking at patients,

First thing you do is look at them, cause sometimes you can find a lot by just looking at them umm, and you've got your sleep study and you've got their questionnaire and the questionnaire is very detailed and very important. So you look at that and that leads you to your future questions and the sleep report, of course you look at and that can form the support or refutation for what you think that diagnosis is.

Dr. Carly lastly talked about "empathy, kindness, using words of one syllable like not talking medically to people."

I think if you are not sure what the matter with them is and you need to do something else then just be very open about it... you want to have somebody who ask the right questions, and they have a good knowledge of internal medicine to be able to follow up and get more specific about things.

For Dr. Carly, having the qualities necessary for a physician also includes not talking down to patients. She talked about a cardiologist who was well-liked by his patients and was a role model for her as she describes "he would go around and he would do the necessary testing and stuff but it was very collegial and he did not talk down to anybody and he was a bit of a model I think."

For Dr. Greg, developing rapport, not talking down to patients, respecting patients, doing

patient education, being open, friendly, and honest with patients, and having updates and extended knowledge of the current area of practice are some important qualities for him. Dr. Greg indicated that he has the ability to use different techniques in educating patients about their conditions and making the encounters successful. He also added that patients often follow his advice:

Let me just take the example I used about the woman who lost 11kgs. She did not know that drinking eight cans of pop a day was giving her extra 1400 calories/day and once I explained that to her she stopped it. Her skin cleared up, her skin looked beautiful, she lost all that weight, she lost 11 or 12cm of her stomach, I think it was 11 or 12cm off her waist. That was perfect because she took that knowledge and she understood it.

For Dr. Adrian, important qualities for a physician are different in emergency practice, family medicine, and speciality practice. He believed that in emergency medicine due to the time limitation regarding the physician's judgment of a patient's condition, making the right decision using his clinical skills is important. However, in family medicine and specialization, he believed that taking time to advocate for and educate patients and make them aware of the available community resources are very important.

For Dr. Bob, the important qualities for a physician in addition to having good communication skills also include "availability, affability and ability, and the standard line is that the patient would value availability over anything else ...So you have to have a balance of availability, affability and ability."

For Dr. Jane, the quality for a physician, in addition to having good and open communication with patients, is the ability to properly delivering serious life threatening information to patients. She talked about one of her patients who was diagnosed with cancer and

how she was able to break the news to her about her cancer in a way that the patient was not threatened as she describes:

So I had a lady come in diagnosed with a lung cancer and I had never met her before, she came in with her two sons and she is very interesting it is like one of those situations I am meeting her for the first time and I had to deliver to her the bad news and before she freaks out and when she hears about her cancer, forget about everything, questions, and investigation and the next steps, and people she has to see following the referrals and it, actually I think it went very well, so that is the part that I really don't have a problem with, so those kind of people I had to know ahead of time and I have to book a little extra time so that I have enough time to answer their questions and that is something I do on purpose. I think being empathetic towards them and answer their questions and not just repeating things over and over.

For Dr. Jane, other important qualities for a physician include “smart, intelligent and compassionate and I think it is important that someone cares about their patients ...someone who is really responsible. I think it is important for people.” Finally Dr. Jane talked about having a good bedside manner as a good quality for a doctor.

Qualities for Successful Nurses

For Crystal, qualities for a successful community nurse are being assertive with patients, encouraging them to get involved in their treatment, and become independent, “in the home we give a lot more autonomy to the patient, I will teach you whatever you have to learn and will increase your ability to learn.” She also talked about having the ability to combine different techniques in encouraging patients to get involved in their care and become independent as important qualities for a community nurse.

When it comes to giving somebody insulin and you are teaching them, they will say “I will do it next time” and you say “no do it this time and I will hold your hand and it is okay to make mistakes, but tomorrow you will do it by yourself” “And the same if somebody has a knee replacement or a hip replacement, you are going to teach them how to take a needle.

For Crystal, taking different and effective approaches with each patient also count as good qualities. She indicated that some patients are slow learners, so the nurse has to spend more time in educating them. She talked about one particular patient who was a slow learner as she adds “took him {the patient} back a little bit and said ‘we can take a step back until you master it’... I will teach you until you feel really comfortable; so you take them in baby steps along with tasks.” Crystal also described how she takes her time in listening to patients’ experiences of illness and chatting with them so they feel they are being heard and she believes that it is a good quality for establishing a good therapeutic relationship. In addition, she added the importance of acknowledging the patients’ knowledge of their condition as she adds:

because somebody came and took an interest in listening to her {patient}...So I think I spent a little extra time like social chatting with her. So just hearing her experience... I think she wanted to see that “I am not an idiot and don’t treat me like one” you know (laugh) and now she has some medical knowledge and she would like to be involved and she wants to know what is going on with her life.

Crystal described the importance of educating and involving patients in their treatment and care, even getting patients on their side when doing a painful procedure is important for a healthy nurse-patient relationship. Further, she adds to say sorry if something goes wrong and it is the nurse’s fault as it helps with establishing trusting patient-nurse relationships. “If you make a

mistake” just say “I am sorry” so acknowledge your own shortcoming. Crystal indicated that some procedures she performs at home, such as giving a needle, dressing wounds, and others, can be painful and it is important to make the patient realize that it is for their own health. Crystal also indicated that an important quality for a community nurse is also not to get overinvolved with patients. She describes that a community nurse should encourage a patient’s independence, what she calls the “self-healing” aspect of care with patients. She described one particular patient who wanted to just socialize and chat with her and she told her that it was not her job but she also had to apologize to make sure she understood the limitations of Crystal’s job and this does not affect the nurse-patient relationship as she further adds:

I just apologized and said ‘I didn’t mean to hurt your feelings but it is not that I don’t like you, I like you very much but it is just that had to do with self-healing. This is not how it is supposed to be and I still see her. So I kinda just let it go you know, I apologized and we had to sort of just repair the relationships a little bit you know.

Paula also talked about health education, honesty, and trust in the nurse-patient relationship as an important quality for a nurse “it is really important that they can be honest with me and trust me.” Paula believed that a public health nurse should also have the ability to connect their clients with all the necessary community resources there are “for me to measure success to provide all the sources I have.” For Paula, some additional qualities for a good nurse include not talking down with patients and having the ability to connect well with her patients by using simple communication approaches; for example, the everyday easy language instead of medical terminology. Paula believed that for a good public health nurse, it is really important to avoid medical terminology that is not familiar to patients, make eye contact with patients, go prepared, and review the patient’s chart ahead of time so that the nurse is not spending so much

time writing stuff down during the interview. Paula also talked about the importance of confidentiality when it comes to the patient's information. She described that the patient-nurse relationship should be nonjudgmental and gives priority to the patient's agenda in their own treatment. For Paula, qualities for establishing therapeutic relationships are different in acute care and public health settings. She believed that in public health, the qualities for establishing a relationship are based on partnership; however, in acute care in the emergency room the nurse is often the expert. For Paula another good quality for a public health nurse is having the ability to provide a safe and comfortable place for the patient as she adds "the fact that I can provide a safe place for them to talk I feel like have done something." She further described the importance of empathy in the patient-nurse relationship. One of the qualities regarding overinvolvement that Paula talked about was similar to Crystal's. They both agreed about not getting overinvolved with patients. In addition, Paula believed in the importance of educating patients on their rights to get involved in their care.

I have learned as much as you want to help and you have the knowledge to help you have to hold yourself back and not be frustrated you can't change people you can provide them with information, opportunity and kindness and openness but they are gonna move on their own pace or they are gonna not move at all and that is their choice and we need to accept that.

For Wendy, being patient focused and supporting patients' choices and decisions are important qualities for establishing good therapeutic nurse-patient relationships.

I am very patient focused, um, I don't have my own agenda when I am going to see the people I spent a lot of time asking them what they want to do and we will talk about the treatment plans and what is best for them.

Wendy believed in the importance of the patients' knowledge, opinion, and choice in their treatment and a nurse accepting and supporting patients' choices and advocating on a patient's behalf. "I rely a lot on clients' inputs for their care and try to support them as best as can."

Wendy indicated that a nurse should be knowledgeable about the available community resources and also have knowledge of the field in which they are working.

I guess really knowing the community resources that are available...you need to have a strong knowledge of whatever speciality you are working for example mine is mental health so for me understanding the mental health piece and how to manage...and if you are this little off of the approach clients can escalate very easily so it is all about being relaxed and how you present yourself and how you are towards them.

Wendy talked about some other qualities specific to mental health and indicated that in mental health it is also important for a nurse to advocate on behalf of her patients and be empathetic with patients.

understanding that the person is ill and you know because if you have that understanding you are not gonna get your back up and you are not gonna be offended by what people say...being an advocate you know in mental health, you need to be a strong advocate.

Wendy believed that knowing about the patient's culture is also an important aspect of the patient-nurse relationship and, therefore, it is important that the nurse learns and educates herself about patients' backgrounds and cultures as she adds "I would like to ask about their cultural history because you need to know what cultural influences are gonna affect the treatment plan."

Similar to all the nurse participants in the study, Barb also talked about gaining patients' trust, being empathetic and nonjudgemental as important qualities for a nurse in establishing a successful nurse-patient relationship.

Qualities for Successful Medical Receptionists

Becky talked about the importance of listening as an important quality for a successful medical receptionist as she describes “I think we have to remember to listen, before you actually say...I think the key is to hear them out and then ask your questions. I think that is something that I am always trying to improve on.”

Glenda also believed that listening to patients and hearing their stories is an important quality for a successful medical receptionist. She adds “sometimes patients just need someone to talk to, they just need someone to say ‘just be calm I want to help you so please let me know what your concern.’” Glenda talked about another quality when handling issues of upset patients as follow “so the best way to deal with someone that is upset is to lower your voice.” She described a particular case where she dealt with an upset patient who had a negative experience with another medical receptionist prior to her but Glenda took her time in listening to this patient’s concern, understanding it, and making sure the patient knew that Glenda was there to help. For Glenda in addition to having good communication skills with patients, having the ability to multitask and having good computer skills are also important. Specific to communication skills, for Glenda, facial expression, tone of voice, and being empathetic to patients are also the important qualities “I think as far as the communication goes the most important thing is the expression on your face, the tone of your voice.” Glenda also talked about making sure patients that come to her clinic have their first experience as positive as this will encourage patients to come back when they need medical assistance again and this also helps with the business aspect of her job.

Similar to all medical receptionist participants of the study, Nancy also indicated that listening is an important quality for a medical receptionist. In addition to listening, she believed

that advocating on the patient's behalf is also an important quality. Nancy believes that helping patients narrow down the reason for their visit does not just help the patient but also the physician and counted that as an important aspect of her job. She describes:

Helps the doctor {narrowing down the reason for a visit} and it also helps the patient cause some of them, don't know how to cope with things and they get all upset and when they talk to me it is more comfortable and they are not scared, cause you know I am not the doctor and they just feel more comfortable, a lot of them.

Nancy also talked about being welcoming, and making people feel comfortable as good qualities for a medical receptionist. "I think I am just good at talking to people and they just feel so comfortable, and you know and the doctor encourages that."

Nancy also talked about being compassionate as a good quality for a medical receptionist.

In addition to listening, Grace also talked about the importance of adhering to good patient confidentiality in front of other people in the reception area. In cases where a medical receptionist has trouble understanding a patient's health concern, she should take her to a separate room or ask a nurse or a doctor to help narrow down the patient's reason for the visit. Grace believed in gaining patients' satisfaction as an important quality for her work.

"Satisfaction, like you want them to be happy, you want them to come back." For Grace, good communication skills and the ability to diffuse any negative circumstances were also among some positive qualities for a medical receptionist. Grace also talked about having positive facial expression in front of clients as a good quality for a medical receptionist

If you see someone upset you usually prepare, you do (pause) you still put the smile on your face, yeah, and you try to make them happy and get them in to the doctor as quick as possible. Cause they are in distress and so you try to do everything as quick as possible

and make them happy.

Glenda also talked about keeping patient confidentiality and using a gentle tone of voice with patients as important qualities for a medical receptionist. Similar to Glenda, Grace also talked about the importance of multitasking as an important quality for a medical receptionist. “We have to be organized and be able to multitask. Answer the phone and just do many things all at once.” Another quality that both Glenda and Grace had in common when dealing with patients was being pleasant with patients and attending to patients who are standing at the reception area have priority over people who are on the phone.

Career Choices (Physicians)

Physician participants of the study had different opinions about career choices. For Dr. Carly, her initial career choice was to become an obstetrician but then it did not appeal to her and she became a psychiatrist instead. After practicing psychiatry for a few years, sleep medicine appealed to her and she trained in sleep medicine and become a specialist in sleep medicine as well. Dr. Carly wishes she had a chance to do an internship between medical school and psychiatry that would have given her more confidence and sharpened her diagnostic skills.

Dr. Greg’s response to the question of career choice was that he loves his current area of practice (sleep medicine); the only thing he misses is research and he wishes that he had more time to write research papers and journal articles.

Dr. Adrian also likes his current area of practice better but he suggests that there should be more community connections between physicians and local communities. He believes having a program in place where physicians during their residency program are sent out to the community to get familiar with the local community and the practice would be valuable. Dr. Adrian does not believe in the phenomenon of “hyper specialization” in medicine and believes

that it negatively affects the more general skills that a physician should have, especially dealing with patients with multiple health issues, “if you have someone who has multiple issues or interacting issues then no doctor or even group of doctors is going to sufficiently satisfy the patient.”

Dr. Bob said that going to medicine for him was because of getting bored in graduate studies and research and he indicated that it did not appeal to him as a career. “I went into medicine because I was bored in my graduate program, I didn’t like research as a personal career.” Dr. Bob enjoys practicing as a general practitioner in family medicine because he gets to deal with varieties of health issues, “in terms of liking better, I like the variety and that is why I am in both family medicine not in speciality so I can’t say I like any one thing best.” Dr. Bob suggests having a training program for physicians after graduation in leadership and management. He believed that new graduate physicians do not have the skills to run a private practice as they never receive any training in it.

Similar to all other physician participants of the study, Dr. Jane is also enjoying her area of practice (internal medicine) but she wishes she did not have to spend so much time in a speciality program. Dr. Jane suggested having shorter working hours during residency training.

Typical Day Physicians, Nurses, and Medical Receptionists

Almost all the participants, except Dr. Carly and Glenda who worked on a part time basis, worked full-time hours and a typical day for most of them starts in the morning and they all worked for 8 hours. Dr. Carly explains “I still work part time and I can’t retire because I never had a full-time job.” In a typical week, Dr. Carly works Wednesdays and Thursdays in a sleep clinic and Tuesday mornings in a psychiatric clinic. Some weeks she also reviews 20 patients’ charts Friday to Monday. In general, she works 3-1/2 days per week.

Typical work week I work Wednesday and Thursdays at the sleep clinic and I work Tuesday mornings in a small psychiatric clinic and sometimes over the Friday to Monday I do 20 charts from the sleep clinic and that keeps me probably busy for a whole day, so I am working about 3-1/2 days in a week.

Dr. Carly's consults include seeing patients and triaging them to see if they need pulmonary function testing or cardiopulmonary stress testing and an assessment clinic for general sleep disorders. Dr. Greg works in three different locations in Ontario and his day starts at 8:30 a.m. and ends at 6:00 p.m. and he often does not take lunch breaks as he adds:

Our day starts at 8:30 and we finish at 6:00 o' clock. And I typically work through lunch and 2 days we have rounds and respirology rounds and in the winter, not in the summer they cut off for a couple of months.

In addition to consults and ordering testing for patients, Dr. Greg is also involved in training new physicians at the local hospitals. Dr. Bob explained that a typical day for him involved a lot of administrative work. In addition to practicing family medicine Dr. Bob also does a lot of administrative work at his clinic. He describes that one third of his work involves administrative duties including dealing with nurses and other medical staff.

A typical week that would be hard to think, it is probably a third of my time is doing medical administrative stuff dealing with the nurses and staff, and questions about patients and dealing with minor issues, when the physician is not here that day.

Dr. Bob described that half of his work involves seeing patients with mental health issues and a third portion of his work in addition to administrative responsibilities is working for a local emergency program "at least 50% if not more than that is now mental health issues, anxiety and

depression are very high along with other mental health serious issues. And a third would be the stuff that I do outside.”

For Dr. Jane, a typical week now is different than it was 2 years ago. She used to stay at the hospital overnight and also do house calls. Her typical week now involves working 2 days at the sleep clinic and half a day at a respiratory clinic. Dr. Jane hopes that she will be able to practice 50% in the sleep medicine field and 50% in respirology.

Dr. Adrian’s typical day varies and depends on the healthcare facility where he works. If he is working at his private clinic, then his day starts at 9:00 am and finishes at 5:00 p.m. but if he is working at the community hospital it varies and depends on the type of cases he deals with. The works hours can vary from 8:00 a.m. to midnight. He described that his practice has changed a lot in the past 5 years due to his family commitments. He used to work mostly at a community hospital dealing with patients with acute internal medicine issues and over the past few years he became involved with the ICU and emergency unit and respirology.

Medical receptionist Becky works full-time Monday to Friday and her days can be different depending on the number of patients she sees per day. She described that she does not really have a typical day and her job involves doing different tasks at the clinic. She described that she has busy days and quiet days “so there isn’t really a typical day, every day is different and you do what you can, there is a lot of multitasking going on.”

Glenda works on a part time basis and she usually works 8 hours per week and in addition to dealing with patients she is mostly involved in training new medical receptionists and administrative work.

I have been here about a year and a half and I only work at maximum 8 hours of a week. I come in 2 days 4 hours, if they need me like if {someone is} going on vacation or

something then I put in a few more hours.

Grace works full-time hours and starts at 8:30 a.m. in the morning and during her first few hours she is dealing with patients and the rest of the day she is often busy doing billing for the doctors

I open up the clinic at 8:30, open up both sides, the walk in side and the family clinic side...deal with patients in my first hour and a half. Registering them and putting them in a room. And the rest of my day is, I normally do billing for the doctors. And looking after workmen's comps and immigrations.

Her job of dealing with patients involves greeting patients, asking the reason for their visit, and also she is responsible for billing.

We first greet them and ask them why they are here and why they wanna see the doctor and just looking after their needs before they see the doctor and the administrative part is, after they see a doctor I am billing for their visit. So I actually find out what the doctor has diagnosed them for and then billing the ministry or the immigration for it.

Unlike other medical receptionists who are mostly involved in customer services and administrative work in their typical day at work, Nancy was also involved in assisting the physician she works for in minor surgeries as she explains:

I do a lot of different things there, so I answer the phone I do billings, um, if the doctor has a minor surgery I assist with that, uh, um, paps smears, baby care, so a lot of different things in the office. And thing that I hate the most is filing.

Her typical day starts in the morning by checking patients' messages on the answering machine, taking messages for the doctor, and calling back patients and reminding them about their appointments as she adds:

I check the answering machine. Take any messages, call people back, uh, um, every patient has a chart he still uses the paper files so you have to update for the next day so um, he calls everybody the day before to remind the patient of their upcoming visit. You know calls for prescriptions refills, the doctor will give you a list of pills to call in for patients, like refills, and stuff like that.

A typical day for Nurse Crystal starts at 8:30 a.m. and continues till 4:30 p.m. and sometimes she might also work till 6:00 p.m. depending on her appointments. She sees 2-5 patients each day. However, her weeks are always different and her appointment length can vary from 1-2½ hours and she looks after different types of patients with a variety of illnesses and she likes the variety about her work. “It depends (pause), and so the interesting thing about community, because I like the change and I don’t like routine.” Paula has two different jobs, her full-time job is working as a public health nurse and her part-time job is working as an RN in an Intensive Care Unit at a local community hospital. Her typical day as a public health nurse starts at 8:00 in the morning and ends at 4:00 in the afternoon. She did not talk about specific hours for her ICU job but mentioned that she works there on the weekends only. Paula described that her work as a public health nurse involves doing a variety of tasks including dealing with patients who have sexual health issues, STD testing, HIV testing, and the outreach program to homeless and shelters.

We are cross trained, we do birth control, sexual issues, STD testing, HIV testing we do it all, and the other piece of this is the outreach program to homeless and to shelters...I would say 60% is sexually transmitted infections, may be 30% is, 35% is birth control, and the other small percentage would be testing the HIV drug abuse.

Wendy works full-time hours Mondays to Fridays, her days start at 8:30 a.m. and ends at

4:30 p.m. Her job involves working in the mental health sector where she interviews clients, does the mental health assessment, and sends the reports to the referring psychiatrist. Depending on her clients' mental stability, she might get their information in one or two visits. In rare cases, she might also have to schedule a third visit. Her visit time varies from 10 minutes if the patient is not ready for their interview to 1 hour.

I work Monday to Friday 8:30 to 4:30. A typical day at work for me involves starting here at the office on a daily basis. We come in (pause) we have team meetings twice a week in the morning to review the clients charts and new referrals, I work in a mental health so I do Tele conferencing via the Ontario Tele health network. ..I interview clients and do mental health assessments and I prepare what they have told me, write down their summary and pass it along to the psychiatrist. Um, as for as how many clients I see in a week it really varies.

Barb also works full-time hours and she works Monday to Thursday. She is not sure how many patients she sees but the clinic she works for accepts 130-150 clients per day. Her job involves doing a variety of tasks including triaging patients before their visit with a doctor, or working as a booking nurse and seeing patients independent of physicians. The third task involves working as an information nurse who is responsible for processing all the lab results, x-ray report, and ultra-sound reports and sending them to the referring physicians and making follow-up calls to patients.

I work Monday to Thursday. Some days have longer shifts and put full time hours on Monday to Thursday. And the way the clinic is set up we do rotate to some different positions which is very nice to get a different duty every day. We see about 130-150 people a day. How many I individually see I am not sure of.

Professional Training and Plans for Further Training

Becky talked about going to school and training as a medical receptionist but added that her professional training did not really prepare her for the job and she learned a lot on the job as she adds “well I see, professional training. I think being on the job and learning is what prepared me and I think being at school, they teach you at school about the folks, but I think you learn on the job.” Becky is interested in taking training programs that might help with improving her skills in dealing with patients but she is not sure what particular training “... any little bit might help and I don’t know if anything in particular but I think maybe.”

Glenda has RN and management backgrounds and she described how these experiences were a big help in her current job as a medical receptionist plus admin assistant. She had to develop a policy procedure manual for the clinic and that was outside her training experiences as she adds: “My nursing is a big help but really the managements skills have really helped in this particular job... they didn’t have the policy procedure and I had to write that so this was the biggest thing for me.”

Glenda talked about taking some training courses just for fun at Brock University and Niagara College. However, she indicated that she is not interested in continuing as she adds:

I have so much training (giggle), I have a RN, I have a bachelor in business economics, I have a masters in industrial technology and I have taken so many different courses and I am retired. But I still take courses with my daughter and we are still friends. So she needs course for her job and we are going to Brock and Niagara College but that is just for fun. But no I don’t see myself continuing.

Grace is trained as a pharmacy technician and has a background in business administration; she worked as a pharmacy technician in a pharmacy before working in her

current job as a medical receptionist/admin assistant as she adds: "I have been working in the clinic part, it will be 2 years and before that I worked in pharmacy for 13 years as a technician...I went to school for business administration." She described that the skills she needed for her current job she learned them all at her previous jobs and her training at school has not really prepared her for her current job. Grace described that in addition to customer service and billing for the doctor, she also does transcribing as she adds: "I worked in the pharmacy I had to learn all those things and I think it all comes with experience and you learn as you go." Grace described that she is interested in taking further training courses but it is to become a medical transcriber as she adds: "I do want to take some further training and I am not sure what is it called, but it is like where the doctor talks and uh transcribing, I wanna take that."

Nancy is trained as a medical secretary but she explained how she received most of the training specific to her current job from the physician she works for and her training at school did not really prepare her for job as she adds:

I completed a medical secretary course in college, and so, then right from there I got hired by this doctor, so you know. And really school you don't learn a lot so you learn a lot on the job that you are doing ... and he was a very good teacher and very patient...I started working for him, I was only 18 years old so, you know he kinda showed me everything, how things need to be done and he was very good that way.

Nancy is also involved in assisting with minor surgeries that the physician often performs at his office and she has not received any professional training for it. She is ready to be retired so she is not really interested in taking further training. She further added:

I am 60years old and I think that I am trained enough (giggle), when I worked full time we used to go to a lot of different dinners like the drug companies put on you know, I used to go to a lot of those so those were good and they were interesting.

After completing medical school, Dr. Carly started doing her internship and was planning on becoming a OBS (Obstetrician) then she did not like the program and started her residency in psychiatry and completed a 4-year training program and described how she really enjoyed psychiatry while she was still in medical school

After about a month that I really did not like... so I left after about a month and came back and went into psychiatry residency cause that is what I enjoyed doing when I was still in medical school the most, so I did that for four years and again I quite enjoyed it.

Dr. Carly is satisfied with her training but she described that she misses doing a general internship between medical school and residency. She believes doing a general internship would have helped with her diagnostic encounters with patients. "I am sure there are things, well are numerous things that I have a harder time picking up on...those things don't come to me as quickly as it might." Dr. Carly described that when she was a medical student, she was impressed with a cardiologist's clinical skills and described that she learned how to engage with patients and observe the patient well before doing a physical examination on them as she describes:

I remember when I was a medical student there was this guy who was (pause) I think he was a cardiologist...this was when I was very young and they were teaching us how to do the physical, he won't let you touch the patients until you had looked them over from stem to gut and talked to them a little bit and learned about their history then he'd let you touch them to find out what physical findings you could have, too often people reach with

the stethoscope first and they don't look and listen first. So I think that prepared me.

Dr. Carly also explained that she took a course called "psychosocial aspects of medicine" and she learned a lot about health psychology and the relationship between health and personality

They (her medical school) had a course in the first year called 'psychosocial aspects of medicine' and it was all about what is behind a patient and we got to go out to a patient's home and interview them...we were allowed to ask questions to see, somebody had say MS or rheumatoid arthritis or something like that. So it was a real attempt to figure out what the patient coped with and difficulties that can be caused.

Dr. Carly described that she is interested in further training but she did not talk about any specific programs. She mentioned going to conferences that helps updating with new knowledge and developments; however, there is nothing specific that could help with learning about different approaches with patients. She explained "going to conferences does improve your knowledge but I am not sure if it can change your approach to your patients, except for the socialization with the other physicians that are there."

After completing medical school, Dr. Greg was trained as a general practitioner and as a general practitioner he was involved in working in different fields of medicine, such as anaesthesiology and general surgery, as he describes: "Sometimes anesthetics, sometimes I had to do surgeries, but typically had to fulfill those types of duties because there weren't other qualified people around. So I practiced as a family physician for six months and internal medicine and respirology." Dr. Greg worked as a general practitioner but he did not enjoy the experience. One particular aspect of the practice he talked about was as follows:

Certainly as a GP I did not like the GP practice from one perspective, which was I was working clinics, walk-in clinics people would come in with three or four or all their

children and say would you check them over, and I would get all of them checked and it was, I was a decision like I worked morning shifts and it was like 'let's go the zoo' and then 'no, we go to the walk in clinic' because medicine, medical care is free, so they don't have to pay for it and receive services, so I found that quite stressing in a way because I found it very disrespectful to the healthcare system.

Dr. Greg enjoyed his training in respirology and sleep medicine and described that it opened up different avenues for him as he explains

Respirology appealed to me in a different way, and so that I have enjoyed doing respirology, respirology encourages whole other aspects, it encourages, physiology, biochemistry, because, you know, so many other things and because it is such an interesting physiologic understanding you know about other organs and systems that you have to know about them. So that, so respirology made a good mix but the sleep medicine certainly opened up a huge set of different windows, and you deal with psychological issues, such as insomnias, and the sleep behaviours, and the whole lot of other behavioural issues that did not influence the very practical pragmatic and very concrete thinking of respirology.

Dr. Greg talked about his clinical skills and explained how a lot of those clinical skills came from his medical school, years of practice, and being exposed to patients from diverse culture,

The skills that I acquired in my undergraduate where numerous, patients and interviews with different people, there are people of different origin, there are people of white origin, black origin, English, Dutch, and there were mixed raced people, all culturally very different, Indians, and there was enormous exposure to many different people and

you had to use different techniques to speak to different people, and just actually engaging them in the different type of banter.

Dr. Greg explained that the training he received in medical school on how to interview patients was limited to interviewing Caucasian patients but he had to read numerous books on interviewing skills. Dr. Greg also describes that when he started practicing sleep medicine, there was no official training for sleep medicine and it was his background in respirology that helped a lot with practicing as a sleep medicine specialist

To be fair we were given deductive training on how to conduct an interview but it was typically conducting interview with a Caucasian person, but it was not about how you conduct an interview with someone who speaks a different language, or are from different culture, how do you conduct an interview with black person, a coloured person, an Indian person, none of that. We were given; we had to read diagnostic skills books, and interviewing techniques that we had to do.

Dr. Greg is interested in further training and believes that there is always a need for progressive training as he adds:

I think it is always worthwhile, I don't think anyone ever becomes expert in one area, and the minute you do you start getting still, if you think you do, one of the most interesting thing for me is that the more I read about sleep medicine, the more interesting it becomes, so what I recognize within that is the learning process so if it stops you forget it and you are not part of it anymore, and I am a firm believer in continuing intellectual enhancement and I love learning and I love reading the stuff though I often don't get enough time".

Dr. Adrian talked about his training in medical school and described that medical school and his residency program helped him with a foundation but there was a lot of figuring out through trial and error for him. He indicated that medical school did not prepare him for his work in a community hospital as he describes:

I think medical school and residency helped and it was a good foundation but I really do think that the residents themselves do a lot of figuring it out through trials and what the medical school did not help us with is in the community setting which is very different.

Dr. Adrian described how seeing patients in a community hospital is different from seeing patients in a teaching hospital during the residency program. He described that in residency, training physicians are exposed to working and seeing different patients with different medical complaints but often have a chance to consult other physicians and specialists when seeing a patient with complex pathology; however, in a community hospital, it is just the physician who has to decide what needs to be done for a patient.

When you do a residency or when you do training you are on call tonight on cardiology tomorrow you are on call for neurology and so very narrow requirements while in the community one patient I am seeing right now might have a cardio-pulmonary problem and the next patient coming to the ICU may have a massive neurological stroke so you all of sudden then have to pull all those different things together so in your training you are doing a lot of one thing and focus on one thing at time and you move on in the community you have to do a little bit of everything.

Dr. Bob explained that medical school did not prepare him for interviewing skills with patients but the residency program was helpful. One specific part of training Dr. Bob talked about was not getting any training in management and leadership programs and he believes that

physicians need to receive training in the mentioned areas as they often run their own clinics without having any skills to run business as he adds:

So the vast majority of physicians work in private practice and they are not employees so they run their own business they are getting paid by the Ministry of Health to see patients but they are not employees so there is whole business aspect of running a practice which means, you need to run your own human resource department, hire and fire people, and know how to do that appropriately so all this practice management business skills etcetera I think are largely lacking.

Dr. Bob also talked about changes in medical care as well. He explained how healthcare in general has changed a lot from the time he finished medical school. Dr. Bob did talk about the need for a training program in leadership and administration but he did not point to any specific training program of his interest.

The complexity of care has gone up tremendously and people that used to be hospitalized for weeks are now seen in day surgeries and sent home so the primary care, not necessarily the doctors, they are much more case managers work interactively as part of teams and that certainly wasn't taught to me 20 years ago, and to what degree it is been taught today I don't know.

Dr. Jane talked about her training and described that she is somewhat satisfied with her training in general. Particular to interaction with patients, she indicated that she got better at it as she saw more and more patients "in terms of patients' interaction I don't know (pause), nothing specific in terms of points you know, should I do this and should do that but you just get better as you go along." Dr. Jane added that medical school and residency programs prepare physicians for some cases but to be prepared for all cases, it takes a long time and she believed even for

someone who has been practicing for 20 years, being prepared for all cases is not a possibility.

Even respirology is one small branch of internal medicine but it is still so broad and there are so much that even someone who has been practicing for 20 years doesn't know everything. So to be completely prepared for every case that walks through the door prepared is impossible. She concludes that training is good in terms of sampling in different disciplines but it is still not thorough. I think the training is good in terms of sampling all the different areas. And I think that is what it is for and not so much to teach you everything.

Dr. Jane said that she has received enough training in her current field of practice (respirology) and she does not want to train anymore "I don't want to train anymore just to do something different. Like I am ready to practice respirology and I am ready to move on to practice instead of training that has been going on forever and ever." However, she described if she wants to practice sleep medicine then she might be interested in more training as she adds "sleep medicine is different and if I want to practice it then I want to make sure that I have done the training."

The nurse participants of the study also talked about their professional training and some of them also showed interest in further training. Crystal said that she was satisfied with her training and explained that she started working in healthcare as a volunteer when she was 14 years old but she completed her nursing degree at the age of 29. She described that her training was comprehensive and she believes that a lot of experience of dealing with patients came to her after practicing for so many years. She described that training in nursing school does not prepare you to be independent and, according to her, being independent is an important part of community nursing "a good community nurse has to be a lot more independent than the ones at the hospitals." Crystal described that completing her training as a RN did not prepare and give

her for what she calls “added skills” such as IV therapy. When she started practicing nursing she had to learn these skills on her own, she described how she learned how to do IV insertion for medication as it was expected that one would know how to as she adds:

The hospital I started working with didn't have an IV team so the expectation was that you start your own IV and I taught many nurses and said it is like fixing a car. It needs to be shown and you need practice. But as far as the basic nursing no I don't think it prepares you for reality I really don't.

Crystal attended a pediatric conference because of her personal interest in taking care of sick babies and she is hoping to become a resource nurse who provides other nurses with expert advice and support with patients who have multiple health issues

It is kind of like an expert to other nurses. Especially if it is someone with multiple problems and is coming home, and I have taken care of some really sick babies but they are always willing to let me do it because babies intimidate a lot of nurses.

Paula initially started practicing nursing with a college diploma and then she completed her RN degree and has been working in different fields of nursing since 1989. Paula has work experience in medical, surgical, emergency, and intensive care departments. Paula described that her training did not really prepare her for her current job but a lot of her skills were obtained over the course of a decade of working with patients. Paula is working two different jobs (full time hours in public health and part-time in ICU) and she is not planning on taking any further training. Wendy is a registered nurse who worked in different nursing fields for 17 years and has two undergraduate and graduate degrees in nursing. At the time of interview, she was going to school to train as a nurse practitioner “I am a registered nurse and I am working on my nurse practitioner's certificate.”

Wendy described that she learned most of the skills on her own. She added that she also reviews websites related to her profession and they help increase her knowledge:

It is a lot of kinda learning on my own, and talking with the clients...so I have a much better understanding and plus I do look on some websites that I do like to do frequently and that helps me increase my knowledge.

Wendy described that through her training she learned a lot about the concepts of ‘client centered and patient centered care.’ Wendy further described that she is currently completing her third degree and added that she is not interested in further training as she indicated “I think three degrees is enough (laugh) I think after the nurse practitioner that is it for me.”

Barb had background experience in emergency medicine and the intensive care unit and she used to work as a critical care nurse. When Barb was asked to elaborate on her training, she described the entire nursing team training experience. She added that all her colleagues are prepared and received basic training in emergency care and they are all constantly upgrading their professional skills as she adds:

I think all the nurses that work here either worked at emergency or intensive care so they are all critical care nurses. So everyone that is employed here has a very good basic training. So, I think even though a real critical emergency is rare around here but the odd times that it does happen we are prepared for that and we are constantly doing professional upgrades so I think the staff is well prepared.

Barb described that even though she had already received enough training in mental health which she deals with a lot, she is still interested in getting more training in this field. “I think, I would like even more training. Because as I said that seems to be such a big issue, so you know I am pursuing more training in mental health because it is such an issue.”

Approaches in Dealing with Patients from Diverse Cultures

Almost all participants of the study talked about dealing with patients from diverse cultures. However, they had different opinions and approaches in their encounters. Grace, for example, talked about dealing with new immigrants and immigrants with language barriers. The only difference in dealing with new immigrant patients for Grace is that “they don’t have a health card and for the communication part she wishes they always come in with an interpreter.” She also talked about how immigrants with language barriers also have trouble completing the paper work at the clinic and they need to bring in an interpreter to help them complete their paper work.

Nancy described that she only dealt with a small number of people from diverse cultures and she used a similar approach with them as she used with the rest of the clients as she adds:

When he {physician} started his practice it was mostly white, you know there is a lot of Dutch people in his practice. But not too, too many others, like he is very cut and dry doctor you know my way or the highway kinda thing.

Dr. Carly explained that she takes the same approach with all her patients. In particular to patients with a language barrier, she adds “It is wonderful if they have interpreters with them...they might be new to Canada or the questionnaires filled out indicates that English is not their first language, so it is nice to try and have an interpreter around.” Dr. Carly was interested in learning more about different cultures and religions. Dr. Carly further explains that in psychiatry it is important that you know more details about your patients’ cultures but not so much in sleep medicine. She also pointed out the time limitation during consults as a barrier in getting details about one’s culture and beliefs.

When Dr. Adrian was asked about his approach with patients from diverse cultures, he talked about patients' education level, religion, and their knowledge of the health system in addition to their culture and added that he often takes different approaches in communicating with these patients. He valued the patient's educational background more than their culture. As he further adds:

It is also general knowledge like um, general understanding of healthcare within the system so people when they come in into the system what is their expectations what is their understandings and what is their personal background as well. Because there are differences in patients I see who are socioeconomically different than those who are less educated or people with different religion. And you have to kind of take different approach with those that are more educated compared to those who are not.

Dr. Adrian also talked about the importance of physicians being exposed to local communities and community connections. He described that the new residents are now given more opportunities to connect and explore local communities "there should be more community connections, they are beginning to do that, too many programs are beginning, so residents that came after me they are getting more community exposures."

Dealing with patients from diverse cultures for Dr. Bob was mostly about sexual differences and language barrier. He described that he uses the same approach with all his patients "I would say somewhere in between." He describes that he encourages female patients who may not be comfortable discussing their health concerns with him to see a female physician or nurse as he states "I will ask the patient if it is a bother if it is a concern, if they say yes, then there are lots of female doctors here, I am the only male here."

Dr. Greg explained that in his practice he was exposed to patients from diverse cultures

and he learned how to use different approaches with people from diverse cultures. He talked about being exposed to people from different origins such as “people of White origin, Black origin, English, Dutch, and there were mixed raced people, all culturally very different.” Dr. Greg described that he did receive training in medical school in interviewing but described that the training was specific to Caucasians as he adds “it was typically conducting interview with a Caucasian person, but it was not about how you conduct an interview with someone who speaks a different language, or are from different culture.” Dr. Greg described that he had to read different diagnostic skills books to learn different interviewing techniques specific to diverse populations. Dr. Greg mentioned the importance of knowing and learning about diverse culture and emphasized that knowing about a culture is not just about speaking the language but also to know about additional cultural norms. He adds:

Doctors are not easily interchangeable from different societies, and different cultures, being in different areas, I mean you know that people’s behaviours, norms and even when they deal with things are different, I mean for example for me to go and practice in Japan, even if I learn to speak Japanese the whole culture is so different, and I wouldn’t do well out there, and I think it is gotta be tailored with the populations you’re dealing with.

For Dr. Jane, dealing with patients from diverse cultures is similar to dealing with any patient. She described that each person is different and it is not because of their culture but their behaviour and personality as she states:

I think it is not so much in terms of different cultures, it is about each person, so each patient that comes in I kinda get a sense about their attitude and get a sense whether they are already a bit unhappy they are a bit hesitant about being here or, so I think my approach to the patient just depends on how they are, are they the kind of person who

wants a lot of explanation, who wants a doctor who is every serious or do they want, or are they the kind of person who sort of comes in angry and I need to talk to them about before they settle down. So not so much based on culture, but I think I slightly take different approach depending on the sense of the person.

Dr. Jane explained that interviewing patients from diverse cultures is similar to interviewing patients from the mainstream culture but depending on how the process of the interview unfolds, she may take a different approach with one patient depending on their personality not their culture.

The nurse participants of the study also talked about their experiences of dealing with patients from diverse cultures. Crystal explained that she is conscious of patients from diverse cultures and indicated that in community nursing, in particular, it is very important to respect patients' cultural beliefs. She gave one particular example of the safety requirement for keeping shoes on at all times but when she goes to see her patients from certain cultures where they take offence to wearing shoes inside their houses, she respects the culture and would take her shoes off as she adds:

In the homes you have to consider that for example health and safety says you have to be wearing your shoes and you don't take your shoes off but you can't keep your shoes on in certain homes, like in Chinese culture it is offensive like in East Indian homes it is offensive to leave your shoes on.

Crystal was interested in learning about diverse cultures and wanted to be well-informed about different patients' cultural practices in their care. She talked about her one particular patient as follows:

I had a Native patient who was a 12 year old and came home to die we had to answer her parents what the rituals were they had some native practices that they wanted to do and we were like sure, and I told them you need to teach me what to do. So if we are dealing with patients from different culture, especially end of life, we just ask this is what we would like to do is there any problems with that? With some traditional practices, So your job as nurse is to decide does the treatment help them or hurt them or doesn't do anything.

Wendy talked about taking a similar approach with all her patients and said that she did try to add and learn about patients' culture as it affected their treatment plans. Similar to Crystal, Wendy also described the importance of learning and respecting clients' diverse cultures and their impact on patients' health. Barb described that in addition to cultural differences, she is also sensitive to patients' sexual orientation "we try to do in services that not just makes us sensitive to different culture but also different sexual orientation and different religions and to try and keep that always in the forefront." She described how she is aware of the cultural differences and if there is something she is not sure about during interactions with clients she takes the initiative of asking the client about it as she states "if there is something that I don't understand I think um, it is better to ask in a polite way." Barb further described that the therapeutic relationship between nurse and client is based on honesty and respect and showing interest in learning about clients' culture. This also helps to gain their trust as she adds:

I think that you know, and I think it is about honesty and respect and I don't pretend to know about all the cultures and every religion or culture and if you are honest with them you know and say 'help me out here, I would like to understand your culture and your religion and how is this going to affect your health' and I find that if you are honest like

that you are not only learning but you are also sending this message to them that you are sensitive to them and that you want them to feel comfortable talking to you.

It is noteworthy to mention that the healthcare providers in this study did not see their own limitations or responsibilities in terms of communication or cultural sensitivity. It was the patient who was the problem or who needed to anticipate what the clinician might need.

Therapeutic Relationship (Nurse and Medical Receptionist)

The nurse participants of the study talked about using different approaches in establishing therapeutic relationships with their clients. Establishing a good therapeutic relationship was central for almost all the nurse participants of the study through good listening, developing rapport, trust, a client centered approach, some required capacities of knowledge, empathy, awareness of communities' resources, ethical issues, as well as knowing the job limitations.

Crystal talked about gaining patients' trust as an important tool in establishing a therapeutic nurse client relationship. Crystal talked about the challenges of having limited visits for patients and describes that a limited number of patient visits is an obstacle in gaining a patient's trust and establishing therapeutic relationships as she adds:

Even for a surgical patient you only have three visits. If you need three more, then you need to get an authorized order...so if you need more than three visits there has to be a great deal of discussion, there is a lot more bureaucracy now.

Crystal also talked about the challenges of developing therapeutic relationships with some clients who have dealt with other healthcare professionals and became used to having different expectations. "I have so much difficulties because I am so much different than they are and a lot more assertive." She believes in assertiveness with patients as an important strategy for better care. As she talked about her one patient as follows "so he is the one who wanted the

socialization I think, but it is not our job, our job is a therapeutic relationship.” Crystal talked about some differences in establishing therapeutic relationships particular to community nursing and described that community nursing involves dialogue with patients and is not similar to establishing therapeutic relationships at the hospital settings.

Dealing with patients in community nursing is totally different because in hospitals you are the authority who has control, “you will be doing what I say” whereas in community in someone’s home, it is more of a negotiation so you have to put a lot more value in how they see you and they are more protective than they are in the hospitals. But in the hospital it is more about control and authority and “you don’t have a choice, you are gonna do what I say” whereas you have to be a lot more diplomatic in someone’s home, they have to like you they don’t have to like you in a hospital, they are more captive.

Crystal talked about patients’ education as an important aspect of developing a therapeutic relationship and stated that she educates her patients to become independent by engaging them in their care and added:

I will teach you whatever you have to learn and will increase your ability to learn...so then when it comes to giving somebody insulin and you are teaching them, they will say “I will do it next time” and you say “no do it this time and I will hold your hand and it is okay to make mistakes, but tomorrow you will do it by yourself.

In addition to patients’ care, it is also important to teach patients how to become independent and take care of their own health as she adds:

I will teach you do you until you feel really comfortable, so you take them in baby steps along with tasks...if they are timid and or motivated you are gonna have to find a way to engage them, like ‘so this is your issue, and you need to take it serious’.

Crystal also talked about following a set protocol in a patient's care and in establishing a therapeutic relationship. "This one patient was fine with me following the Nova Scotia protocol with her in care of her wound." Crystal also talked about the challenge of gaining some patients' trust as they expect to be looked after by a physician. She talked about one particular patient who expected a physician to take care of his wound and, according to Crystal, the patient did not even qualify to be visited by a nurse and when she explained this to her patient the patient was upset about it as she adds:

He {the patient} was a little bit stressed and because he did not see the doctor to take out the stitches and I went to see him on Sunday and said "well, you don't really need to see us anymore" and he said "yes, I do I have stitches" I said you don't qualify for a home nurse, because he can deal with stitches without a nurse, I said "I am leaving you and you will see the doctor in a week and if you have a problem then call him.

In establishing a therapeutic relationship, Crystal believes in apologizing to patients in case of making mistakes during their care "if you make a mistake, just say 'I am sorry' to acknowledge your own shortcoming." Crystal also talked about some cases where the protocol expects the nurse to follow certain steps but the patients refused to go with the protocol and she believes that in such situations following with patients' choice is more important "there are certain routines that we will follow but if the person still refuses and says no you respect that." Crystal also explained that developing a therapeutic relationship with patients also involves their families as their family is often involved in the patient's care,

Family was very involved in the care and we communicate it with the family that we will give the patient the injectable medication and there was a lot of reassurance, because this is part of their care and you want the person to stay home and be comfortable so there is

always this little chat I have with them. Because you don't want to leave and someone being traumatized.

Crystal explained that depending on different patients, establishing therapeutic relationships may take more time. To her, a therapeutic relationship is about bringing positive change in a patient's health as she adds "That is the way it is supposed to work and I like to change, I like to see people progress along their learning and that to me is a therapeutic relationship."

Paula talked about the terms patient and client and said that the term patient is often used in the hospital setting and the term client is often used in the public health setting "in interviewing the clients, we don't call them patients, um, in hospital they are patients, here they are clients." Paula talked about a challenge particular to gaining patients' trust in developing therapeutic relationships. She described that patients often trust physicians more than they trust nurses as she adds:

We interview them we need to get the reasons and why they need to be seen they need their exam they will say for example 'I want to be tested for this STD because I am suspicious of my partner' but when the doctor comes back often the story will be different like 'oh yes, I had an affair' so what the nurse gets is not always the truth".

Paula described the challenge of gaining clients' trust in nurse client relationships and added that some patients are not comfortable discussing their health concerns with a nurse and they only want to be seen by a doctor as she explains:

Sometimes it is the perceptions of the client that 'I really don't want to be intimate with this nurse, I want to get to the doctor' and we accept that, so they do have to see the nurse first so we have some idea what the story is, because the doctor, of course their time is

precious and the nurse we have a little more time to talk so, but it is interesting they don't always disclose everything, but the doctors know the truth.

Paula explained about establishing therapeutic relationships with clients who are not open about their health issues and those who are and describes the differences between these two groups.

So tell me why you are here you know so we can get an idea of how we can help you, so um, when people are the first time, they are dying to tell you everything 'took me a long time to get here' blah, blah, blah, but sometimes people are very closed, 'no I don't want to be tested, no, no, no, no' and you don't get the whole story. So everybody is different.

Paula also talked about the differences in establishing trusting therapeutic relationships in two different places that she works, for example, ICU and the public health setting.

To be able to provide a solution to the problem depending on what the problem is like the problems in intensive care are physiological and, there are emotional problems but they come secondary because it is acute care because they are sick and we need to treat what is there. In the sexual health center someone needs to come and talk to me about their pregnancy I can't help them unless they are honest with me.

She also described that being assertive with patients often works in the ICU setting but in the public health setting it is different.

I come from a clinical point of view, I have all the information and I know more than you do and therefore you need to listen to me. In acute care that often works in this situation it doesn't always work.

Some effective strategies Paula uses to establish therapeutic relationships with her clients include honesty, the use of simple everyday language, being non-judgemental, and providing a space that is comfortable for clients to share their concerns. Making eye contact with patients, avoiding

taking notes during the interview, being nonjudgmental, and focusing on the client's agenda were also some strategies Paula used to establish good therapeutic relationships with her clients. Wendy talked about some challenges of establishing therapeutic relationships with clients who had mental health illnesses. She described that it takes more time and an increased number of visits to gain the patient's trust. She talked about the importance of being knowledgeable about the community resources such as "Niagara transportation, financial thing, you (pause) you really do need to have a broad scope" available for patients for establishing sound therapeutic relationships. In addition, she also believes having "strong knowledge" related to one's field of speciality is also a key to having a successful client-nurse relationship. Some of the strategies she uses for successful patient-nurse relationships include gaining a client's trust, respecting clients, client centeredness, and educating patients about the reason of her visit,

For me the patient centered approach really needs the focus on the clients making the decision about their healthcare and also working with healthcare professionals. I normally start by introducing myself and why I am coming to see them and I may also ask the clients why I am there to see them.

Wendy also talked about using some standards and guidelines for establishing therapeutic relationships based on guidelines from the College of Nurses of Ontario as she adds "one of their best guidelines is client centered, patient centered care and the focus for us is how to implement patient centered care."

Barb uses a sense of humour, gaining their trust, protecting their confidentiality, and developing rapport as her strategies for establishing relationships with clients. She further believes in having good communication skills and care as central parts of establishing therapeutic relationships with clients. Additional skills for establishing client-nurse therapeutic

relationships for Barb include “sensitive to different cultures but also different sexual orientation and different religions and do try and keep that always in the forefront.”

In addition to nurse participants of the study, two medical receptionists (Glenda and Nancy) also talked about being involved in therapeutic relationships with patients. Nancy, for example, talked about participating in minor surgeries that the physician she works for performs in his clinic. Another way that Nancy gets involved in therapeutic relationships with patients is by listening to their stories. She added that she helps patients with multiple health issues narrow down their concerns and that helps patients go in prepared during their interviews with the physician. Glenda talked about indirect involvement in therapeutic relationship as she often advises physicians who take more time with patients and address multiple health issues instead of only one that is specific to the nature of the patient’s visit in a walk-in-clinic as she says:

So I think sometimes when we have a new doctor here and he is from a family practice he used to dealing with the whole person. We don’t deal with the whole person; that is for their family doctor to do. We deal with the complaint...the medical receptionist helping physician understand the nature of this type of business {walk in clinic}.”

Preferred Method During Interview (Physicians)

The physician participants of the study talked about using different approaches with their patients during interviewing. The participants use biomedical approaches, psychosocial approaches, emotional support approaches, and also a mixed approach during interviewing their patients. Dr. Carly uses a mixed method approach that includes both objective and subjective information about patients in her medical encounters with patients. She describes that most often she looks at patients and in addition to reviewing their medical reports, she finds additional information that helps her with patients’ diagnosis. Dr. Carly also uses different techniques

common in psychiatry, such as the psychosocial model, which in addition to a patient's physical examination, also involves family members who have observed the patient's condition at home, and also medical models for depression to learn about a patient's general medical condition.

Dr. Greg uses both subjective and objective data as well as psychosocial and biomedical approaches in his encounters with patients. In using objective and subjective data, he often relies more on objective. In addition to this if the objective representation of the data does not support the subjective information gathered from the patient, then Dr. Greg also recommends a repeat on the bio-medical test to make sure the test was not false positive. Despite using a mixed approach in the diagnostic encounter, Dr. Greg's preferred method with some patients is mostly an evidence based approach. Some additional methods Dr. Greg uses in addition to listening to the patient's subjective complaints and results from biomedical tests are physical examinations of the patient, demographic and vital signs:

With the interviewing process...the history and the physical examination, the history involving what they write down in the questionnaire and help define some of these problems quite nicely, and, and I do take a history that obviously that is a very directed history, a lot of the information is already gathered before that, which is extremely helpful and then the diagnostic, the examination involves the physical examination, the blood pressure, height, weight and the other demographic issues.

Similar to Dr. Carly and Greg, Dr. Bob talked about using a mixed method based on subjective and objective data from patients in his encounters with patients as well. However, he describes that if a patient is complaining about too many symptoms, it is difficult to start a specific treatment plan. Sometimes he would do a trial treatment to see if it helps; otherwise, he would order further medical test to investigate their conditions as he explains:

They are called alarm symptoms, has there been fever, has there been a weight loss, vomiting, diarrhea, blood involved, if diarrhea, changes that happen, if there are those symptoms then you can't treat then you have to investigate, and then do a trial of treatments. So ultimately a lot of that could be, um, could be subjective but I think there are a lot of aphorisms that you kinda internalize sequentially and not necessarily write down on paper. So even if it seems like a mental health issue, if you think it is depression, it is gonna be some standardized test, or some standardized questions that you are seeking and various things that lead to the diagnostic criteria of depression, same with anxiety, same with bipolar disorder and so on.

Dr. Jane describes that using both medical and psychosocial approaches is important in patients' treatment plans. However, she indicated that it really depends on the speciality and the patient, as some specialities might require more engagement with patients and others not so much. Dr. Jane takes a patient's history in addition to the physical examination but believes that the physical examination helps with confirming what she already found through the patient's history and medical tests as she adds:

The history, cause the physical exam is usually very short, I am not, I mean my point of investigation has not frequently changed with the physical exam because basically it just confirms what you are thinking and so very rarely I picked up something in physical that I was like 'hum' that was kinda surprise and then I might do an extra test to find out more, but this is very infrequent.

Dr. Jane also talked about some complex cases where she has to refer patients to other specialists if she cannot find a good reason for treating them. She talks about one specific patient with a chronic cough as follows:

A very simple example will be if someone comes with chronic cough for more than three months and usually they come in coughing for 10 years...so I tell them up front at the first visit, 40% of the time we can't find the cause of the cough even extensive investigation...I have had probably three in the last week. So all of them (pause) um one of them it was after a few investigations. And one of them a lady was there for the third time. But she has problems, like esophagi mortality, so I think she had, so I think that was the reason for chronic cough for 10 years, so I sent her to a GI specialist.

According to Dr. Jane, the most important part of her approach with her patients is taking a thorough history as she states "so initially the history is very important in terms of differential diagnosis or narrowing things down... so that is important in the following investigation when ruling things out and confirming stuff." Despite using both subjective and objective findings and approaches, Dr. Jane values objective evidence based over subjective ones. She talked about cautioning her patients in the case of using traditional treatments as she adds

I will talk to them in terms of evidence it doesn't matter what it is, is it something that you rigorously studied and what type of studies we are talking about you know and I also caution people in general about alternative treatments.

Dr. Jane explained how her knowledge and confidence in diagnostic interviews improves as she gains more clinical experience. She believes that as a clerk, physicians ask too many questions and write a long history but as consultants they can be more focused on the illness and ask specific questions. Dr. Jane further adds:

I think the difference between the consultant and clerk is that the clerk knows all the questions to ask and the history is going to be three pages long, they ask every question but we don't know where to put the extra piece of information to group it altogether but

as a consultant you're knowledgeable so you can escape some of the questions that you know it will be irrelevant, so it becomes a lot more focused, so for each patient it depends on what you think it is.

Accomplishment During Interview and Intake Protocol

Almost all the study participants talked about accomplishments during interviewing and intake with their patients. Successful accomplishments varied from diagnosing patients with complex medical conditions, to bringing positive change in patients with mental health issues. Dr. Carly talked about how developing rapport with patients helped them open up and enabled her to help them with their conditions. She also believes in listening to patients as she adds: "I think it helps them to feel they are valued too and to have a little bit of time spent with them." One particular case she talked about was a patient who had "bipolar disorder and severe generalized anxiety disorder." This patient was a university student who was trying to go back to school and continue her studies but due to her severe condition was unable to do so. However, after Dr. Carly's effective treatment she became successful. She adds:

{S}he's improved incredibly...she works uh, she raised her daughter by herself and did a good job she had to cope with a very abusive husband and she did that she is beginning to get some sense of worthiness about herself, she works part-time and only works part-time because that is what she can manage, and she has her own little house now and a car and she is way ahead where she thought she would ever be and that is a very nice case to have.

Dr. Carly further talked about what gives her satisfaction from encounters with patients. She described how once patients follow her advice and bring positive changes to their medical conditions, it gives her satisfaction. As she explained:

What gives me joy to see them come back and to say “doctor you changed my life” is very satisfying umm I am surprised most of them brought me flowers, Tim Horton’s and things like that (giggle) cause they are really grateful for what you have done for them.

Dr. Greg talked about multiple patients with complex medical conditions and successful encounters. One particular patient he talked about was as follows:

The one patient that I will never forget, probably my best diagnostic pick up was, a fellow from Philippines uh, who came in with his wife and had a sleep study, and they came and sat in my office, and we had the sleep study results, in his history his wife described him as dying in his sleep, where in Philippines it was explained to me that if someone does that, then bite their toes.

Dr. Greg’s biggest accomplishment is when patients understand and follow his advice to bring positive change in their health. Dr. Adrian also talked about his biggest accomplishments during his clinical encounters. He described that during the H1N1 outbreak, his internal medicine colleague and himself were able to save lives of seriously ill patients admitted to their community hospital. He added that patients admitted to other major hospitals did not survive:

we had a very high incidence of people who had extreme H1N1 we had the highest per capita in Canada. And that the situation that satisfied me and my other colleague as pulmonary doctors we work together we took care of those people and not a single one of those people died. And we have done such a good job under difficult circumstances.

When Dr. Adrian was asked about his job satisfaction, he said that he feels satisfied when he knows patients appreciate his help and he is able to bring a positive change in patients’ lives.

He explains:

on occasions that I feel that I do help people that are appreciative and that I can see that

there was a benefit that I see, maybe if I hadn't been there or had not helped that patient, they might not be here.

Dr. Bob also talked about his accomplishments during his encounters with patients. He added that patients with mental health issues are a huge issue in his practice. He believes that patients would not have been able to get back to their normal lives without his help:

There are many {patients} particularly in the mental health field, that I have no doubt they wouldn't graduate if we haven't treated them and possibly withdrawn, get things improved, got things back on the way and say they couldn't receive that care elsewhere. The medical care that was crucial to their success.

For Dr. Jane, the biggest accomplishment she had in her encounters with one particular patient was communicating effectively and being able to develop rapport and trust through effective communication skills. She described that through effective communication she was able to break the news about her cancer to this patient and the patient remained calm through the interview. Dr. Jane also talked about another accomplishment with a patient and described how she was able to save her life by taking a holistic treatment approach with her rather than a specific approach limited to her profession. Dr. Jane described that "I feel like if I hadn't been paying attention and just had her sent home, I would have missed a lot of stuff...but I was like huh I might save your life."

For medical receptionist participants of the study, accomplishment during intake means patients being satisfied with their visit, particularly where the receptionists were able to help. Becky, for example, explains: "when you see them walk out and they are no longer tearful and you know you see that, just by their, you know, their look, their facial expression is that is okay, 'I am gonna be okay.'" Becky further described "just to reassure them {patients} and just to

know that you have helped to calm them down and that they are gonna get some care very quickly is rewarding.” For Becky, it is satisfying when patients appreciate the help and support she provides during their visits. She adds “somebody just says ‘thank you’, not complicated at all.”

Nancy described her successful encounters with clients by listening to them and also when necessary, checking up on them. “...Nobody has the time to listen to them, and they always want somebody to talk to and that is what, just basically listening is what they want.”

Grace talked about helping patients in as many different ways as possible. She describes her satisfaction as follows:

When patients leave happy, when they take out of their time and when they are walking out the door and they say good bye to you. That is always nice. And when they say your name obviously my name is here (pointing to her name tag) and when they say ‘hi’ is nice, getting to know them.

The nurse participants of the study also talked about their accomplishments and successful encounters with patients. Crystal talked about using different approaches from standard protocol to her clinical experience in patient care and achieving desired goals for patients. As she describes:

I can use different ways, to monitor the results and see how effective they are and I was totally impressed with drainage and I am using a different protocol to keep the drainage to 50...we are on the right track and she {patient} is agreeable with that but when I met her she was totally frustrated. Because she was not fully followed up through and she was going to the wound care and nobody knew what the problem was because it was a different nurse.

Crystal further describes that it is not just looking after a patient's wound; she also took an interest in talking to her which helped with gaining the patient's trust. "So I think I spent a little extra time like social chatting with her. So just hearing her experience... I think she appreciated that I just sat down and talked to her and heard her story."

Paula talked about her accomplishment with patients and mentioned that the most important part of her approach with patients is she ensures that she educates patients and connects them to available community resources. In addition Paula described effective communication with patients as her strength in achieving success during her encounters with patients.

Wendy also talked about her accomplishments with patients. She discussed one particular accomplishment she had with a patient with mental health and addiction issues. She described how she not only focused on managing her patient's immediate support for addiction but also continued support for long-term results:

He {the patient} had addiction issues, he was linked up with a person who manages addiction but what I did is, on top of doing the interview I am sitting in on the consultation with him, I also supported him until he was able to enter a long term treatment program so I think for me it is a huge success because he was able to remain almost drug free until he entered the treatment program.

For Barb, her biggest accomplishment is when she was able to provide help and facilitate patients' needs in their care. She adds "I find that the most rewarding part, and of course it is rewarding if you've helped, you know facilitate...there is certain amount of satisfaction when you see that they become physically better."

Table 8

Summary of the Within Group Analysis by Interview Questions (Physicians)

	Greg	Adrian	Bob	Jane	Carly
Typical day	<ul style="list-style-type: none"> • Our day starts at 8:30 and we finish 6:00 o'clock. • I typically work through lunch and two days we have rounds and respirology rounds and in the winter, not in the summer they cut off for a couple of months. And Wednesdays we are down {two different locations in Niagara Region) and Thursdays is just a clinic day and Fridays, I do studies reporting. 	<ul style="list-style-type: none"> • I first started it was mostly hospital based doing acute internal medicine and then couple of years ago it became more intensive care with a little bit of sleep and now with family and other commitments it is becoming more sleep disorders related may be like 60% , 70% now and then 30 to 40% is still acute care 	<ul style="list-style-type: none"> • a typical week that would be hard to think, it is probably a third of my time is doing administrative stuff dealing with the nurses and staff, and questions about patients and dealing with minor issues, when the physician is not here that day. 	<ul style="list-style-type: none"> • I work two days of work of Sleep and half day of respiratory clinic” Dr. Jane hopes that she will be able to practice 50% in the sleep medicine field and 50% in respirology “ I am hoping to do half, half in terms of 50% respirology and 50% sleep. 	<ul style="list-style-type: none"> • I work Wednesday and Thursdays at the sleep clinic and I work Tuesday mornings in a small psychiatric clinic and sometimes over the Friday to Monday I do 20 charts from the sleep clinic and that keeps me probably busy for a whole day, so I am working about three and half days in a week.
Challenges	<ul style="list-style-type: none"> • some of the biggest challenges I have had were, people who have conditions that we don't understand, people with fibromyalgia and chronic fatigue, the chronic pain syndrome. • they've {patients} got nothing obvious and there is nothing definable on testing either, we don't know how to treat them • an incredibly difficult diagnostic interview with her because no matter what I would have suggested to her she had tried it on and some else had tried it on...so the resources to treat someone like that are not 	<ul style="list-style-type: none"> • the biggest challenge is always about time, it is about bouncing the needs of one patient against the other patients and the needs of the family and personal needs and community because there is also other patients in the office that are waiting to be seen. • I have to be honest 10 minutes is sometimes all I have, the family certainly feel not sufficient but I have to hit the highlights.... • in acute emergency you know sometimes I go to families and say 'no we have to make a decision now' and they might say 'I am being pressured' 	<ul style="list-style-type: none"> • the average bipolar disorder takes about 10 years to diagnosis so there is an extreme example of a condition that is almost never diagnosed. • It is like 'how long have been short of breath' they would be like 'I have been short breath since my grandmother's birthday party' and then you are like when was that (giggle) and they are like a long time so those are sometimes challenging because you have a timeframe and also patients who are angry patients who don't want to talk to you because they have a barrier 	<ul style="list-style-type: none"> • patients who are circumstantial talkers who won't answer the questions, angry patients and patients who can't really give you a history and you have to ask everything ten times before they can give you an answer. • as soon as they hear ministry of transportation they stop listening and they don't want to hear the treatments options • I think, the problem with that is also the patient doctor relation break down a little bit cause usually it is mostly based on trust and you are there 	<ul style="list-style-type: none"> • You have to make it clear that they are there to deal with the sleep part of it. Cause I think I tend to get over involved with patients but it is not my ball of wax to figure out their pain. • I've seen lots of patients and they speak disruptive... you have to see them a few times before they admit that they are depressed... • I'm reading a sleep study and getting the idea that they might be new to Canada...so it is nice to try and have an interpreter around

	<p>there so that is a very difficult one.</p>	<ul style="list-style-type: none"> • if we don't make a decision your family member would be dead. 		<p>for them. In this case as soon as you tell them that you have to report them to the ministry they feel like you betrayed them</p>	
<p>Evidence based Versus Narrative Medicine</p>	<ul style="list-style-type: none"> • I use both (objective and subjective), if it is unequivocal from our data, if it proves something that they don't know what is going on, then I need to use that evidence because obviously denial is an important part of patient management • if they say something that we were unable to prove then ...consider if our test was a false negative • sometimes I will treat them even though the test did not show, based on the symptoms and responds from patients. • I usually use the evidence more powerfully because if it is unequivocal I don't have any other way of explaining it. • It is their perceptions that don't always joint with what we find. • I do practice Western medicine because I am Western trained, but I often encourage people to seek acupuncture and chiropractor and some holistic type of thing that can be helpful, because there is not one side of it all 	<ul style="list-style-type: none"> • unfortunately we don't have discussion time to morally, ethically go through this because if we don't make a decision God will be making a decision and the patient will be dead and we only have 10 or 15 minutes. • my whole training was always around patient centered and family centered. • family suddenly have to make a very quick decision and value judgments about survival versus quality versus length of life. • I think it is actually both you need a combination of both to make a decision. I need to know how the patient feels and values and concerns about a situation but I also need some objective data because medicine is ultimately driven by. • My personal belief is to let the patient um, it came from my training as a medical student that we have to value the patient's believes but I let the patient, I always tell them about the value of western medicine and that it is rigorous, it is very 	<ul style="list-style-type: none"> • I have seen times and times in medicine that 80% of your diagnosis comes from your history, not from your physical exam, so usually physical exam is to confirm or refute your diagnostic impression at the end of the history, and the history is usually composed of the complaint. • So even if it seems like a mental health issues, if you think it is depression, it is gonna be some standardized test, or some standardized questions that you are seeking and varies things that lead to the diagnostic criteria of depression, same with anxiety, same with bipolar disorder and so on. 	<ul style="list-style-type: none"> • The physical exam because basically it just confirms what are thinking and so very rarely I picked up something in physical that I was like 'hum' that was kinda surprise and then I might do an extra test to find out more, but this is very infrequent. • I would caution people that in general depending on what sort of thing they are talking about, something that don't have a lot of evidence so I will talk to them in terms of evidence it doesn't matter what it is, is it something that you rigourously studied and what type of studies we are talking about you know and I also caution people in general about alternative treatments and that they really should do research before they sort of undertake it if there is significant cost associated. 	<ul style="list-style-type: none"> • in the first year called 'psychosocial aspects of medicine' and it was all about what is behind a patient and we got to go out to a patient's home and interview them...we were allowed to ask questions to see, somebody had say MS or Rheumatoid Arthritis or something like that. So it was a real attempt to figure out what the patient coped and difficulties that can be caused.

		<p>scientific and we see the benefit and we can show you it objectively and in numbers but I tell them that if you want to pursue other avenues that is fine.</p>			
<p>Communication Skills</p>	<ul style="list-style-type: none"> • {s}ometimes getting that trust with someone where they actually leave and they listen to you and they take your advice and they come back and they say ‘thank you, this has impacted my life’ and obviously this is very satisfying • most people will appreciate that you just talked to them like a human and most of the times they are surprised when I look at them and I talk to them and I sat next to them • they also appreciate the fact that I examine them properly and I found a lot of thyroid cancers by examining people’s neck properly • I treat people very respectfully and I, my language with them is often very basic, I don’t speak down to them. • use the odd bad words, they quite like that it makes you much more human in their eyes and you are not an authority that they have to try and push against. 	<ul style="list-style-type: none"> • There are differences in patients I see who are socio-economically different than those who are less educated or people with different religion. And you have to kind of take different approach with those that are more educated. • you don’t have to go through some of the basics as much but then there is also the challenge of because they are more educated they are also even they might not be the expert in medicine they might see that they already have knowledge so they might be given you pre-set opinion that might be necessarily correct so there is a challenge that way. And with the other group they may not have a pre-set opinion but they also have a lack of knowledge and understanding. 	<ul style="list-style-type: none"> • my communication skills, at least if patient speak English, I think I am satisfied from my communication skills. 	<ul style="list-style-type: none"> • I am very chatty...I have always known this is strength from talking to other people. Like some people really have a hard time talking to patients and explaining things, I have never really have that trouble and I, there is nothing specific that I do. And I thought everybody could do this. 	<ul style="list-style-type: none"> • I am open and empathetic with patients and yeah so I certainly try to do that. And as you can see I am not a clear disk (giggle) you know one piece of writing paper in front of me and you better get it right the first time cause that is the only chance you are gonna have.

<p>Strengths in communication</p>	<ul style="list-style-type: none"> • my strengths are probably that I can communicate with them in a way that they feel comfortable they don't feel that I am threatening they don't feel that I am proselytizing or even you know just, uh, being arrogant towards them I think that is one of my strength. • I treat people very respectfully and I, my language with them is often very basic, I don't speak down to them 	<ul style="list-style-type: none"> • I know that I can certainly improve upon the communication and I know that there are some positive interactions I have with families and patients and sometimes there are negative interaction when I know that the patient and families are not satisfied or happy so I think it is a dynamic process that continue throughout your career and you learn from your experiences both the positive and the negative 	<ul style="list-style-type: none"> • I would say people seem comfortable in doing that with me. Not necessarily in the first five mins but the majority do... having said that I am, I mean especially in mental health. 	<ul style="list-style-type: none"> • I think being empathetic towards them and answer their questions and not just repeating things over and over. • I have always known this is a strength from talking to other people. Like some people really have a hard time talking to patients and explaining things, I have never really had that trouble. 	<ul style="list-style-type: none"> • I think my strengths are try to get to know them a little bit and then try to put their symptoms into context and I think I am pretty good at that I am pretty good at listening to patient and what is the reason behind what they are saying.
<p>Hopes and Desires</p>	<ul style="list-style-type: none"> • I think I would probably not want to work this hard, because I would have liked to have done more research, whole lots of reasons things just didn't pan on the way I thought they would. 	<ul style="list-style-type: none"> • In the community you have to do a little bit of everything so what I would recommend to residency is, in the beginning you need to teach residence that way but as they get closer, because majority of the physicians are not going to work in big teaching hospitals and university settings the majority are gonna go into communities like me and where their gonna be expected to be much more flexible and dynamic. 	<ul style="list-style-type: none"> • looking at that I don't think residence get a lot of training as far as the business aspect of running a practice. I don't think family medicine residence or even medical school receive any training in terms of leadership and training in management. 	<ul style="list-style-type: none"> • I like where I ended up, I just don't like it terms of it is taking me so long and sort of having a difficult time to get here (laugh), so in retrospect I am not sure, I think I could have gone into family medicine where you do two years of training as oppose to five. 	<ul style="list-style-type: none"> • I did not do a general internship between my medical school career and going in to psychiatry I think you should be made to do that because that would have given me the confidence. • to do a general internship in internal medicine before you go on to do whatever residency you are doing. I think that would be an important thing to do to sharpen your diagnostic skills
<p>Qualities for successful physician</p>	<ul style="list-style-type: none"> • ...the basic knowledge is very well contained. So that is very important to keep update meetings, and knowledge based, uh basic science based education sessions. • the woman who lost 11kgs she did not know that drinking 8 cans of pop a day 	<ul style="list-style-type: none"> • I have to direct the patients, I need certain information to make certain clinical decisions so...I am trying to direct to get certain pieces of information so that I could make a clinical decision. 	<ul style="list-style-type: none"> • availability, afaibility and ability, and the standard line is that the patient would value availability over anything else ...So you have to have a balance of availability, afaibility and ability..” 	<ul style="list-style-type: none"> • smart, intelligence and compassionate and I think it is important that someone cares about their patients ...someone who is really responsible I think it is important for people. • If you have bad bedside manners and if you can get things right or you are 	<ul style="list-style-type: none"> • I think first you have to develop a rapport with the patients because if you don't they won't listen to anything you say and not give you the honest truth about what is going on so that is very important. • it is important to try to handle patients symptoms.

	<p>was giving her extra 1400 calories/day and once I explained that to her she stopped it. That was perfect because she took that knowledge and she understood it.</p>			<p>a crappy doctor. But it is important that physicians make sure you know as much as she and he can to try and do the right thing to a degree that they can.</p>	<ul style="list-style-type: none"> • it is important to start with an open ended question and end with much more specific questions, you have to let them feel that they had been heard • you can find a lot by just looking at them • I think if you are not sure what is the matter with them and you need to do something else then just be very open about it.
<p>Professional training and plans for further training</p>	<ul style="list-style-type: none"> • Sometimes anesthetics, sometimes I had to do surgeries, but typically had to fulfill those types of duties because there weren't other qualified people around. • I practiced as a family physician for six months and internal medicine and respirology. • Certainly as a GP I did not like the GP practice. • Respirology appealed to me in a different way, and so that I have enjoyed doing respirology. • the skills that I acquired in my undergraduate where numerous patients and interviews with different people, there are people of different origin, there are people of white origin, black origin, English, Dutch, and there were mixed raced people, all culturally very different... • To be fair we were given 	<ul style="list-style-type: none"> • I think medical school and residency helped and it was a good foundation but I really do think that the residence themselves do a lot of figuring it out through trials and what the medical school did not help us with is in the community setting which is very different. • when you do a residency or when you do training you are on call tonight on cardiology tomorrow you are on call for neurology and so very narrow requirements while in the community one patients I am seeing right now might have a cardio-pulmonary problem and the next patient coming to the ICU may have a massive neurological stroke. 	<ul style="list-style-type: none"> • ...the vast majority of physicians work in private practice and they are not employees so they run their own business they are getting paid by the ministry of health to see patients but they are not employees so there is whole business aspect of running a practice which means, you need to run your own human resource department, hire and fire people, and know how to do that appropriately so all this practice management business skills etcetera I think are largely lacking. 	<ul style="list-style-type: none"> • in terms of patients interaction I don't know (pause), nothing specific in terms of points you know, should I do this and should do that but you just get better as you go along. • ...respirology is one small branch of internal medicine but it is still so broad and there are so much that even someone who has been practicing for 20 years does not know everything. • So to be completely prepared for every case that walks through the door prepared is impossible. • I think the training is good in terms of sampling all the different areas. • I don't want to train anymore just to do something different. Like I am ready to practice respirology and I am ready to move on to 	<ul style="list-style-type: none"> • After about a month that I really did not like {OBS}...went into psychiatry residency cause that is what I enjoyed doing when I was still in medical school the most, so I did that for four years. • I did not do a general internship between my medical school career and going in to psychiatry I think you should be made to do that because that would have given me the confidence and it hadn't come from the clinical experience. • had a course in the first year called 'psychosocial aspects of medicine' and it was all about what is behind a patient and we got to go out to a patient's home and interview them...we were allowed to ask questions. So it was a real attempt to figure out what the patient coped and difficulties that can be caused

	<p>deductive training on how to conduct an interview but it was typically conducting interview with a Caucasian person.</p> <ul style="list-style-type: none"> • I think it is always worthwhile, I don't think anyone ever becomes expert in one area. 			<p>practice instead of training that has been going on forever and ever.</p> <ul style="list-style-type: none"> • sleep medicine is different and if I want to practice it then I want to make sure that I have done the training. 	<ul style="list-style-type: none"> • going to conference does improve your knowledge but I am not sure if it can change your approach to your patients, except for the socialization with the other physicians that are there
<p>Approaches in dealing with patients' from diverse culture</p>	<ul style="list-style-type: none"> • ...interviews with people of different origin, there are people of white origin, black origin, English, Dutch, and there were mixed raced people, all culturally very different, Indians, and there were enormous exposure to many different people and you had to use different techniques to speak to different people, and just actually engaging them in the different type of bantam. • we were given deductive training on how to conduct an interview with a Caucasian person. • it was not about how you conduct an interview with someone who speaks a different language, or are from different culture, how do you conduct an interview with black person, a coloured person. • Doctors are not easily interchangeable from different societies, and different cultures, being in different areas. 	<ul style="list-style-type: none"> • It is also general knowledge like um, general understanding of healthcare within the system so people when they come in into the system what is their expectations what their understanding is and what is their personal background as well. Because there are differences in patients I see who are socio-economically different than those who are less educated or people with different religion. And you have to kind of take different approach with those that are more educated comparing to those who are not. • there should be more community connections, they are beginning to do that, too many programs are beginning, so residence that came after me they are getting more community exposures. 	<ul style="list-style-type: none"> • I will ask the patient if it is a bother if it is a concern, if they say yes, then there are lots of female doctors here I am the only male here. 	<ul style="list-style-type: none"> • I think it is not so much in terms of different cultures, it is about each person. • I kinda get a sense about their attitude and get a sense whether they are already a bit unhappy they are a bit hesitant about being here. • I think my approach to the patient just depends on how they are, are they the kind of person who wants a lot of explanation, who wants a doctor who is every serious or do they want, or are they the kind of person who sort of comes in angry. • It is not so much like you are from certain culture, I know specific culture you need to ask specific question...I would be cognisant of and it is not in terms of different culture it is in general so I get a sense about the person and I also depends on how the interview goes. 	<ul style="list-style-type: none"> • It is wonderful if they have interpreters with them...they might be new to Canada or the questionnaires filled out indicates that English is not their first language, so it is nice to try and have an interpreter around. • I think I had a patient who was a Muslim and he wouldn't shake my hand because I was a woman but I did not shake his hand and I just bounded the same way he bounded. • I think in psychiatry it would um definitely, that would be essential, in sleep medicine probably not so much umm at least I have not been in way of doing that.

Summary of the Within Group Analysis by Interview Questions (Nurses)

	Crystal	Paula	Wendy	Barb
Typical day	<ul style="list-style-type: none"> It depends (pause), and so the interesting thing about community, because I like the change and I don't like routine. 	<ul style="list-style-type: none"> We are cross trained, we do birth control, sexual issues, STD testing, HIV testing we do it all, and the other piece of this is the outreach program to homeless and to shelters...I would say sixty percent is sexually transmitted infections, may be 30% is, 35% is birth control, and the other small percentage would be testing the HIV drug abuse 	<ul style="list-style-type: none"> I work Monday to Friday 8:30 to 4:30. A typical day at work for me involves starting here at the office on a daily basis. We come in (pause) we have team meetings twice a week in the morning to review the clients charts and new referrals, I work in a mental health so I do Tele conferencing via the Ontario Tele house network. ..I interview clients and do mental health assessments and I prepare what they have told me, write down their summary and pass it along to the psychiatrist. Um, as for as how many clients I see in a week it really varies. 	<ul style="list-style-type: none"> I work Monday to Thursday. I some days have longer shifts and put full time hours so Monday to Thursday. And the way the clinic is set up we do rotate to some different positions which is very nice to get a different duty every day. We see about 130-150 people a day. How many I individually see I am not sure of.
Challenges	<ul style="list-style-type: none"> {E}ven for a surgical patient you only have three visits. If you need three more, then you need to get an authorized order...so if you need more than three visits there has to be a great deal of discussion, there are a lot more bureaucracy now having difficulties with clients who dealt with other nurses due to different approaches... because I am so much different than they are and a lot more assertive. 	<ul style="list-style-type: none"> sixteen years old, sexually active and needs to go on birth control...we are trying to prevent the spread of disease, she'd gonorrhoea, herpes, cephalous, she is homeless we can't find her I can't tell her {patient} that, you can't give up that money because that is the only money she makes so a big challenge for us 	<ul style="list-style-type: none"> He {patient} had too much difficulties maintaining his focus and answering the questions and became agitated. if they don't know you are coming they are quite defensive, accusatory of their neighbors, their families 	<ul style="list-style-type: none"> one person that I may be was concerned about may be the staff's physical safety with this person
Evidence based Versus Narrative Medicine	<ul style="list-style-type: none"> Protocol says if you are using the \$10 dressing with anti-microbial etcetera that dressing shouldn't be changed for three days and but this lady's frustration was that it was leaking and she also was on haemodialysis... I can use different ways, to monitor the 	<ul style="list-style-type: none"> someone that is coming in and they are not showing you their bits and pieces, they don't have anything to show you except their stories in intensive care they can tell me all the stories they want. But I have got clinical evidence that blood test; I 	<ul style="list-style-type: none"> I am very patient focused, I don't have my own agenda when I am going to see the people I spent a lot of time asking them what they want to do and we will talk about the treatment plans and what is best for them...you need to be a strong advocate and 	<ul style="list-style-type: none"> I don't think my approach is a whole lot different than (pause) although I tend to use humour a lot and I would certainly turned that down if I have somebody coming with anxiety and depression they are not in a joking mood so I would tuned

	<p>results and see how effective they are and I totally impressed with drainage.</p>	<p>have got everything to tell me the story, even if that person can't talk. I know what is happening with their body.</p> <ul style="list-style-type: none"> • If I get a positive pregnancy test my lab results does not collaborate your story. So for me to get the correct information and try to help them with their issues it is really important that they can be honest with me and trust me. • the ICU patient can lie and say what they want but I still have the evidence and I have to treat them based on that. • the problems in intensive care is physiological. 	<p>I think it is one of my strongest skills that just advocating.</p> <ul style="list-style-type: none"> • they {clients} don't want to take the medications and so then you know we have to respect their decisions despite knowing that they may benefit from them, some sort of medication treatment and we have to look at the alternatives and how are we gonna support them. So it is really I rely a lot on clients inputs for their care and try to support them as best as you can" • . 	<p>that down defiantly. I think it is important with someone with a mental health issue to, to um stress to them confidentiality cause they are very concerned about that.</p>
<p>Communication Skills</p>	<ul style="list-style-type: none"> • you have to allow them to know that they have some choice. • I think she appreciated that I just sat down and talk to her and heard her story. 	<ul style="list-style-type: none"> • you have to have good communication skills, absolutely have good communication skills and you have to be caring and I think um ethical those would be I think the top training. • I think it is about honesty and respect and I don't pretend to know about all the cultures and every religion 	<ul style="list-style-type: none"> • I spent a lot of time asking them what they want to do and we will talk about the treatment plans and what is best for them...we have to respect their decisions... I rely a lot on clients inputs for their care and try to support them as best as can. • being an advocate in mental health, you need to be a strong advocate and I think it is one of my strongest skills that just advocating 	<ul style="list-style-type: none"> • I tend to use humour a lot and I would certainly turned that down if I have somebody coming with anxiety and depression. • I think it is important with someone with a mental health issue to stress to them confidentiality cause they are very concerned about that. • if you {patient} didn't click with that physician that is okay too because we don't always click with everybody
<p>Strenght in communication</p>	<ul style="list-style-type: none"> • If you do something that is painful or if you make a mistake" just say "I am sorry" so acknowledge your own shortcoming. 	<ul style="list-style-type: none"> • I am not sir, I am not madam' I might be just the brown chick the chick with the brown hair that I saw last time and to talk to them at their level and speak to them with their own language. 	<ul style="list-style-type: none"> • you need to be a strong advocate and I think it is one of my strongest skills that just advocating. 	<ul style="list-style-type: none"> • One of my strengths, I think having a sense of humour and be nonjudgmental I think I rely on. And I hope that I portray compassion...I hope I make people feel comfortable I hope that that is atmosphere that nonjudgmental atmosphere
<p>Qualities for successful nurses</p>	<ul style="list-style-type: none"> • we can take a step back until you master"... I will teach you until you feel really comfortable, so you take them in baby steps along with tasks. • ...because somebody came and took an interest in listening to her {patient}...So I think I spent a little extra time like social chatting with her. So just hearing her experience. 	<ul style="list-style-type: none"> • it is really important that they can be honest with me and trust me. • for me to measure success to provide all the sources I have. • First what I find is they {patients} have to be comfortable speaking to you in their own language... 'I am not sir, I am not madam'. 	<ul style="list-style-type: none"> • I am very patient focused, • I don't have my own agenda when I am going to see the people I spent a lot of time asking them what they want to do and we will talk about the treatment plans and what is best for them. • I rely a lot on clients' inputs for their care and try to support them as best as can. 	<ul style="list-style-type: none"> • I think they {patients} need that time to trust us or may be feel comfortable and then talk about it and that is okay... • be more empathetic with the patient... • I hope I make people feel comfortable • I hope that that is atmosphere that nonjudgmental atmosphere.

	<ul style="list-style-type: none"> • if you make a mistake” just say “I am sorry” so acknowledge your own shortcoming. 	<ul style="list-style-type: none"> • So they have to understand and that is really important and the relationship has to be one to one so my body language is really important not sitting at the desk holding a pen, with typing on the computer. • the fact that I can provide a safe place for them and to talk I feel like have done something 	<ul style="list-style-type: none"> • I guess really knowing the community resources that are available... • you need to have a strong knowledge of whatever speciality you are working for • understanding that the person is ill and you know because if you have that understanding you are not gonna get your back up and you are not gonna be offended by what people say • ...being an advocate • ...ask about their cultural history because you need to know what cultural influences are gonna effect the treatment plan. 	
Professional training and plans for further training	<ul style="list-style-type: none"> • I always had an interest in nursing and but I didn’t actually go to college until I was 29... • I really believe once your graduate from college or university you need to learn to work with team and you have colleagues that you could go to and you can work independently. • The hospital I started working with didn’t have an IV team so the expectation was that you start your own IV and I taught many nurses • ...as far as the basic nursing no I don’t think it prepares you for reality <p>Further training</p> <ul style="list-style-type: none"> • It is kind of like an expert to other nurses. Especially if it is someone with multiple problems and is coming home, and I have taken care of some really sick babies but they are always willing to let me do it because babies intimidate a lot of nurses. 	<ul style="list-style-type: none"> • I am a registered nurse, I obtained a college diploma um, a two year program initially, graduated in 1982 and that was after the Bachelor of Arts degree at Western in London Ontario. I practiced until 1989 with the College diploma then I got Bachelor of Arts degree... • I have been public health nurse for 12 years and still work in critical care a month as my second job over the ten years that I have been in this department I had learned more” I tend to get more successful at least form that population and working with them from the rehab point of view. <p>Further training</p> <p>No interest in further training</p>	<ul style="list-style-type: none"> • I am a registered nurse and I am working on my nurse practitioners certificate. • It is a lot of kinda learning on my own, and talking with the clients...so I have a much better understanding and plus I do look on some websites that I do like too frequent and that helps me increase my knowledge. <p>Further training</p> <ul style="list-style-type: none"> • I think three degrees is enough (laugh) I think after the nurse practitioner that is it for me. 	<ul style="list-style-type: none"> • I think all the nurses that work here either worked at emergency or intense care so they are all critical care nurses. So everyone that is employed here have a very good basic training. So, I think even though a real critical emergency is rare around here but the odd times that it does happen we are prepared for that and we do constantly doing professional upgrades so I think the staff is well prepared. <p>Further training</p> <ul style="list-style-type: none"> • I think, I would like even more training. Because I said that seems to be such a big issue, so you know I am pursuing more training in mental health because it is such an issue on.
Dealing with patients from diverse culture	<ul style="list-style-type: none"> • ...health and safety says you have to be wearing your shoes and you don’t take your shoes off but you can’t keep your shoes on in certain homes, like in Chinese culture it is offensive like in East Indian homes it is offensive to leave your shoes on. • I had a Native patient who was a 12 		<ul style="list-style-type: none"> • I do find it effective because you need to find the likes and dislikes and you need to find the cultural history of that client because it is so important you know not to break down any specific cultures but I think you need to be aware of the cultural diversity and we are in such a diverse religion and we need to respect. 	<ul style="list-style-type: none"> • we try to do in services that not just makes sensitive to different culture but also different sexual orientation and different religions and do try and keep that always in the fore front. • if there is something that I don’t understand I think um, it is better to ask in a polite way.

	<p>year old and came home to die we had to ask her parents what the rituals were they had some native practices that they wanted to do and we were like sure, and I told them you need to teach me what to do. So if we are dealing with patients from different culture, especially end of life, we just ask this is what we would like to do is there any problems with that?</p>		<ul style="list-style-type: none"> • 	
<p>Therapeutic relationship</p>	<ul style="list-style-type: none"> • {E}ven for a surgical patient you only have three visits. If you need three more, then you need to get an authorized order. • I have so much difficulties because I am so much different than they are {nurse colleagues} and a lot more assertive. • {patient} wanted the socialization but it is not our job, our job is a therapeutic relationship. • Dealing with patients in community nursing is totally different because in hospitals you are the authority who have control, “you will be doing what I say” whereas in community in someone’s home, it is more of a negotiation. • this one patient was fine with me following the Nova Scotia protocol with her in care of her would. • if you make a mistake” just say “I am sorry” so acknowledge your own shortcoming. • I like to see people progress along their learning and that to me is a therapeutic relationship. 	<ul style="list-style-type: none"> • in interviewing the clients, we don’t call them patients, um, in hospital they are patients here they are clients. • Sometimes it is the perceptions of the client that ‘I really don’t want to be intimate with this nurse, I want to get to the doctor’ and we accept that. • In the sexual health center someone needs to come and talk to me about their pregnancy I can’t help them unless they are honest with me. • the problems in Intensive care is physiological and, there are emotional problems but they come secondary because it is acute care because they are sick and we need to treat what is there. • So they have to understand and that is really important and the relationship has to be one to one so my body language is really important not sitting at the desk holding a pen 	<ul style="list-style-type: none"> • I had one particular client that I could think of, had a diagnosis of schizophrenia he had too much difficulties maintaining his focus and answering the questions and became agitated and to be able to escalate the situation it was better for him to come back. • You need to have a strong knowledge of whatever speciality you are working for example mine is mental health so for me understanding the mental health piece and how to manage. • For me the patient centered really need the focus on the clients making the decision about their healthcare and also working with healthcare professionals. 	<ul style="list-style-type: none"> • I tend to use humour a lot ...reassure people that the doors are always open and they can always come back. I hope I make people feel comfortable I hope that that is atmosphere that nonjudgmental atmosphere...I think I do portray compassion to my patients.

Summary of the Within Group Analysis by Interview Questions (Medical Receptionists)

	Becky	Glenda	Grace	Nancy
Typical day	<ul style="list-style-type: none"> so there isn't really a typical day every day is different and you do what you can there is a lot of multitasking going on. 	<ul style="list-style-type: none"> I have been here about a year and a half and I only work at maximum 8 hours of a week. I come in two days four hours, if they need me like if {someone is} going on vacation or something then I put in a few more hours. 	<ul style="list-style-type: none"> I open up the clinic at 8:30, open up both sides, the walk in side and the family clinic side. deal with patients in my first hour and a half. Registering them and putting them in a room. And the rest of my day is, I normally do billing for the doctors. ...we first greet them and ask them why they are here and why they wanna see the doctor and just looking after their needs before they see the doctor. 	<ul style="list-style-type: none"> I answer the phone I do billings, um, if the doctor has a minor surgery I assist with that, paps smears, baby care, so a lot of different things in the office. I check the answering machine. Take any messages, call people back, uh, um, every patient has a chart he still uses the paper files so you have to update for the next day so um, he calls everybody the day before to remind the patient of their upcoming visit.
Challenges	<ul style="list-style-type: none"> It is absolutely challenging {dealing with aggressive clients} because your first instinct as a mother is comfort the child and you do what you can and you hope that you are saying the right thing that you really don't know this person and you don't know if you can hang on to their arm or if, are they gonna find that intrusive so you have to be careful 	<ul style="list-style-type: none"> you have to deal with the good and the bad so one person that I could think was someone who came and had dealt with several people at the front desk and was very frustrated and did not understand what we did and why we did it. the biggest challenge here is developing the staff to a level that we have a consistent approach 	<ul style="list-style-type: none"> client on the phone who wouldn't listen kept saying that we are disrespecting her... we try to talk over her and she wouldn't listen when they{patients} say 'I have this issue, this issues' then so you will say 'you can come back tomorrow and see the walk-in doctor. There are different documents, for immigration that need to fill out we always hope that they have somebody{interpreter} with them 	<ul style="list-style-type: none"> there are some people with mental health issues that are very aggressive and you know and you just kinda, but there are some people, I guess everywhere you have to deal with the good and the bad.
Strength in communication	<ul style="list-style-type: none"> I think we have to remember to listen, to listen before you actually say. 	<ul style="list-style-type: none"> the expression on your face, the tone of your voice, um, don't be abrupt...you need to be open and willing to listen 	<ul style="list-style-type: none"> First greet them you have to have a smile on your face. And 'how are you? What is the weather like out there?' and you know try to get them into a conversation.... putting on a smile, try to defuse a difficult situation. 	<ul style="list-style-type: none"> I think basically just listening to what they have to say, and advocating on their behalf cause a lot of them don't know how to do that. I think I am just good at talking to people and they just feel so comfortable. {h}uffing them some of these people, like a 90 years old lady calls in and well she can't come to the office, so when you do a house call you check on her and make sure she is okay and then when you are all done then

				think, well you made this person's day a little better.
Communication Skills	<ul style="list-style-type: none"> I think we have to remember to listen before you actually say...we have the tendency to start talking and you have a million questions but I think the key is to hear them out and then ask your questions 	<ul style="list-style-type: none"> sometimes patients just need someone to talk to, they just need someone to say 'just be calm I want to help you so please let me know what your concern is. she {the patient} was very calm cause she knew I listened to her, I had taken some actions I had investigated the situation and I had got back to her so she was really happy about that. Whereas she had dealt with several people who had said that there was nothing they could do and that just made her more frustrated. I think courteousness, greeting the patient with a smile and you will get a better reception and by asking 'yeah, what do you need?' you know, the approach is everything. I think as for as the communication goes the most important thing is the expression on your face, the tone of your voice, um, don't be abrupt because these people are sick they are not at their best, you need to be open and willing to listen. people don't wanna discuss their medical problems in front of the other people in line. So keep it very brief, and if they say it is personal then just write it down because they may not say it in front of other people 	<ul style="list-style-type: none"> Satisfaction, like you want them to be happy you want them to come back. try to do whatever they want, if they are asking for certain things...say, if they need a specialist appointment try to adamant it. good conversational skills you have to know how to diffuse the issue If you see someone upset you usually prepare, put the smile on your face, try to make them happy and get them in to the doctor as quick as possible. they are in distress and so you try to do everything as quick as possible and make them happy. What helps is that if they are excitable at that particular time, you would get their name, and their phone number and will call them back. May be in an hour may be the cooled off a bit. So that kind of helps if they are on the phone, and you kind of say 'right now I have many people in front of me can I call you back' kind of thing. they have to be first, the person in front of you not the person on the phone, so the person in front you is first, so if the phone is ringing or if you are writing something down you have drop what you are doing because there is a person in front of you. 	<ul style="list-style-type: none"> I am really good at interacting with old people, the elderly have a lot of problems and nobody has the time to listen to them, and they always want somebody to talk to and that is what, just basically listening is what they want I think basically just listening to what they have to say, and advocating on their behalf cause a lot of don't know how to do that. ...they come with a whole list of aches, and pains and the doctor does not have the time to listen to 20 different things so, you know what they have got to say and when he comes in he can just look at it and he knows what the patient is really complaining about
Qualities for successful medical receptionists	<ul style="list-style-type: none"> I think we have to remember to listen, before you actually say...I think the key is to hear them out and then ask your 	<ul style="list-style-type: none"> so the best way to deal with someone that is upset is to lower your voice. The calmer you are, it make them pretty stupid by yelling at you. 	<ul style="list-style-type: none"> Because people don't wanna discuss their medical problems in front of the other people in line. 	<ul style="list-style-type: none"> I think basically just listening to what they have to say, and advocating on their behalf cause a lot of them don't know how to do that, um, they come with a whole list of aches, and pains and the doctor does

	<p>questions. I think that is something that I am always trying to improve on</p>	<ul style="list-style-type: none"> • I think personality is a big thing; you have to have a certain amount of computer skills, a certain amount of multitasking... but I think the biggest thing for the receptionist, it is very basic computer skills, the programs that are there does it all for you, and answering the phone. But I think courteousness, greeting the patient with a smile and you will get a better reception by asking ‘yeah, what do you need?’ 	<ul style="list-style-type: none"> • keep it very brief, and if they say it is personal then just write it down. • If you see someone upset you usually prepare, • I think just being pleasant with them, because they are sick you know, so you have to understand when they come to the window and they may not be happy so you still have to be pleasant with them. • They have to be first, the person in front of you not the person on the phone, so the person in front you is first, so if the phone is ringing or if you are writing something down you have drop what you are doing because there is a person in front of you 	<p>not have the time to listen to 20 different things so, you know what they have got to say and when he comes in he can just look at it and he knows what the patient is really complaining about this and so, you know that kinda thing.</p> <ul style="list-style-type: none"> • I think I am usually pretty compassionate.
<p>Professional training and plans for further training</p>	<ul style="list-style-type: none"> • ...professional training. I think being on the job and learning is what prepared me and I think being at school, they teach you at school about the folk but I think you learn on the job. • ... any little bit might help and I don't know if anything {training} in particular but I think maybe 	<ul style="list-style-type: none"> • My nursing is a big help but really the managements skills have really helped in this particular job...my training helped to me to see where the house were and they dint' have the policy procedure and so I had to write that and so this was the biggest thing for me. • I have so much training (giggle), I have a RN, I have a bachelor in business economics, I have a masters in industrial technology and I have taken so many different courses and I am retired. But I still take courses with my daughter and we are still friends. So she needs course for her job and we are gone to Brock and Niagara College but that is just for fun. But no I don't see myself continuing. 	<ul style="list-style-type: none"> • I worked in the pharmacy I had to learn all those things and I think it all comes with experience and you learn as you do. • I have been working in the clinic part, it will be two years and before that I worked in pharmacy for 13 years as a technician...I went to school for business administration. • I do want to take some further training and I am not sure what is it called, but it is like where the doctor talks and uh transcribing I wanna take that. • 	<ul style="list-style-type: none"> • I completed a medical secretary course in college, and so, then right from there I got hired by this doctor, so you know. And really school you don't learn a lot so you learn a lot on the job that you are doing ... and he was a very good teacher and very patient...I started working for him, I was only 18 years old so, you know he kinda showed me everything, how things need to be done and he was very good that way. • I am sixty years old and I think that I am trained enough (giggle), when I worked full time we used to go to a lot of different dinners like the drug companies put on you know, I used to go to a lot of those so those were good and they were interesting.
<p>Approaches in dealing with patietns from diverse culture</p>	<ul style="list-style-type: none"> • There are different documents, for immigration • there are document that need to fill out and they have to sign. 	<ul style="list-style-type: none"> • When he {physician} started his practice it was mostly white, you know there is a lot of Dutch people in his practice. But not too, too many others, like he is very cut and dry doctor you know my way or the highway kinda thing. 	<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> •

Findings Phase I, b) Narrative Elements in Transcripts

According to Mishler (1984, 1995) physicians' approaches in patient care are based on objectification, abstraction, and decontextualization. Similar to Mishler, Charon (2005, 2006a) referred to the differences between physicians' and patients' views of mortality, dissociation, the context of illness, beliefs about causality, emotions of shame, blame and fear, as well as alienation. Both authors agree that medical encounters tend to objectify, alienate, decontextualize, and discount subjective insight and emotional states and abstract out of the concrete. This was also evident in participants of the current narrative study. Mishler (1984, 1995) and Charon (2005, 2006a) suggested correcting for this by using narrative features such as temporality, singularity, causality (meaning making), intersubjectivity (co-construction), and ethicality (bond, contract of responsibility). Behavior that should result from this is, according to Charon (2005, 2006a), attention (minimal interruption, suspension of assumptions), representation (patient's life work is acknowledged, patient understands and confirms physician revision of patient's description), and affiliation (partnership).

Charon's Narrative Medicine Features in Informant Accounts

The use of attention, representation and affiliation were different among the study participants. For physician participants of the study, the use of attention in three physicians' approaches was focused on learning about their patients' situations through careful listening, and observation of patients' conditions through interviewing and physical examinations. For two other physicians, it was also about establishing rapport. However, attention in clinical encounters was based on physician participants' understanding of patients' conditions. The dictated language appeared to be technical and based on physicians' understanding of patients' conditions. The attention seems to be given in terms of similarities in clinical encounters as

opposed to oriented towards a fresh vision of patients' uniqueness. Representation of patients' conditions and writing reports about patients seems to be in the language of medicine. The physician participants of the study reflected on the importance of being passionate and gaining patients' trust in medical encounters.

For the nurse participants of the study, attention to patients' conditions was seen through attentive listening, and in two cases, creating a nonjudgmental environment for patients. In representation of patients' conditions, the nurse participants seem to be relying on other nurses and healthcare professionals' reports. In the case of one nurse, representation of a patient with mental health conditions appeared to be more on representation of the patient's emotional state as well as their physical complaints. Creation of the report was based on application of different protocols (e.g., public health, community nursing, intensive care, and walk-in clinic). Affiliation was through being an advocate for the patient in two cases. Gaining patients' trust was apparent; however, engagement in patient care meant relying on other healthcare professionals' feedback, and following expected policies, procedures, and protocols.

For medical receptionist participants of the study, attention was given to patients through careful listening to patients' spoken and unspoken expressions. Showing care for patients was through listening to their stories and, in two cases, helping patients with multiple health conditions narrow down their concerns, and preparing the patients for their visit with the doctors. Representation of patients' conditions was often through creating notes using patients' language; however, fitting patients' complaints in a specific category and triaging for patients' reason of visit could vary depending on the medical receptionist's understanding. Reflective verbal notes of patients' feelings were given recognition during the visit. Affiliation in medical receptionists' accounts was through showing care for patients' conditions and gaining their trust.

Mishler's (1995) Narrative Structure in Informant Accounts

The narrative templates that follow are based on a structure suggested by Mishler (1995) for narrative studies of medicine including a consideration of (a) the relationship between the order in which events happened and the order in which they are told in narration, (b) textual consistency and structure relating to the linguistic and narrative strategies on which the story was constructed, and (c) the importance of narrative elements in clinical encounters as studied against the larger disciplinary narrative(s) plus the grand narratives within the greater society or culture.

Mishler's (1995) narrative structure, as applied to the interviews of the three different groups of informants, allowed for an analysis which yielded comparative differences across the three groups in how the narrative elements were manifested and how they functioned within the clinical encounters described in the interviews. Each group's narrative tendencies (using Mishler's approach) are offered below.

The Physician Group

Using a consideration of the relationship between the order in which the events happened and the order in which they are told in narrative (i.e., temporal order, referential order), the physician group ordered events referentially rather than temporally, relying on memory mining and topic preference and reliance for problem solving and sense making. This is not to suggest that the physician group were unaware of the temporal order and nature of an unfolding event, but rather in these re-telling the temporal order was subordinate to the referential order. However, in their referential re-telling, the preferences and relevancies frequently were based in past similar cases. Using a consideration of narrative and linguistic structure and strategies (i.e., the tropes of narrative such as plot, character, unfolding action, conflict, climax, resolution and the numerous categories of stories, semantic elements of parts of speech, sentence structure, verb

tense, stylistics, person and voices) the physician group accounts portrayed the physician within the account as a “saga like” protagonist, overcoming barriers and obstacles and finding a way to prevail in often challenging and difficult circumstances. There is an intriguing blend of technical discourse and medical shorthand co-existing with metaphor and abstraction—an interplay of opposites as it were. There are frequent pronoun and verb tense changes, although given the referential quality of the re-telling, it is not surprising that the pronouns and verb tenses would shift to match the shifting nontemporal order.

Using a consideration of the narrative elements in clinical encounters situated against the disciplinary and sociocultural grand or master narrative, the physician group does not seem to be unfolding the purported disciplinary master narrative of patient-centred care, at least not on their own. However, they do uphold the contemporary WENA (Western and North American) valorisation of physicians as having immense cognitive and social authority (Goodley, 2011; Wendell, 1996). Most of the participants adopted rigid and inflexible interviewing approaches with their clients. The physician participants’ accounts were placed in the medical culture, compartmentally out of the lifeworld. These accounts were consistent with abstracting, decontextualizing, and discounting (Mishler, 1995).

The Nurse Group

The nurse participants’ accounts were mostly based on temporal order (present moment), with a single event unfolding in the order of time with little or no referential tendencies (unless it was a complication). The temporal order of events was place-based but had inconsistencies and contradictions regarding details and actual order of unfolding.

In terms of the textual, linguistic, and narrative structural strategies, the nurse group accounts portrayed the nurse within the account as an “unsung hero” and the events themselves

had a vignette or episodic quality, likely due to the serial and repetitive character of sequential clinical, patient-based encounters. (This was also evident in how ‘place-based’ the nurse accounts were, as noted in the previous statements). The nurse group used metaphors, and organized the details of their re-telling around the patients’ condition or the condition under which the nurses administered treatment.

Similar to physician participants of the study, the use of language among the nurse participants of the study involved changes in verb tense, as well as changes and shifting in pronouns. The nurse participants’ accounts also exhibited a range of different approaches to reminiscing. They include personal reminiscences which assisted in consolidating, and resolving present action. When considering the larger narrative connections at discipline and cultural levels, the nurse group’s re-telling has a transient and almost nomadic quality, perhaps reflecting the challenging nature of their jobs and work assignments. Additionally, even though there is a chart-centered, protocol-driven, and necessarily time bound quality to nurse encounters with patients, thereby compromising and constraining patient-centeredness, the nurse group accounts, in the main, were triggered by events and descriptions from the patients’ world/s.

The Medical Receptionist Group

Medical receptionist participants’ accounts unfolded in a temporal order as they talked about seeing patients before their visits with the doctor, during the visit, and after the visit.

Their language use with patients was less metaphoric, usually using everyday language, and focused on what was often in front of them. The receptionist participants reported details about experiencing chaos, awareness about emotional states of patients, and awareness of being nonjudgmental. The use of pronouns was typically a “we,” creating a partnership between medical receptionist and patients and/or other medical staff. The uses of verbs were consistent as

their stories unfolded in order of beginning, middle, and end. In terms of relating to larger disciplinary and cultural narrative, the medical receptionists' re-telling indicates an enactment of patient-centred care. Further, the medical receptionists demonstrated an appreciation for the narrative character of the patients' experience and attended to the consequences and context of the patients' care. The medical receptionist group accounts portrayed their role within the re-telling as supporting characters who know who the main character is (the physician) and what the receptionist's responsibilities are relating to this supporting role (uphold and maintain the chain of command of the office, prepare the patient to be focused and symptom selective with the physician), perform "other duties as required" depending on what is needed by the physician or the nurse, debrief the patient, and set up whatever follow-up is required).

Table 9

The Selective Coding, Finding Phase I, B. Examined Within the Context of Charon's Narrative

Medicine Movements Features

Charon	Physicians	Nurses	Medical Receptionist
Attention	<ul style="list-style-type: none"> • for three physicians focused on learning about patients' situations through careful listening • observations of patients' conditions through interviewing and physical examinations. • For two other physicians about establishing rapport 	<ul style="list-style-type: none"> • through attentive listening, and in two cases, creating a nonjudgmental environment for patients 	<ul style="list-style-type: none"> • careful listening to patients' spoken and unspoken expressions • care for patients by listening to their stories • helping patients with multiple health conditions narrow down their concerns • preparing the patients for their visit with the doctors
Representation	<ul style="list-style-type: none"> • Technical in medical language 	<ul style="list-style-type: none"> • relying on other nurses and healthcare professionals' reports • representation of a patient with mental health conditions appeared to be 	<ul style="list-style-type: none"> • creating notes using patients' language • fitting patients' complaints in a specific category and triaging for patients' reason of visit

		<p>more on representation of patients' emotional state as well as their physical complaints (1nurse)</p> <ul style="list-style-type: none"> • creation of protocol based reports, technical language 	<ul style="list-style-type: none"> • reflective notes
Affiliation	<ul style="list-style-type: none"> • being passionate and gaining patients' trust in medical encounters. 	<ul style="list-style-type: none"> • being an advocate for patient • gaining patients' trust • relying on other healthcare professionals' feedback • following expected policies, procedures and protocols 	<ul style="list-style-type: none"> • showing care for patients' conditions and gaining their trust

The Selective Coding Finding, Phase I, B. Examined Within the Context of Mishler's Narrative structure

Mishler	Physicians	Nurses	Medical receptionists
Order elements	<ul style="list-style-type: none"> • non temporal • memory mining • preference 	<ul style="list-style-type: none"> • order within single event • no reference • place based 	<ul style="list-style-type: none"> • temporal (before, during, after)
Narrative and linguistic	<ul style="list-style-type: none"> • technical and shorthand • change in verb tense, changes in shifting pronouns • "Saga like" protagonist • Metaphors, abstraction, decontext, discounting 	<ul style="list-style-type: none"> • Metaphors • Reminiscing • "unsung heroes, vignettes" • Pronouns (we), verb tense change 	<ul style="list-style-type: none"> • Everyday language • Patient complaint • Pronouns (we, second person) • Supporting characters
Larger culture (Patient centered paradigm)	<ul style="list-style-type: none"> • Rigid inflexible styles • Medical culture located • Control, lifeworld on periphery 	<ul style="list-style-type: none"> • Reminiscing • Triggered by patient's world • Transient and nomadic 	<ul style="list-style-type: none"> • Chaos, emotion, nonjudgmental • Chain of command

Findings Phase II, a) Manifest and Latent Content Analysis of Communication and Cultural Competency Website (CCC), b) CCC Website with Charon, c) Policy Documents for Physicians, Nurses and Medical Receptionists and d) Policy Documents with Charon.

Phase II a) Manifest Content Analysis CCC Website

The communication and cultural competency website is developed by The College of Physicians and Surgeons of Ontario and The Medical Council of Canada (2007). At the top of the home page a title Communication and Cultural Competence Program appears in white font with a black background. Underneath the title there is a photograph of three people. From left to right there is a Black male with a beard, a dark Asian female, and a dark-skinned female with a scarf covering her head. All three persons in the picture wear white lab coats. On the left of the photo you can see The College of Physicians and Surgeons of Ontario logo. Underneath the photo there is a black screen, by clicking on it, a White native female English speaker appears and talks about the communication and cultural competence program and its objectives. Under the screen in an orange background the title About this Program sign is showing. The CLEO -2s or C2-LEOs (Considerations of the Cultural-Communication, Legal, Ethical and Organizational Aspects of the Practice of Medicine) objectives are described in the following two paragraphs. In a greenish background the title What are the CanMEDS Roles? appears and it explains the six different qualities identified by the Royal College of Physicians and Surgeons of Canada for a physician including communicator, collaborator, manager, health advocate, scholar and professional. Below this in a brown background one can read the title Why do doctors need to know CLEOs-2 and CanMEDS? A detailed answer is then provided to the above-mentioned question. Next under the blue background The Roles of a Family Physician title appears and is referenced to Canadian Medical Association Code of Ethics. Continuing in a blue background

“Communication and Cultural Competence Program Objectives” are provided with special focus on program expectations and language assessment. Under another blue background titled “Computer & Internet Requirements” icons for software programs required to access the materials such as video and PDF files are shown. The last item shown on the home page is a disclaimer. At the very end of the home page, additional titles in a white background read: Home. About this Program. Language Assessment. Registration. E-Learning Case 1. E-Learning Case 2. E-Learning Case 3. E-Learning Case 4. E-Learning Case 5. Communication Skills Module. Resources. Credits.

On the second page titled Interpretive Commentary on Core Interview, Version#1, a screen appears with videos on patient-centeredness approaches in interviewing. Below the screen under a title Attitudes that appears in black font, some expectations about physicians’ attitudes during interviewing patients appear. Below this under another title written in black font Styles and Techniques, some interviewing styles focused on patient-centeredness are discussed. An emphasis is made on doctors not just hearing patients’ answer their questions but also carefully listening to patients. A direct quote from Richard Zaner is included in this section. Also, in bold text, the importance of careful listening rather than selective listening in translating patients’ experiences of illness into the language of medicine based on hypotheses has been emphasized. Other statements appearing in bold text include, empathic statements, special consideration of gathering sufficient quantity and quality psychosocial and contextual information as well as finding common ground. At the bottom end of the page under the title Attitudes Revisited, physicians are advised about the appropriate use of interviewing techniques and styles. Language assessment is the third page on the CCC website. At the top right side of the page a title called An integrated educational program focusing on medical literacy and CLEOs-2

objectives for physicians trained outside North America is showing. This page has a welcome message guiding the users about the aim of language assessment and the required software for listening to and watching the audio and video files. At the bottom of this page, two icons for required media player software appear.

The next page is the registration page designed for interested users; once International Medical Graduates (IMGs) register then they are able to access the program materials. This page requires user's information such as name, password, personal information, and professional information including first language, instruction language, country of practice, and years of practice. In the following four pages, one can access five different cases (E-learning Case1-5) of everyday medical practice examples in Canada. The aim of these five case presentations is not on diagnosis and treatment but on communication during medical encounters. After clicking on the next page titled Resources the message "this page under construction" pops up. After clicking on the very last page of this website, titled Credits underneath the photo with three persons in lab coats described earlier the following logos appear: The College of Physicians and Surgeons of Ontario, Medical Council of Canada, Ontario provincial logo and the University of Toronto's logo. At the bottom of the last page under the title Communication and Cultural Competence Program Development Team, a list of contributors and individuals involved in developing the website is provided.

Phase II, a) Latent Content Analysis CCC Website

The website for communication and cultural competency (CCC) for physicians practicing in Ontario is mainly developed to attract physicians trained outside North America often referred to as IMGs. The program is intended to help IMGs gain familiarity with medical competencies expected of physicians in Canada. In addition, the website aims to help IMGs understand the

objectives (called the CLEO -2s or C2-LEOs) of the Medical Council of Canada. According to the website communication, ethical and professional behaviours were recently added to the revised Medical Council Objectives. According to the CCC website, IMGs have not received formal training in the mentioned areas and the information provided is not available in textbooks and other sources of information used in medical schools. The website intends to emphasize the importance of interaction between physician-patient rather than the diagnosis and treatment of disease. The website intends to draw IMGs' attention to a patient-centeredness approach during medical encounters.

Five different cases are designed and presented with some feedback to help IMGs to familiarize themselves with communication and behaviour issues raised during diagnostic encounters. Language competency has been mainly emphasized as it is assumed that most IMGs are trained in languages other than English and would need to obtain these skills before practicing in Canada. Because English is often the second language for IMGs, the language self-assessment tests focused on reading and listening skills in Medical English are given priority over other issues identified on the website. According to the website, topics such as bioethical, professional behaviour, and the standards of communication issues are identified to be the most critical ones for IMGs. The website draws IMGs' attention to the complex role of the physician focused on ethical and organizational complexity rather than treatment and diagnosis. The website recommends that IMGs need to change their focus during medical encounters with patients from their own agenda (also known as physician-centeredness) to the patient's needs and their patients' agenda (also known as patient-centeredness). It is assumed that a patient-centeredness approach is already being practiced by physicians trained in Canada. The website also expects the IMGs to be able to learn about professional attitudes and behaviours expected of

physicians in Canada such as adopting cultural sensitivity and patient-centeredness approaches in their practice as well as being able to recognize some common bioethical issues and conflicts during clinical encounters. It is indicated that Canadian bioethics are focused on individualism and empirical sciences values. Even though the website recommends cultural competence as an important aspect of IMG training, it only focuses on the significance of individualistic culture. It fails to suggest acknowledging and recognition for cultural variations in patients' beliefs and behaviours for improved patient satisfaction.

Case 1 is based on a physician's general attitude towards patients during medical interviews. The aim of the interview is to explore the physician's attitudes related to friendliness, cheerfulness, and confidence. One of the strengths being reflected during the encounter is the physician being friendly with the patient. Some weaknesses identified include the physician not making eye contact with the patient and instead looking at the patient's chart. The physician interviewing the patient is not introducing himself and not shaking hands with the patient, as well as starting the interview without proper greetings. Further, the physician is asking more closed-ended questions during the encounters. Some assumptions expressed are: the physician is being seen as arrogant and disrespectful. Also, it is connected to the history of physician-patient encounters within the past century. Another weakness presented in this case reflects how the physician is taking a deductive approach and missing some important information provided by the patient. This leaves the physician with making the diagnosis based on his understanding of the patient's situation. The physician's approach in this encounter is also described as being like an interrogation rather than being a dialogue between physician-patient. The style adopted by the physician in this case is ignoring the view of the patient as a person. The closed-ended character of the physician's questions makes it difficult for the patient to express herself. Early

interruptions while the patient is expressing her issues and the physician trying to seek answers to his questions makes the interview focused on the physician's agenda and interest. The patient's story and her experience of illness are being ignored. After presenting all five cases, some recommendations are made on the importance of the patient's subjective and embodied experience of illness being equally important as objective bio-medical information. Further, the importance of the patient-centeredness approach has been emphasized. A recommendation made by the website is that physicians need to adjust their interviewing styles to the patients as opposed to the patients adjusting to the physicians. Further, the website suggests proper use of the "FIFE formula (feelings, ideas, function, expectations)." The page further provides details on adding open-ended questions during the interviews as well as appropriate probes based on each patient's situation. Listening to the patient's experience of illness is also being reflected on this page. Another recommendation made by the website is looking at both biomedical and subjective information as valuable sources.

After completing the educational materials available on the websites, it is expected that IMGs will be able to learn about professional attitudes and behaviours expected of physicians in Canada, adopt a cultural sensitivity and a patient-centeredness approach in their practice, and be able to recognize some common bioethical issues and conflicts.

The following six different qualities have been identified by the Royal College of Physicians and Surgeons of Canada (2007) for a physician: communicator, collaborator, manager, health advocate, scholar, and professional. As a communicator, a physician is expected to provide high quality care, and set up effective relationships with both their patients and colleagues. Good listening skills have been emphasized as an important aspect of physician-patient interaction in receiving and conveying information. Communication abilities have been

also identified as critical in extracting patients' concerns and prospects about their illness. As a collaborator, a physician is expected to work closely with professionals from different disciplines to provide optimal patient care and education. As a manager, a physician is expected to use different resources (co-workers, policies, tasks, and personal lives) to involve patients in the decision-making process and connect them to healthcare resources. This role is carried out based on an individual patient's care, within the practice, and in the broader framework of the healthcare system. When allocating healthcare resources, a physician is also expected to effectively use the available resources, prioritize patients' care, and make systematic decisions through teamwork. As a health advocate, the physician is expected to recognize the importance of advocacy activities in patient care and addressing the societal, environmental, social, and biological challenges that affect patient health. The advocacy role also needs to be considered as an important element of health promotion affecting public health and policy at the individual patient's level, the practice population level, and the broader community level. As a scholar, a physician is expected to take the role of an active lifelong learner to quest after mastery within the medical profession. It is also expected that physicians adopt effective educational strategies in updating their knowledge about patients. A physician's scholarly activities are central in obtaining healthcare information and contributing to creation of new knowledge in the medical field. This also includes educating peers, medical students and patients, and other stakeholders. As a professional, physicians are expected to play a unique societal role in using their skills and knowledge dedicated to continuous improvements in patients' health and well-being. A physician is also expected to have the highest standards of excellence, knowledge, and commitment to clinical care. The care is expected to be provided with an honest, compassionate, integral, and consistent degree of medical ethics.

While the above roles are required and expected of IMGs, it is assumed that physicians trained in Canada already know and have the above-mentioned competencies. Analyzing the communication and cultural competency website for physicians helped with clarifying the expectations and interactive competencies required of Canadian physicians in clinical encounters and also cultural and communications competencies expected of IMGs.

Phase II, b) CCC with Charon

As reported in the literature, Charon (2005, 2006a) described three movements within narrative medicine that include attention, representation, and affiliation. These three movements are all embedded in the six different physician competency qualities identified by the Royal College of Physicians and Surgeons of Canada (2007).

There are usually two people involved in clinical encounters, the teller of a story (often a patient) and the listener (often a physician). In order for a physician to grasp a thorough experience of a patient's illness, he/she needs to have the most crucial skill in clinical encounters which is listening (Charon, 2005, 2006a). It is important for physicians to listen to patients' stories by suspending any prior assumptions, distractions, and goals to grasp a broader picture of the patient's experience of illness. The website suggests having good listening skills for IMGs in addition to adding more open-ended questions. It further suggests that IMGs need to change their routine clinical practice. In routine clinical practice, physicians often ask a series of questions which begin with the current illness and all its symptoms and manifestations and followed by patient's medical history, surgeries, allergies, medications, family health history, and occupational history, followed by a list of questions in "Review of Systems" going from the head down to identify any disorders. Charon (2005, 2006a) takes a different approach in her routine clinical practice as she describes "I'm going to be your doctor. I need to know a lot about your

body and your health and your life. Please tell me what you think I should know about your situation” (p. 264). Charon (2005, 2006a) emphasizes how this approach changes the process of a diagnostic interview from a physician’s controlled interview and a biomedical explanation of patients’ experience of illness to patients having the opportunity to describe their real life experience. Charon (2005, 2006a) suggests attention as an essential skill in any physician’s encounter with patients.

Attention is followed by representation in which physicians write patients’ descriptions of their embodied experiences in a reflective way representing patients’ voices and sharing their notes with patients for a member check (Charon, 2005, 2006a). This is not being recommended and covered by the CCC website. However, the website does suggest listening to patients’ stories without interrupting them and obtaining more subjective information for fruitful results. A good reflection of patients’ experiences of illness can create a medical practice that will encourage patients to follow physicians’ recommendations and gain their trust. Unlike narrative medicine in which notes are created in ordinary language, in everyday medical practice, acts of reflection were followed privately by the clinician and notes are reflective of physicians’ thoughts, feelings, and perceptions filled with the language of medicine. The website does not provide any details or ways in which the physician could document and include notes in simple everyday language familiar to the patient rather than the language of medicine. Charon (2005, 2006a) recommends reflective writing as a helpful skill for clinicians and emphasizes that including reflective skills helps physicians discover aspects of experiences that were not clear to them till the writing. The third aspect following attention and representation suggested by Charon (2005, 2006a) is affiliation. The author describes that a close attention to a patient’s narrative increases representation of the patient’s conditions and the physician’s representation skills and together

they move toward affiliation with patients, other healthcare professionals, and colleagues. Similar to Charon's (2005, 2006a) description of attention, representation and affiliation, most of the competencies expected of physicians in Canada are described in the physician's different roles as a communicator, collaborator, manager, health advocate, scholar, and professional (Royal College of Physicians and Surgeons of Canada, 2007).

Phase II, C) Policy Documents for Physicians, Nurses, and Medical Receptionists

To better identify interactive competencies among the study participants, it was important to review the educational standards expected of them after completing the requirements for their degree/diploma programs. The educational requirements for physicians, nurses, and medical receptionists have been retrieved from McMaster University MD program Admission (2013), McMaster University Nursing, Admission Details (2013), and Academy of Learning College Ontario (2013) as shown in Table 10.

Council of Ontario Faculties of Medicine (COFM) Policy Document Analysis

Manifest Content Analysis

A three-page PDF file with a white background and black type (Policy Document) developed by Council of Ontario Faculties of Medicine (COFM; 2003) is a general policy paper used by medical schools in Ontario. At the top of the document under the title Council of Ontario Faculties of Medicine a subtitle in bold type Essential Skills and Abilities required for the Study of Medicine is showing. Underneath this sub-title some information regarding the skills (communication, sensory, motor, and social), knowledge, and professional behaviour expected of applicants interested in studying medicine in Canada is provided. This part also includes an explanation about completion of "an accredited" residency training program and successful completion of the licensure examinations of the Medical Council of Canada. Under a second

Table 10

Requirements for Becoming a Physician/Nurse/Medical Receptionist

Description	Physicians	Nurses	Medical Receptionists
Program requirements	<ul style="list-style-type: none"> • Applicants must have completed a minimum of three years of undergraduate degree level work • Or a four year honours B.Sc or BHSc with academic standing of 10.5/12 (McMaster University scale). • write the Medical College Admission Test (MCAT) • complete a 90 minute computer-based test, called CASPer 	<ul style="list-style-type: none"> • A secondary school diploma (OSSD), or equivalent • a minimum of six (6) grade 12 courses with a minimum cumulative average of 75%, 	<ul style="list-style-type: none"> • Grade 12 or equivalent or mature students. • The program is offered to individuals who possess a good command of the English language and are able to follow instructions.
Years of formal education	<ul style="list-style-type: none"> • 3 year program plus a residency training 	<ul style="list-style-type: none"> • 4-year bachelor's degree in nursing or a practical nursing diploma 	<ul style="list-style-type: none"> • 27 weeks diploma program • or four semesters training • or 3 months program
Essential Skills, Abilities and Technical Standards	<ul style="list-style-type: none"> • Observation, communication, motor, intellectual-conceptual, integrative and quantitative abilities, behavioural and social attributes • special considerations for students with disabilities to meet the above mentioned standards <p>McMaster University MD Program Admissions (2013)</p>	<ul style="list-style-type: none"> • Successful completion of the Canadian Registered Nurse Exam (CRNE) or the Canadian Registered Practical Nurse Exam (CPRNE) <p>McMaster University Nursing, Admission Details (2013)</p>	<ul style="list-style-type: none"> • Organizational and problem-solving skills • ability to multi-task • a friendly, patient behaviour • good communication skills • accurate data entry skills • a team player • computer skills • ensure patient confidentiality • a good memory and an ability to multitask <p>Academy of Learning College Ontario (2013)</p>

subtitle in bold type Technical Standards for Students in the MD Program, some important abilities required of students interested in the MD program are explained. These skills include: observation, communication, motor, intellectual, integrative and quantitative abilities as well as behavioural and social attributes. At the very end of the policy document under a subtitle in bold lettering “Students with Disabilities,” considerations of essential skills and abilities for interested students applying for medical schools are provided.

Latent Content Analysis

The candidates for medical programs in Canada are expected to demonstrate professional behaviour, skills, and knowledge. The candidates are expected to be able to diagnose and manage health problems and provide “compassionate” care. The candidates are also expected to have competence in areas such as “cognitive, communication, sensory, motor, social skills” interviewing patients, examining patients, and providing counseling services. Completion of technical procedures in a timely manner and patient safety are other areas included in this section. Potential candidates would be able to practice medicine after completion of the MD program requirements, passing the licensure examinations in addition to completion of a residency training program. An emphasis is made of the importance of time/timeliness during patient encounters. Observation is listed first in technical competencies expected of the candidates. It is expected of individual applicants to be good observers and generate good visual and aural skills as well as being able to create concrete patient reports. The second technical standard is communication. The communication skills expected of candidates include speaking, listening, and observation. Also, a candidate is expected to pay attention to nonverbal communication and describe mood and activities observed during patient encounters. A third area of technical skills includes demonstration of adequate motor functions and ability to

complete a safe physical examination in a short period of time. The candidates are expected to effectively use diagnostic instruments. The last set of technical competencies included in the policy document is intellectual-conceptual and quantitative abilities. For synthesizing and analysing information, a candidate is expected to memorize, measure, and calculate patients' information in a timely fashion.

In addition to communication skills, the policy document provides details about expectations from potential candidates in areas such as “emotional health,” having intellectual capacity, commitment in completion of all assigned tasks, and using good judgment. Potential candidates are also expected to handle “physical, emotional and mental” challenges related to the program.

The policy document is candidate centered and uses the discourse of problem based approaches in patients' encounters. Despite reflection on the importance of verbal and nonverbal communication during encounters with patients, the document does not provide details on the skills that are necessary to identify and address nonverbal communication. Compassionate practice is one of the competencies noted in the document. However, the document lacks details on the importance of patient-centered approaches, attentive listening, developing rapport, and gaining patients' trust. The document emphasizes the importance of technical standards supportive of biomedical approaches including scientific skills that help candidates in diagnosing and treating illnesses but lacks noting the importance of holistic approaches. The document also emphasizes gathering information through interviewing and medical examinations in a timely manner as an important competence expected of the candidates. It appears that adopting a different approach that may take more time could be evaluated as a less desirable quality of a candidate's competence. The document further secures the candidate's dominance and control of

the clinical practice and appears to underemphasize or ignore the importance of the patient's life experience. There is no mention of mutual understandings between physician and client during clinical encounters. Overall timeliness is a dominant theme in the document.

The Canadian Association of Schools of Nursing (CASN) Position Statement Document

Analysis

Manifest Content Analysis

In a five-page PDF file developed by CASN appearing in white background and black text some educational standards for Registered Nurses (RNs) in Canada are provided. At the top right of the document in a purple colour the CASN logo is showing. Under the main title "Position Statement" a subtitle "Education of Registered Nurses in Canada" some information on education background for RNs is provided. Further under another subtitle "CASN Position on the Education of Registered Nurses" different expectations of RNs after completion of degree programs such as Baccalaureate, Master's and PhD levels are provided. Page one ends with citation of authors and sources that contributed to the information provided by CASN. In the middle of the second page, the title "Rationale" appears and in this section some general challenges faced by the Healthcare system in Canada is explained. At the end of page 2 another authors and sources list is provided in a parenthetical citation. At the end of page 3 an approval of this document by CASN Board of Directors (2011) is provided and it is also indicated that the current documents replace the early documents developed in 2003 and 2004. A list of references used in the paper is provided in the final page (5) of the document.

Latent Content Analysis

The emphasis in the document is made on competencies related to nurse education particularly for Registered Nurses (RNs) and contribution to the healthcare system. It is also

noted that education in nursing is broadly affected by development in science and technology. The text further explains best RNs practices and care for Canadians. Different levels of competencies expected of RNs are listed after completion of Baccalaureate, Master's, and PhD levels of training. Achieving standard education is a dominant theme listed in the document. Further, after achieving standard education and CAS accreditation, a knowledge and ethical based practice is expected of RNs. In addition, education is linked to addressing health disparities and better patient outcomes. The document indicates that the RN education standards are in line with other health professions. The document also emphasizes the importance of the training of RNs by qualified nurse trainers and networking with fellow nurses.

Content Analysis of Medical Receptionist Program Offered by Academy of Learning College Ontario (2013)

Manifest Content Analysis

This is a webpage appearing in a blue, white, and red colour background. At the top left of the page in a red, blue, and black lettering on a white background the logo of "Academy of Learning College" appears. At the right top of the page in white text on a blue background the contact number for interested candidates is provided. In the middle of the page a photograph of a Black female wearing a blue uniform is showing. This person is sitting behind a computer and looking at the camera. At the top of her computer screen another person's hand with a white lab coat is visible. At the right side of the photograph a "request info" sign is showing. Under the "request info" a list of blanks asking for interested candidates' information such as first name, last name, contact number, email, and program of interest are appearing. At the very right side of the "Request info" a White female's photograph is showing with a "CHAT LIFE" sign. At the bottom of the "Request info" in a blue background the "submit" sign is showing. At the left side

of the main photograph in a box with blue, red, and black lettering in a grey background a list of different programs offered by the Academy of Learning College is provided. Under this box in white type with a blue background a space for “Student Testimonials” is provided. Under a title at the center of the page written in upper case “MEDICAL RECEPTIONIST” some subtitles appearing in blue text “Industry Overview, Duties & Responsibilities, Skills & Attributes, Career Opportunities and Graduate in 27 Weeks” can be seen. At the end of the webpage in white text on a blue background the copyright 2013 sign is showing. Underneath the sign a list of different programs offered by the Academy of Learning College is provided.

Latent Content Analysis

The webpage acknowledges the importance of the medical receptionist’s job and highlights that a medical receptionist is the first person of contact with patients. A medical receptionist’s role in making a good impression during the patient visit is also noted in the document. Answering phone calls, taking messages, recording patient information, scheduling and confirming appointments, and other administrative tasks are among those listed in the document. Some competencies and skills expected of medical receptionists include problem solving, multitasking, being cheerful and friendly, having good communication skills, computer skills, data entry skills as well as a good memory, and being job focused despite interruptions.

Phase II d) Policy Documents with Charon:

After analysing the above three documents for manifest and latent content, I will now move to a further review of these policy documents using Charon’s (2005, 2006a) notions of attention, representation, and affiliation as important features of, or movements within, narrative medicine. As reported in the literature, the focus in *attention* is on the importance of attentive listening to patients’ stories, suspending any prior assumptions, and grasping a broader picture of

patients' experiences of illness. In the policy document for physicians, listening to patients and paying attention to verbal and nonverbal communication are listed. Having quantitative skills and ability to memorize, measure, and calculate are some other skills expected of the candidates. The document lacks details about attentive listening and suspending any prior assumptions that may prevent physicians from gaining a broader picture of the patient's experience of illness. The approach expected of candidates appears to be more positivistic and reductionist in general. In the policy document for nurses, emphasis is made on achieving education and providing care for all and addressing economic and cultural disparities in healthcare. Despite the mention of good outcomes for patients, the document lacks details about the client's uniqueness, and about attentive listening and establishing good nurse-patient relationships. The document supports following a standard approach in dealing with all clients. Unlike the policy documents for physicians and nurses, the webpage on competence for medical receptionists emphasizes the importance of having a friendly and professional approach, as well as good communication skills with patients. In addition, since a medical receptionist is the first person that contacts patients, being attentive to patients and making a good impression are other skills related to attention noted in the mentioned webpage.

The second movement in narrative medicine described by Charon (2005, 2006a) is *representation* in which clinicians write patients' experiences of illness in a language that is familiar to patients and supportive and reflective of patients' embodied experiences of illness. Further, in representation, priority is given to representing patients' voices and sharing the notes made about patients' conditions for a member check. As opposed to the representation described by Charon (2005, 2006a) which is supportive of bringing forward the patient's voice, the policy document for physicians suggests a more candidate controlled and medical explanation of the

candidate's understanding of the patient's condition. The document supports provision of a coherent summary of the patient's condition and ways of managing it verbally and in writing by the candidate in a timely fashion. In the nurses' policy document regarding representation of patients' conditions, consideration is given to a standardized approach in care for clients as opposed to taking different approaches based on a patient's uniqueness. On the webpage for medical receptionists, it is expected that medical receptionists have good memories, precise data entry skills, and represent patients' conditions accurately. None of the documents provide details on the reflective writing skills emphasized by Charon (2005, 2006a) as a way to help clinicians involved in patient care to discover aspects of the patients' lives that were not clear to them until they engaged in rereading and reflective writing. Further, the documents fail to provide details on honoring cultural values in representing patients' voices.

The third movement within narrative medicine suggested by Charon (2005, 2006a) is *affiliation*. Affiliation can be established after close attention is given to a patient's experience of illness and fully and accurately representing it to other healthcare professionals and colleagues. In the policy document for physicians, affiliation with the patient, the patient's family, and other healthcare team members appear to be mentioned in social and behavioural attributes expected of the candidates. The document for nurses encourages RNs to establish affiliation and partnership with other nurses in order to deliver high quality health service and education. It further suggests training of nurses by other trained nurses. The webpage on competencies for medical receptionists suggests being a good team player as an important competence expected of medical receptionists that can be related to the notion of affiliation described by Charon (2005, 2006a). Further, medical receptionists are expected to be efficient and ensure patient confidentiality.

Table 11

Manifest and Latent Content Analysis of the CCC Website and the Policy Documents

	CCC website	Physicians	Nurses	Medical receptionists
Manifest	<ul style="list-style-type: none"> the six different qualities identified by the Royal College of Physicians and Surgeons of Canada for a physician including, communicator, collaborator, manager, health advocate, scholar and professional. expectations about physicians' attitudes during interviewing patients the importance of careful listening rather than selective listening in translating patients' experience 	<ul style="list-style-type: none"> is a general policy paper used by medical schools in Ontario communication, sensory, motor and social skills required for candidates completion of residency training program and successful completion of the licensure examinations of the Medical Council of Canada technical standards required including observation, communication, motor, intellectual, integrative and quantitative abilities 	<ul style="list-style-type: none"> some educational standards for Registered Nurses (RNs) in Canada are provided different expectations of RNs after completion of degree programs such as Baccalaureate, Master and PhD levels are provided some general challenges faced by the Healthcare system in Canada are explained 	<ul style="list-style-type: none"> Industry overview duties & responsibilities expected skills include being friendly, having ability to multi-task, being cheerful and good communication skills Career opportunities and graduate in 27 Weeks
Latent	<ul style="list-style-type: none"> developed to attract physicians trained outside North America often referred to as International Medical Graduates (IMGs) is intended to help IMGs gain familiarity with medical competencies expected of physicians in Canada the website intends to draw IMGs' attention to a patient centeredness approach during medical encounters it is assumed that a patient centeredness 	<ul style="list-style-type: none"> The candidates are expected to be able to diagnose and manage health problems and provide "compassionate" care Completion of technical procedures in a timely manner and patient safety attention to verbal and non-verbal communication a candidate is expected to memorize, measure, and calculate 	<ul style="list-style-type: none"> Achieving standard education is a dominant theme education is linked to addressing health disparities and better patient outcomes the document also emphasizes the importance of training of RNs by qualified nurse trainers and networking with fellow nurses. 	<ul style="list-style-type: none"> a medical receptionist is the first person of contact with patients a medical receptionist's role is to make good impression during the patient visit being job focused despite interruption

	<p>approach is already being practiced by physicians trained in Canada</p> <ul style="list-style-type: none"> • the website also expects the IMGs to be able to learn about professional attitudes and behaviours expected of physicians in Canada such as adopting a cultural sensitivity and patient centeredness approaches in their practice as well as be able to recognize some common bioethical issues and conflicts during clinical encounters. 	<p>patients' information in timely fashion.</p> <ul style="list-style-type: none"> • the document lacks details on the importance of patient centered approaches • adopting a different approach that may take more time could be evaluated as a less desirable quality 		
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Table 12

Charon's Narrative Medicine Features as Applied to the Documents and Website

Charon	CCC Website	Physicians	Nurses	Medical Receptionist
Attention	<ul style="list-style-type: none"> • having good listening skills for IMGs • adding more open ended questions. • the need to change routine clinical practice 	<ul style="list-style-type: none"> • for three physicians focused on learning about patients' situations through careful listening • observations of patients' conditions through interviewing and physical examinations. • For two other physicians about establishing rapport 	<ul style="list-style-type: none"> • through attentive listening, and in two cases, creating a nonjudgmental environment for patients 	<ul style="list-style-type: none"> • careful listening to patients' spoken and unspoken expressions • care for patients by listening to their stories • helping patients with multiple health conditions narrow down their concerns • preparing the patients for their visit with the doctors
Representation	<ul style="list-style-type: none"> • listening to patients' stories without interruption and obtaining more subjective information • representation based on physicians' thoughts, feelings and perceptions of patients' conditions • description of patients' embodied experience in a reflective way not recommended • patients' voice and sharing their notes with patients for member check not recommended 	<ul style="list-style-type: none"> • Technical in medical language 	<ul style="list-style-type: none"> • relying on other nurses and healthcare professionals' reports • representation of a patient with mental health conditions appeared to be more on representation of patients' emotional state as well as their physical complaints (Nurse) • creation of protocol based reports, technical language 	<ul style="list-style-type: none"> • creating notes using patients' language • fitting patients' complaints in a specific category and triaging for patients' reason of visit • reflective notes
Affiliation	<ul style="list-style-type: none"> • Affiliation made based on physicians' 	<ul style="list-style-type: none"> • being passionate and gaining 	<ul style="list-style-type: none"> • being an advocate for patient 	<ul style="list-style-type: none"> • showing care for patients' conditions

	<p>understanding of patients' conditions.</p> <ul style="list-style-type: none"> • The use of reflective notes based on patients' conditions in referrals to other medical professionals not recommended 	<p>patients' trust in medical encounters.</p>	<ul style="list-style-type: none"> • gaining patients' trust • relying on other healthcare professionals' feedback • following expected policies, procedures and protocols 	<p>and gaining their trust</p>
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Table 13

Mishler's Narrative Structure Elements as Applied to the Website and the Policy Documents

Mishler (1995)	CCC website	Physicians	Nurses	Medical receptionists
Order elements	<ul style="list-style-type: none"> • Mostly based on references rather than temporality. 	<ul style="list-style-type: none"> • Based on referencing and temporality 	<ul style="list-style-type: none"> • Referencing and temporality 	<ul style="list-style-type: none"> • temporal
Narrative and linguistic	<ul style="list-style-type: none"> • The level of details provided is technical and medical shorthand. • The word choice is often for second person and third person singular. 	<ul style="list-style-type: none"> • The word choice is often used in the form of third person singular (e.g., the physician, the candidate, a candidate) 	<ul style="list-style-type: none"> • The word choice is often for second person and third person singular (e.g., you, RN, RNs). 	<ul style="list-style-type: none"> • The word choice is often for second person (e.g., you)
Larger culture (Patient centered paradigm)	<ul style="list-style-type: none"> • Encourage IMGs to give recognition to the lifeworld. However, the main focus is on abstracting, decontextualizing, discounting and timeliness 	<ul style="list-style-type: none"> • Evidence based, practice, focused on success for candidates • Technical competency • Timeliness and compassionate practice • Medical culture 	<ul style="list-style-type: none"> • Connection with other RNs • Achieving standard education 	<ul style="list-style-type: none"> • Good team player • being cheerful and friendly • and being job focused despite interruption

Phase III, Mishler and Charon across All Data Sets

Phase III, a) Mishler's (1995) Narrative Elements across All Data Sets

The composite narratives constructed below are based on a structure suggested by Mishler (1995) for narrative studies including a consolidation of (a) the relationship between the temporal orders in which events happened and the referential order in which they are told in narration, (b) textual consistency and structure concerning the linguistic and narrative strategies on which the story was constructed, and (c) the importance of narrative with the broader place of the story within the greater society or culture.

The order of events in physicians' accounts and policy documents appeared to be based on references and memory mining, but the policy document also included the order of temporality. Similar to the physicians' transcripts, the level of details provided in the policy document for physicians appeared to be technical and based on medical shorthand.

There were consistencies in physicians' roles in the transcripts, policy document, and website; all the sources supported the role of physicians in patients' encounters as heroic or saga like protagonists overcoming barriers and obstacles. All three data sources including physicians' accounts, policy documents, and the CCC website appeared to be supportive of medical culture and professional control of the lifeworld as opposed to patient-centeredness. There was also some textual consistency and structure between physicians' transcripts and the policy document; for example, the change in verb tense (past, present), changes and shifting in pronouns (third person singular and first person). Unlike the policy document and CCC website, the word choices in the physicians' transcripts were metaphoric at times. The preferred approaches suggested for clinical encounters in physicians' transcripts and policy documents were mostly based on memory mining, piecing together rationale using preferences and similarities with previous cases. The CCC website, however, also suggested attention to patients' narratives and

cultural beliefs. Both physicians' transcripts and policy documents were consistent with regards to abstracting, decontextualizing, and discounting.

The nurse participants' transcribed accounts and policy documents were supportive of place based temporal order based on a single event; for example, a present moment unfolding in the order of time. There were place-based inconsistencies and contradictions in both nurses' transcripts and policy documents. The use of metaphors was apparent in both nurses' accounts and the policy documents.

The nurse participants' roles in the transcripts were portrayed as "unsung heroes" and had more of a vignette quality. The use of language written in the nurses' transcripts and policy document involved change in verb tense, as well as changes and shifting in pronouns (e.g., we and third person singular in the transcripts, you, RN, RNs in the policy document). In both nurses' transcripts and policy documents, stimuli for reminiscing are placed in the context of the narrative grounded in the patients' world. Both the transcripts and the policy document support connections with other RNs and establishing standardized patient-nurse therapeutic relationships.

Both the medical receptionists' accounts from the transcripts and policy documents support the order of temporality based on beginning, middle, and end. The use of language in both transcripts and policy document appears to be based on everyday language and focused on one person at a time. Both the transcripts and the policy document emphasize adopting a nonjudgmental role and awareness about emotional states of patients.

There were consistencies in the uses of verbs in both transcripts and policy document for medical receptionists; for example, their stories unfolded in the order of beginning, middle and end. Adopting a role of good team player for medical receptionists was supported by both the transcripts and policy document. Similarly, adopting a supportive role during patients'

encounters was apparent in the transcripts and policy document. Having a narrative sense of the patients' lifeworld and attending to the consequences and context of patients' care both mutually and temporally were identified in the medical receptionists' transcripts and recommended in the policy document.

Phase III, b) Summarizing Charon across All Data Sets

The use of attention, representation, and affiliation were different among the three different data sets including transcripts, policy documents, and the CCC website. The physician participants' narratives were mostly focused on learning about their patients' situations through careful listening and observation. Attention in clinical encounters was mostly based on physicians' understanding of patients' conditions as well as similarities between clinical cases. Representation of patients' conditions appeared to be in the language of medicine. Affiliation was expressed through the importance of passion and gaining patients' trust in medical encounters.

For most of the nurse participants, attention to patients' conditions through attentive listening, and creating a nonjudgmental environment for patients was identified. Representation of patients' condition was done based on reports developed by other nurses and healthcare professionals. Affiliation was expressed through advocacy and gaining patients' trust; however, engagement in patient care meant relying on other healthcare professionals' feedback and following expected policies, procedures, and protocols.

Attention in the medical receptionists' narratives was expressed through careful listening and noticing patients' verbal and nonverbal communication. Representation of patients' conditions was often through creating notes using patients' language. Documenting reflective notes of patients' feelings was also included in patients' reasons for the visit. Affiliation in

medical receptionists' narratives was through showing care for patients' conditions and gaining their trust.

In the CCC website, attention was apparent through emphasis on having good listening skills, the need for a change in routine clinical practice, and adding more open-ended questions. Representation in the CCC website includes the patient's subjective experience in addition to objective data; however, representation is still based on physicians' thoughts, feelings, and perceptions of the patient's condition. The CCC website recommends including reflective notes in patients' records.

Pause, Review, and Return

Before proceeding onto the consolidating narrative that follows, I will review the statement of intent offered in the preface. This narrative study is the first to explore narrative elements operating within the accounts and professional/disciplinary discourses of the informant groups. These elements have been explicated through a multilayered series of analyses: open, axial, inductive coding followed by selective coding, guided by the literature driven typologies of the accounts (deductive), this supplemented by manifest and latent analysis of the discourses with all data sets undergoing a further analysis guided by Mishler's (1984/1995) and Charon's (2005, 2006a) narrative approaches. These intersected and internally compared analyses yielded narrative elements and salient discursive features that are presented below in a consolidated, albeit generic, narrative unfolding. This consolidated narrative is the critical application of these narrative elements and discursive features. It also serves to inform the other thematic insights by ongoing recursive, description, reduction, and interpretation.

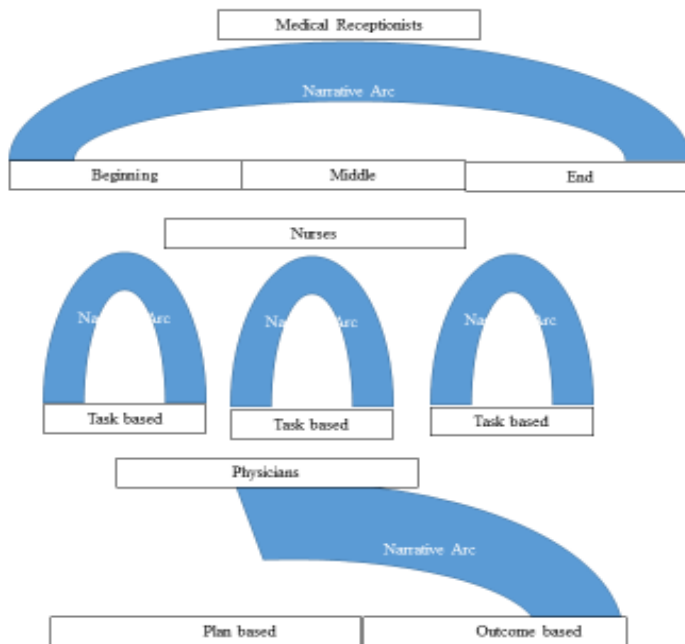
Consolidation of Narrative Elements: A Composite Narrative

A patient enters the clinical setting and a cheerful, friendly medical receptionist greets him, and carefully attends to his spoken and unspoken expressions. The medical receptionist skillfully obtains the patient's information and assists the patient in preparing an appropriately focused presentation of self and symptoms for the physician. The medical receptionist also provides support and reassurance while keeping reflective notes and being job-focused despite interruptions. The medical receptionist's ability to use everyday language and be attentive, in the moment focus, allows for the possibility of developing patient trust and rapport.

The medical receptionist escorts the patient to phase two of the encounter, the consult with a nurse or nurse practitioner. This consult is a significant, nonjudgmental encounter that transforms the patient's experience of protocolized and standardized information gathering into a therapeutic event based in intense training and affiliation with other nurses and transfer of this professional commitment into an efficient, and underappreciated, delivery and presentation of care.

Following his preparation with the supporting character (medical receptionist) and his therapeutically focused engagement with the unsung hero (nurse), the patient moves on to the main event, his encounter with the hero of the saga, the physician. The patient delivers an appropriately sanitized and reduced rendition of his perceived medical reason for being there, and the physician performs good listening skills, translating the patient's complaints into technical medical shorthand for further reference, while noting previous and/or related experiences with some bearing or relevance for the patient of the moment. Following a timely and compassionate relaying of important information to the patient, the physician then returns

the patient to the medical receptionist for a translation of the recently relayed information and instructions on next steps.



Comment. These narrative arcs (pictured above) have been extracted from the consolidated summary to demonstrate how these overlapping narrative tendencies operate simultaneously within a typical clinic experience, described in the preceding consolidated narrative. This, albeit “tongue in cheek,” consolidation of narrative elements gleaned from the findings illustrates the disparity between temporal and referential order (patient and medical receptionist in a sequential story line, nurse and physician in an episodic, and referentially oriented story line) as well as the intriguing interdependencies across the characters in the unfolding plot: a patient ought to be sick and miserable enough to call forth both the unsung hero and saga like protagonist but not so sick and miserable as to complicate an efficient therapeutic relationship or a timely and compassionate diagnostic encounter.

This composite also does not do justice to the many clinical encounters where trust, rapport, compassion, attentiveness, and time are authentically enacted by the medical professionals involved. It represents the narrative elements disclosed by the nine levels of analysis in the present study of five physicians, four nurses, and four medical receptionists. This composite also should not overshadow the interesting finding that patients-healthcare workers interactions and attempts at communication are actually relative and context dependant and not single form. The interactions seem to depend on the type of settings and the goals of the encounter (e.g., emergency ward, clinic (family physician), walk-in-clinic, hospital, home visit). Additionally, the ages, specialities, and backgrounds of the physician and nurse informants seemed to influence how they provided information and how they described encounters that were based in diversity.

The analyses have also yielded several further insights. One, that communication (as Lanigan, 1987, claims) is the goal, not the ground, and the presumptions of shared communication must be checked against the elements suggested by Charon-attention, representation, and affiliation and placed against the backdrop of cultural competency. Clinicians have responsibilities regarding cultural sensitivity and responsiveness that seemed largely unacknowledged in this study Secondly, that “patient-centered care” is an important concept that has achieved discourse status, but that has also, likely inadvertently, become reduced to that status, discourse as practice, without a concomitant enactment of a practice of patient centeredness. In this study, it is the medical receptionists who are enacting patient centeredness in practice, and the nurses and physicians who are working at the level of discourse as practice.

Clinicians with increasing time constraints will need to develop strategies for becoming “efficiently” patient-centered. Third, there are numerous factors affecting how clinicians interact with patients and also affecting how possible changes can be made in these interactions.

CHAPTER FIVE: DISCUSSION AND CONCLUSIONS

The purpose of this qualitative narrative study was to explore accounts of patient encounters within the interaction contexts of physicians, nurses, and medical receptionists after 2 decades of a paradigm of patient-centered care. The theoretical frameworks for this study were drawn from the research literature on narrative medicine, evidence based medicine, cultural and communication competency, and therapeutic nurse-patient relations. A narrative inquiry approach was used to explore physicians', nurses', and medical receptionists' everyday experiences of dealing with patients. Intertwining, recursive, inductive, and deductive analyses allowed for interaction and consolidation across the data sets.

In this chapter, the themes emerging from the open, axial, and selective coding are explored in further detail and examined within the context of the literature.

Following this, a conceptual framework based on participants' narratives is presented as the themes and narrative elements are brought together with the literature to create a detailed picture of participants' encounters with patients. This section also includes answers to the research questions.

Table 14 shows the dominant themes from the literature that speaks to the participants' experiences of patient encounters.

The literature on EBM suggests that when practitioners make decisions regarding patient outcomes, they should do so with significant reliance on scientific, peer reviewed, published research. The physicians and nurses in this study were more than aware of this mandate and seemed committed to enacting these values in their conduct and their discourse. However, there seemed to be some tension between the imperatives of EBM and timeliness, and the representation and affiliation needs of patients.

Table 14

The Dominant Themes from the Literature that Speak to the Participants' Experiences of Patient Encounters

	Phenomenology and Medicine (Embodiment)	Patient Centeredness (Listening Joint decision, Collaboration)	Positivist/Post positivistic Approach (Expert opinion Inferential)	Evidence Based Medicine (Objective Peer reviewed Empirical)
Focus and features	<ul style="list-style-type: none"> • Almost all the participants in the study acknowledged the importance of embodied experiences of patients' medical conditions. • The focus of most physician and nurse participants in the study was on the importance of objective realities and evidence. • Two physicians and two nurses also talked about the importance of lived experience and subjective evidence • The focus of almost all medical receptionists was on the importance of lifeworld and in three cases patients' stories 	<ul style="list-style-type: none"> • The physician and nurse participants of the study appeared to be taking an active role in patient-physician communication. • Listening appeared to be crucial during medical encounters for both physicians and nurses • Subjective experience and meanings of illness to patients appears to be explored but the focus is still on objective facts. • The medical receptionists appeared to be taking a supportive role during patient encounters. 	<ul style="list-style-type: none"> • Broad attention is given to physical aspects of patients' experiences of illness • Physicians in most cases and nurses in one case appeared to be an authoritative position • Explanation of illness based on biomedical model was central in most physicians' approaches during encounters • Less emphasis was made on communication skills and their impact on diagnosis and treatment. 	<ul style="list-style-type: none"> • Most physicians and nurses focus on generalization rather than uniqueness of individual health needs. • Decision making in most physician cases appeared to be made based on clinical evidence (objective). • Two physicians and two nurses included subjective evidence in addition to biomedical evidence in patients' records

	<p>Cultural Competency Training</p> <p>(Multiple realities)</p> <p>Cultural contexts)</p>	<p>Narrative Medicine (Charon)</p> <p>(Attention, Representation & Affiliation)</p>	<p>Therapeutic Relationships</p> <p>(Consistency, standards/ time bound, dyadic Case & task based)</p>
<p>Focus and features</p>	<ul style="list-style-type: none"> • Most physician participants acknowledged the importance of cultural competence during patient encounters. • delivery of health services appeared to be based on western cultural values • almost all the participants in the study acknowledged the importance of cultural competency in patient care • For a few participants (one physician, one nurse) cultural competencies were viewed as linguistic skills. 	<ul style="list-style-type: none"> • Some values of narrative medicine have been acknowledged by two physicians and two nurse participants of the study. • Effective clinician patient interaction and fruitful results through attention, representation and affiliation mostly present in medical receptionist and patient relationships. • <i>Attention</i> appears to be present in most physicians' and nurses' patient relationships 	<ul style="list-style-type: none"> • Most nurse participants in the study talked about establishing therapeutic relationships with patients through establishing trust and empathy. • Two medical receptionists were also directly engaged in therapeutic relationships by providing care to the patients in addition to completing their own responsibilities.

The literature on therapeutic relationships suggests that nursing is a relational practice and that the therapeutic relationship with a patient, while valued, is subject to professional and scope of practice constraints, and bounded by the medical needs of the patient. As documented in this study, these features of therapeutic relationships are illustrated by the episodic and nomadic character of nurse-patient encounters and by the strong affiliation between nurses.

A Model of Patient Encounter Accounts of Physicians, Nurses, and Medical Receptionists after Two Decades of a Paradigm of Patient-Centered Care

The results of this study clearly articulate that the experiences of the study participants in patient encounters were linked to their training and dominant biomedical cultural beliefs. The findings indicate a close relationship between the participants' personal beliefs, areas of practice, and their understanding of interactive competencies in patient encounters. In most of the participants' cases, particularly physicians and nurses, the patient-centered practice is operating at the discourse level. A lack of balance between the objective and subjective evidence in participants' encounters with patients may have resulted in an implicit paternalistic practice that was not patient-centered and likely not brought to critical self-awareness. These findings clearly demonstrate that the encounters were mostly based on clinicians' understanding of patients' conditions and, in four cases, also about taking a reductionist approach based on a biomedical model as opposed to a patient-centered model supportive of embodiment.

A conceptual diagram of participants' experiences of patient encounters is presented in Figure 1. The purpose of this diagram is to give an overall picture of the present study's participants' experiences of patient encounters after 2 decades of a patient-centered paradigm. The diagram brings together the existing dominant themes from the literature and the findings from analyses of the participants' accounts. This model can be used by individuals and organizations involved in patient care in designing initiatives focused on patient-centeredness and narrative medicine approaches. The conceptual diagrams in Figures 1 and 2 were developed based on discussion of the theoretical frameworks in the review of literature in Chapter Two.

The conceptual diagrams assist in understanding the experiences and processes a clinical practitioner goes through in the movement toward patient-centered (embodied) and narrative

medicine paradigms and away from a biomedical approach based on a medicalized body and a paradigm of clinician control. We can place different participants in the circles in Figure 2. The circle in the center of the diagram reflects the approach taken by most physicians and nurses in this study. For two physician participants in this study, in addition to taking a biomedical approach, an approach with support for subjective experience and embodiment was also acknowledged. In two physician participants' experiences, recognition is given to the "lived body" but interventions are still based on the biomedical model. Individuals closer to the center of the diagram are adopting interventions based on the medical model (evidence based, positivistic) only (e.g., the different components of the biomedical model based on generalization and reductionism shown in Table 5). Based on the participants' experiences, it is evident that the "medical body" and the embodiment approaches are not and ought not to be binary opposites but complementary of each other (see Charon, 2005, 2006a; Goyal et al., 2008; Mishler, 1995).

In Figure 2, the circle in the center of the diagram articulates the two physician and two nurse participants' approaches in patient encounters. This includes adopting an approach based on biomedical interventions.

As indicated in the literature, the emphasis in clinical encounters is mostly on treatment and diagnosis (Flynn et al., 2012) and less on communication competencies for medical professionals. The second circle shows establishing therapeutic relationships, the participants closer to the center believe in establishing therapeutic relationships based on a biomedical model and those away from the center believe in establishing therapeutic relationships based on a holistic approach supportive of embodiment. Most of the participants (physicians and nurses) in the study acknowledged the importance of patients' narratives in their encounters.

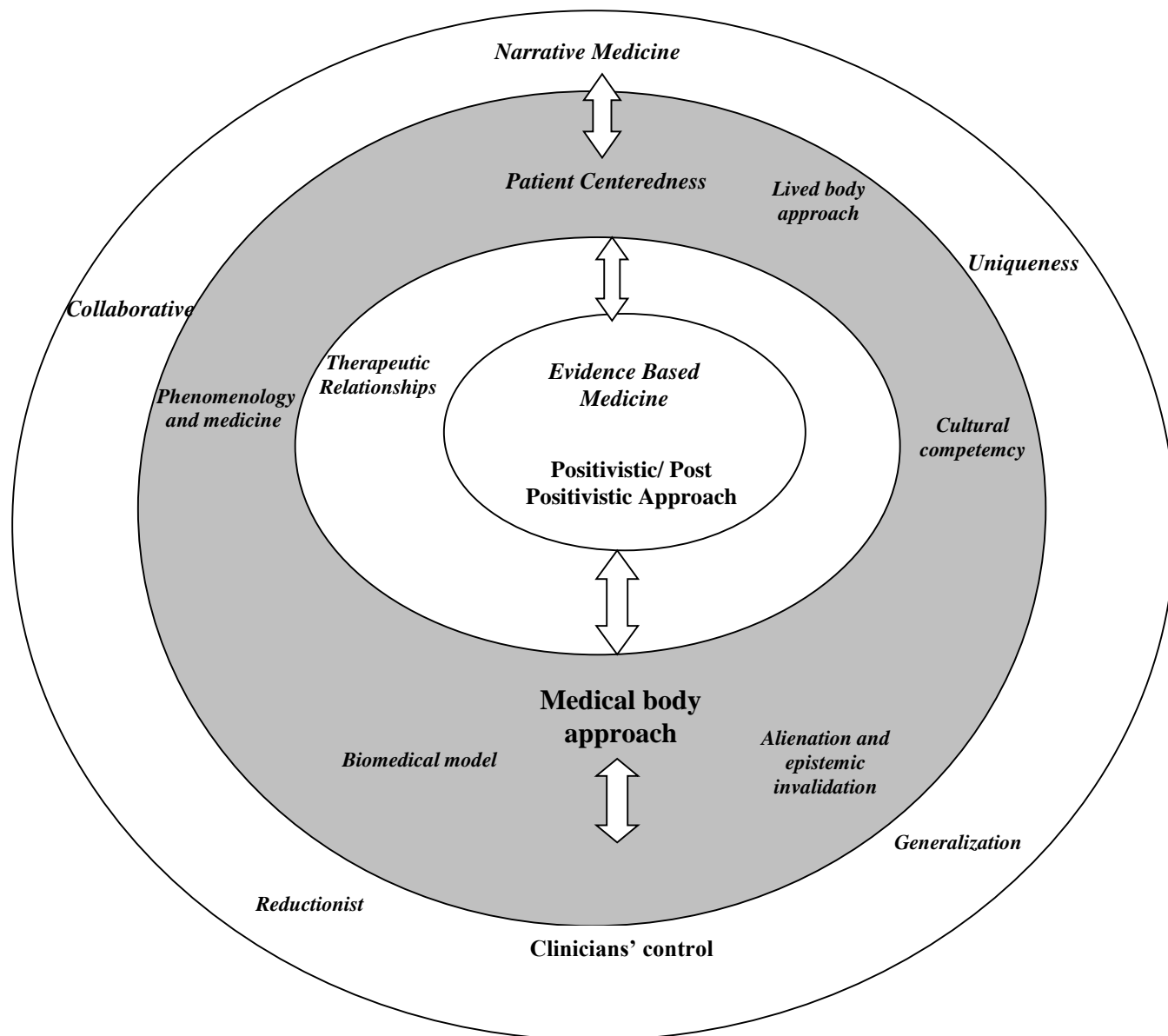


Figure 1. A conceptual diagram of participant-patient encounters.

The third circle includes different themes derived from the literature and talked about by the participants during encounters with patients. The middle and top parts of the third circle

depict the participants' adoption of different interventions based on embodiment (phenomenology and medicine), and recognition of cultural differences and patient-centeredness. The lower part of the third circle shows participants' adoption of interventions based on the biomedical model.

The upper part of the fourth circle of the conceptual diagram reflects the interventions based on collaboration and individuals' uniqueness, while the lower part of the fourth circle shows interventions based on generalization, supportive of the medicalized body and clinician control.

Despite some similarities in adoption of different interventions, each participant's patient encounter is different. For example, the experiences of adopting a mixed method approach based on the medical body and embodiment are similar between Dr. Greg and Dr. Carly, but their belief in objective and subjective evidence in patient encounters is different. Similarly, Dr. Bob and Dr. Jane take a relatively similar approach in regards to the biomedical model, and Dr. Jane still sees adopting different communication approaches with her patients but Dr. Bob uses a standard communication approach with all clients. Nurse Wendy believes in, and often adopts, an approach supportive of her clients' cultural beliefs and so does Nurse Crystal. However, in completing patients' records Nurse Crystal follows a standardized protocol closely and Nurse Wendy adds reflective notes supportive of patients' subjective experiences.

Comparing the experiences of patient encounters based on a biomedical model among most of the participants, there are differences and uniqueness in each participant's approaches in adopting a mixed method approach.

Based on the participants' accounts and encounters, two participants (Dr. Greg and Carly) are closer to practicing a patient-centered approach. In an emergency setting, Dr. Adrian takes an

approach based on generalization but in his office setting, he adopts a mixed method approach supportive of patient centeredness. Dr. Bob mostly and Dr. Jane partly adopt approaches based on biomedical models. Nurse Crystal respects and listens to the patients' stories and Nurse Wendy also advocates for her clients. Nurses Barb and Paula are more supportive of generalized and standardized approaches with all their clients.

As reported in the literature, narrative medicine provides the means to understand the personal connections between clinician and patient, the meaning of medical practice for physicians and their team, as well as the relation of medicine to the society (Charon, 2006a; Goyal et al., 2008). If clinicians were more aware of how they are enacting particular biomedical, embodied, blended, and narrative elements in their everyday clinical encounters, perhaps these encounters might align more authentically with the discourse of patient centeredness.

Unlike the physician and nurse participants of the study, the medical receptionists appeared to be more engaged in gaining patients' trust by working collaboratively and narratively in connecting with patients and establishing human relationships. Therefore, all the medical receptionists are located in the top of the fourth circle in the conceptual diagram.

Training programs designed for physicians, nurses, and medical receptionists who are in search of adopting a more patient-centered and narrative medicine approach would allow them to gain patients' trust and might produce more fruitful results in clinical encounters.

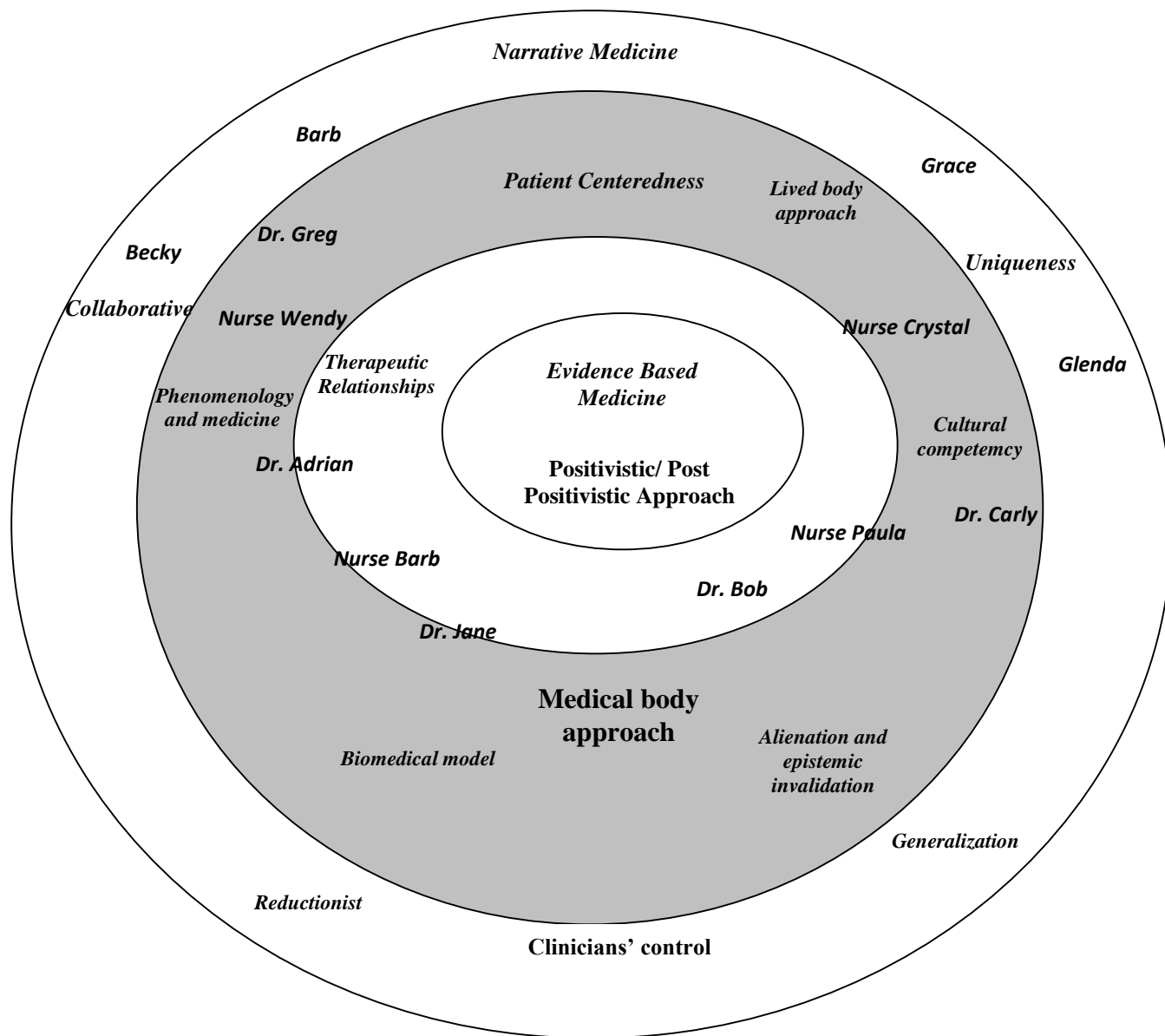


Figure 2. Participants' experiences of patient encounters.

As shown in Figure 2, participants closer to the center are taking a positivistic approach (i.e., Dr. Bob and Dr. Jane, Nurse Barb, and Nurse Paula). All the medical receptionists, however, are located closer to the edge of the diagram indicating the more positive and supportive encounters based on patient-centered approaches. In Figures 3 and 4, participants' experiences of narrative medicine are shown:

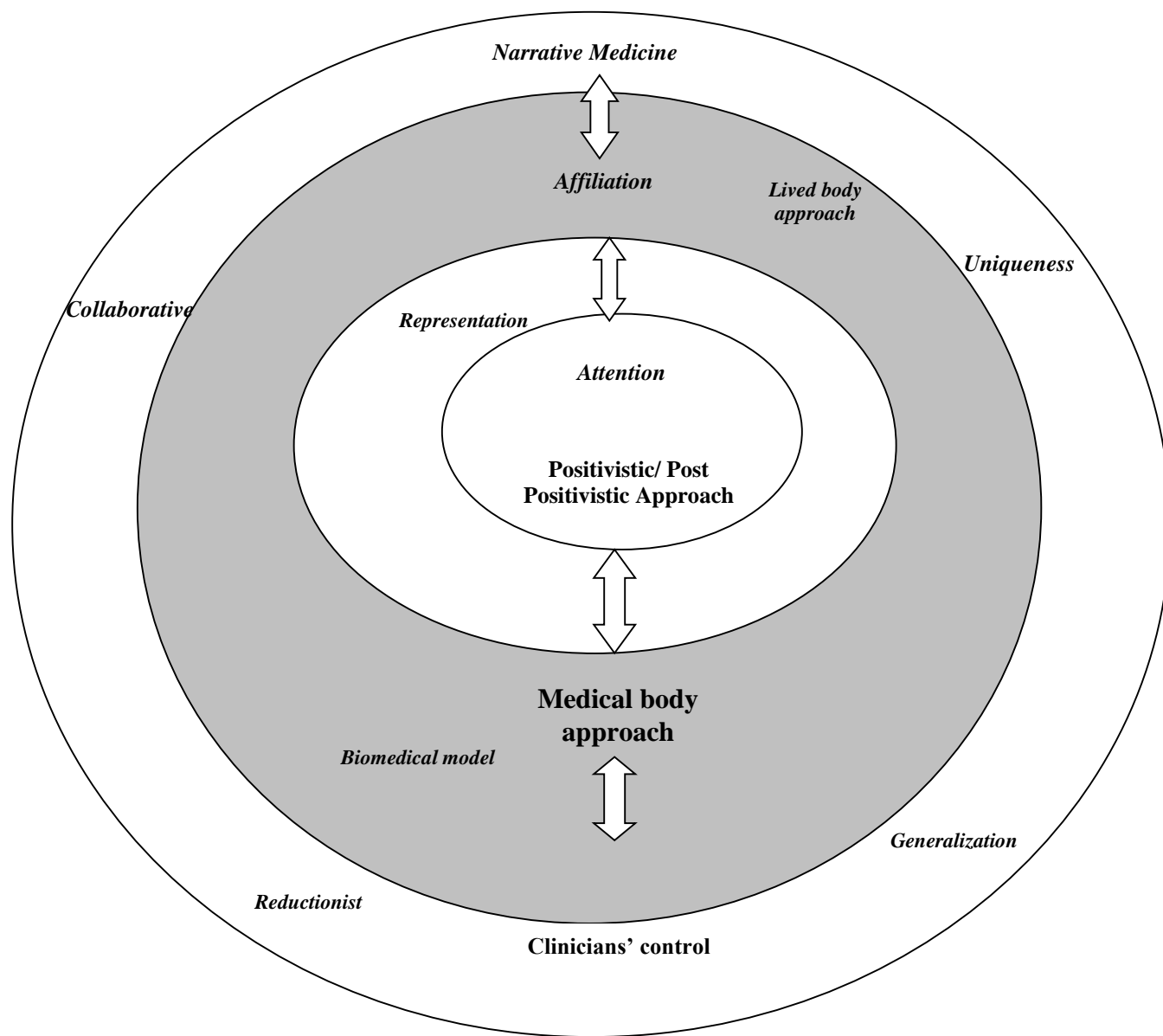


Figure 3. Participants' experiences of narrative medicine.

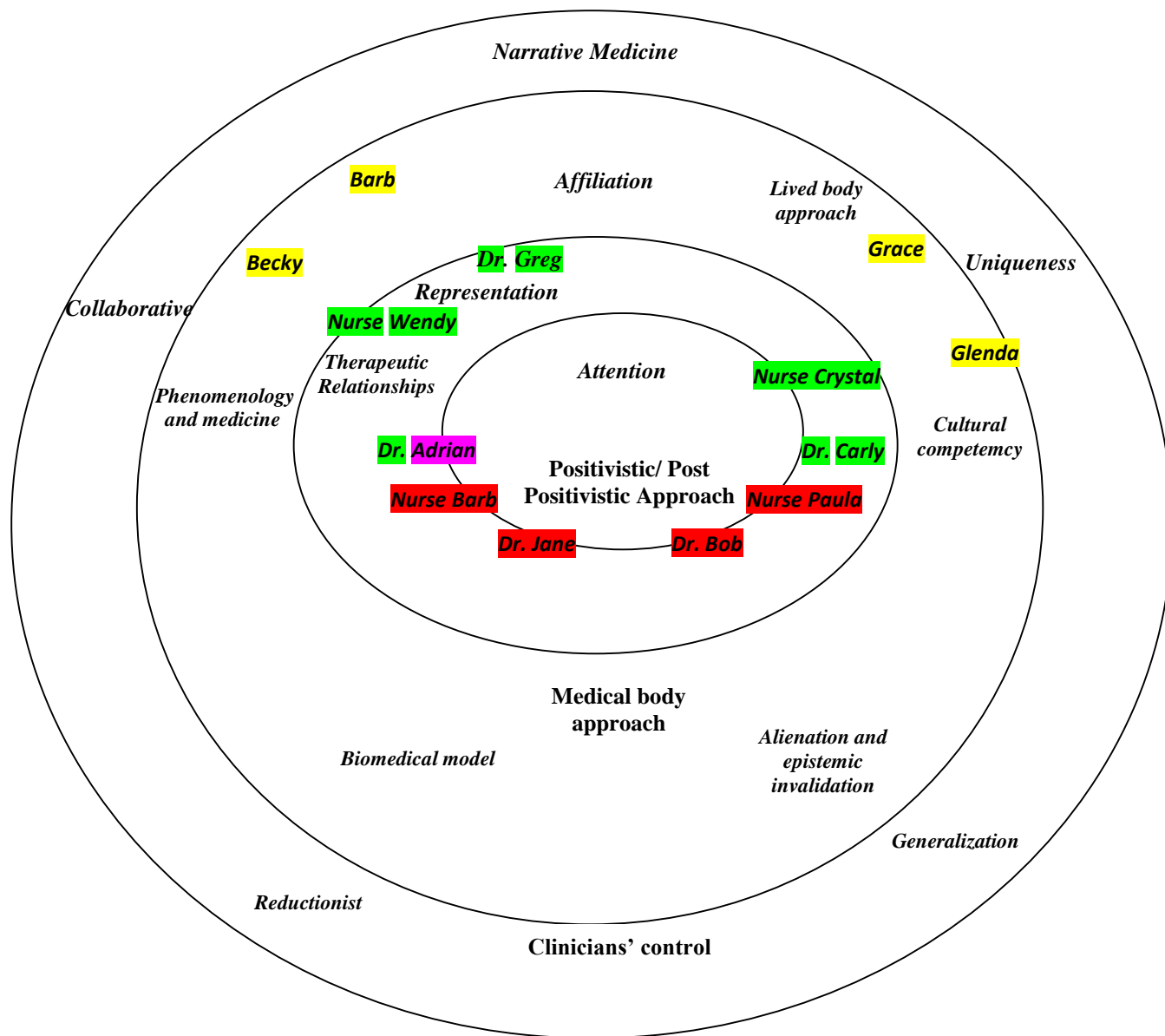


Figure 4. Participants' experiences of narrative medicine.

The following narrative arcs demonstrate the present study's participants' experiences in clinical encounters.

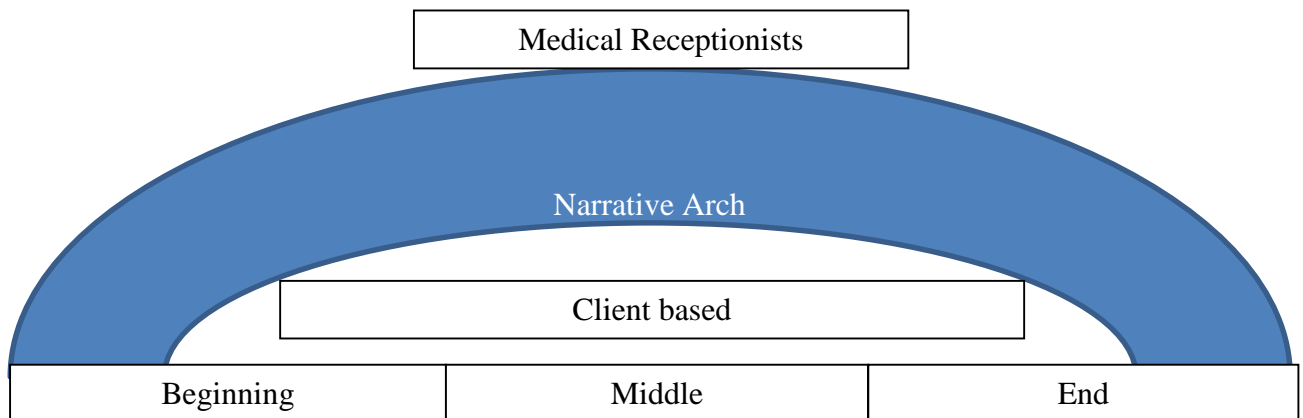


Figure 5. Narrative arc: Medical receptionists.

Certainly North American culture is heavily enacted in the cognitive and social authority of medicine (Wendell, 1996), and in that arena it is the physician whose cognitive and social authority has the most value. Perhaps without the status and pressure of such authority, medical receptionists are able to be more relaxed in their role as supporting characters more attentive to the person and process based dynamics of clinical encounters and interactions.

Even so, medical receptionists' roles are not without risks and pressures. The research findings by Arber and Sawyer (1981) indicate that medical receptionists were often involved in important decision making processes relating to patient care. One example was whether a patient received a house call from his/her physician or not, or whether the patient was contacted to book

a follow-up appointment as an alternative. A second example was the decision about whether the physician needed to immediately visit the patient's home or not based on the medical receptionist's understanding of the patient's medical condition.

Eisner and Britten (1999) reported the importance of the medical receptionist's role in making appointments for patients based on what was available. Medical receptionists expressed stress regarding making appointments for patients who did not comply with practice appointment rules. In addition, there were experiences of stress among medical receptionists from "difficult patients" when the available spot for the appointment did not fit the patient's demand expectations. Medical receptionists do not carry the burden of physician or nurse responsibilities. Yet, increasingly, and as evidenced by the participants in the study, medical receptionists in clinical contexts take on more responsibilities and are more involved in more aspects of patient care. As Ward and McMurray (2011) suggest, receptionists are a key part of the relationship between patients and physicians. We should be thinking of the relationship not as two-way, between physician and patient or nurse and patient, but as a three-way relationship among clinician, patient, and receptionist. Hewitt et al. (2009) reported that medical receptionists are expected to display three dominant competencies at all times: first, be administrative task oriented; second, be conventionally polite; and third, build rapport. In this study these translated into being process and person centered, and understanding the implications of "the supporting character role." The application of Mishler's (1984/1995) narrative strategies has allowed us to recognize the value of person (I, you, she-he), voice, time, consistency, continuity, and connectedness between discourse and behaviour in both medical receptionists' pre-service education and in medical receptionists' communication competencies. These tendencies seem to carry forward into their clinical practice. Further, these tendencies also allow the medical

receptionist to enact Charon's (2005, 2006a) narrative movements of attention, representation, and especially affiliation with patients, physicians, and nurses, thereby enacting the three-way relationship described by Ward and McMurray (2011). Further research should explore how consciously this relationship is both taught to and enacted by medical receptionists in clinical contexts.

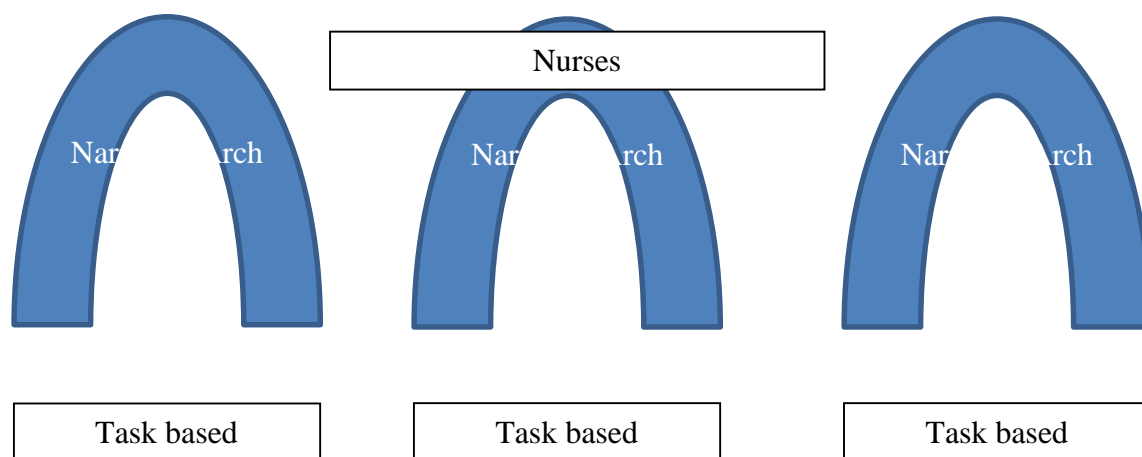


Figure 6. Narrative arc: Nurses.

The nurses' narrative arcs are necessarily shorter and more task focused, given the varying interpretations of the therapeutic relationship with patients, the constraints of various clinical contexts and collegial interactions between nurses, technicians, and physicians. Indeed, it seems that nurses are more task focused than medical receptionists given nurses' nomadic and episodic experiences with patients. In this study, interaction between nurses and patients was primarily about the procedures being done or to be done, and not about the patient as an

embodied human. This is not to suggest that the interactions are lacking in compassion or therapeutic support, but rather to propose that the accountability to representation (charting and record keeping) and attention (correctly administered time bound procedures) likely contributes to primary affiliation being with other nurses (rather than patients). Also, with nurses, as with physicians in this study, the context was a heavy determinant of interactive style, and as per Mishler's (1984/1995) narrative applications, of their role in the larger narrative. As we will also see in the physicians' narrative arc, expertise is not the issue, communication is.

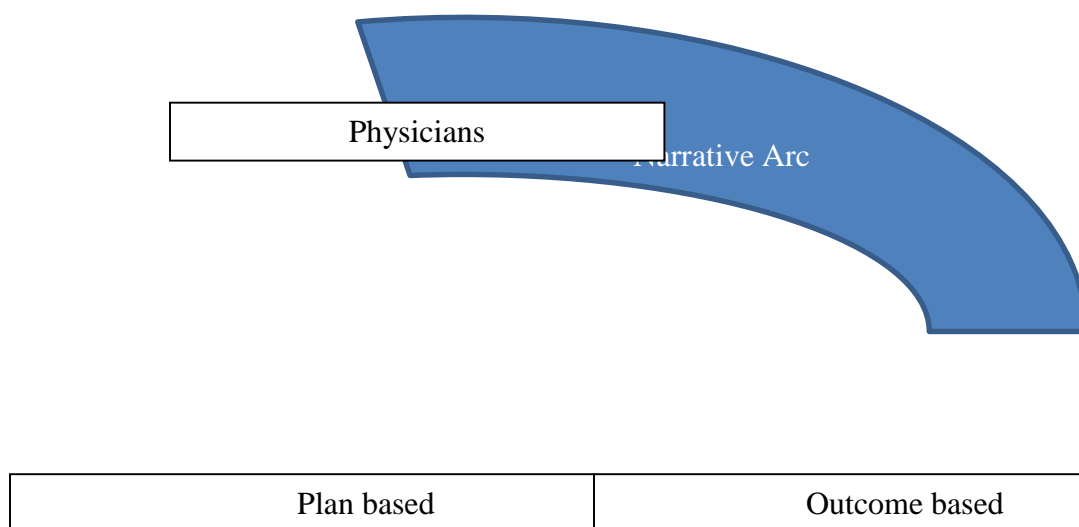


Figure 7. Narrative arc: Physicians.

As the reader can see, the physicians' narrative arc (in this study) does not have an actual situated beginning but rather extends toward an outcome, one that usually involves intense focus on and commitment to, a successful outcome, presumably with the patient's well-being as a strong motivator. As with nurses, the physicians in this study experienced context as a strong

influence on interaction style, and on their role in a larger narrative. Further, given the time, space, and discourse liberties in the physicians' accounts (and documents) it is not surprising that the Emergency Room (ER) context allows for the greatest "heroic" role freedom of enactment, while the office or the clinic accountability to attention and affiliation offer a lesser opportunity for this preferred narrative role. This in no way discounts the immense task and responsibility physicians have in their many contexts; it simply proposes that outcomes, more so than a particular situated individual patient, are the motivator for the shape of the narrative arc.

Charon (2005, 2006a) suggests that there are behaviours associated with patient-centered care that can be trained and enhanced with narrative strategies. Sharing one's notes with a patient, for example, or engaging with an attentive focus on a patient's history with disease or pain. Charon's (2005, 2006a) research also asserts that doing these behaviours takes no more time than procedural or discrete interactions with patients. Further, according to Warren et al. (2014), situated learning and narrative provide useful frameworks for strategies to encourage integration of theory and practice.

Perhaps if physicians, for a whole list of reasons, are not inclined or able to do these behaviours, then more team-based approaches to "narrative load distribution" within clinics or offices may be called for in both pre-service and professional development education. Or as Charon (2005, 2006a) and Warren et al. (2014) suggest, physicians in training need to become familiar with narrative as a planning, thinking, communicative, and reflective strategy.

The research questions are partly addressed in the narrative structure suggested by Mishler (1995) and in the themes described in the conceptual diagrams. The following is a direct discussion and response to the research questions. Following this, at the completion of Chapter

Five, the implications, strengths, and limitations of the study and suggestions for future research are discussed.

The research questions that guided the study were as follows:

1. a). What are physicians' and nurses' perceptions of the role of diagnostic and therapeutic encounters in patient care? Related to this what constitutes diagnostic encounters from the perspectives of physicians and nurses?
- b). What are medical receptionists' perceptions of the role of intake protocols in patient care?

Subquestions relating to a) and b) include:

- i. What interactive competencies do physicians and nurses believe are required/expected in diagnostic encounters?
 - ii. What interactive competencies do medical receptionists believe are required and expected of them in intake protocols?
 - iii. How might physicians, nurses and medical receptionists view these competencies' influence on the overall healing process?
2. For physicians
 - a. What interactive competencies are physicians expected to have?
 - b. What are Canadian patients' expectations from physicians trained in Canada?
 - c. What are Canadian patients' expectations from internationally trained physicians?
 - d. How are physicians expected to behave during diagnostic encounters?
 - e. What assumptions undergird these expectations?
 3. For nurses and healthcare facility medical receptionists

- a. What interactive competencies are the nurses and the healthcare medical receptionists supposed to have?
- b. What are some expectations of nurses and medical receptionists from the patients?
- c. What assumptions undergird these expectations?
- d. What kind of training do the nurses and the medical receptionists receive?

Research question one was to explore the study participants' perceptions of the role of diagnostic and therapeutic encounters in patient care. The role of diagnostic encounters for physician participants was different among the participants. For Dr. Greg, it was about gaining patients' trust, using everyday language, respecting their cultural beliefs, and above all educating patients so that they understand their conditions and follow his advice to bring about positive change in their health. For Dr. Carly, diagnostic encounters were about developing rapport with patients, listening to them, gaining their trust, helping them to open up, and the ability to help them with their conditions. For Dr. Adrian, it was about listening to his patients, gaining their trust, including them in decision making, and saving their lives. For Dr. Jane, it was about gaining their trust through effective communication. For Dr. Bob, the encounters were not diagnostic particularly in mental health but rather were based on helping patients' find a solution to their issues, connecting them to other specialists and resources.

The interactive competencies expected of physicians, nurses, and medical receptionists as well as the training they receive are described in the policy documents (see Findings Part III). Interactive competencies during diagnostic encounters appeared to be acknowledged and adopted by one participant of the study in particular (Dr. Greg) and by two other physicians (Dr. Carly and Dr. Adrian) to some extent. However, for the remaining two physicians (Dr. Jane and Dr.

Bob), it did not appear to play an important role in diagnostic encounters. From the six different qualities identified by the Royal College of Physicians and Surgeons of Canada (2011), the roles of a professional, scholar, and health advocate appeared to be present in most physician-patient encounters. In three physician participants' cases, the role of communicator and to some extent collaborator was also adopted in their approaches with patients. Diagnosing a patient's medical condition and treating it appeared to be the main focus during the encounters in most physician participants' cases but, in one case, it was also about explaining things in easy language, gaining patients' trust, and making them comfortable.

Some barriers undergirding these expectations included: time limitation, dealing with difficult patients, lack of available resources, inability to meet patients' expectations, lack of adequate training, dealing with patients with unknown medical conditions, and dealing with patients from diverse cultures. Three physicians talked about their inability to explore detailed subjective experiences with patients due to limited time during the interview. Drs. Adrian and Jane, for example, explained how they often have to do more of the talking as there is not enough time to listen to patients' detailed stories. Dr. Adrian talked about time limitation in particular in emergency situations, and added how the physician as well as the patient's family both feel under pressure and, hence, decisions are often made based on objective evidence. Dr. Bob talked about complexities in diagnosing mental health issues and patients withholding information during the interviews. Dr. Greg talked about dealing with patients with unknown or less described illnesses and complex medical conditions. However, as reported in the literature, allowing a narrative flow in the consultation does not necessarily require a lot of time (Charon, 2006a; Rollnick et al., 2008). Patient narratives are often limited by clinician's behaviours not by the elements or act of narration itself. Each physician's behaviour appeared to be different during

patient encounters. For Dr. Greg, having a friendly attitude, using everyday language, and not talking down to his patients appeared to be effective behaviour that contributed to his accomplishments. For Dr. Carly, asking open-ended questions, taking time in listening to patients who are often upset because their family physicians will not listen to them, helped gain her patients' trust. For Dr. Adrian, his behaviour during the interview depends on patients' education and belief in Western medicine. He also talked about the tendency to do most of the talking during the interview due to time limitations. Both Dr. Bob and Dr. Jane take similar approaches with all their patients, however, Dr. Jane also takes a different communicative approach with patients with severe health conditions (e.g., cancer).

The act of establishing a therapeutic relationship among most of the nurse participants of the study was through listening, developing rapport, taking a client-centered approach, awareness of communities' resources and ethical issues, as well as knowing job limitations. Each nurse participant's interactive style during therapeutic relationship appeared to be different. For two participants, it appeared to be mostly about showing empathy and advocating for their patients in addition to following a standardized protocol for establishing therapeutic relationships (Crystal and Wendy). For another nurse participant, it appeared to be about creating a nonjudgmental environment (Paula). And for the fourth nurse participant, it appeared to be about gaining the patient's trust and using a sense of humour (Barb). In all nurses' cases, following set protocols during patient encounters was central to achieving therapeutic goals for patients.

Some challenges that undergird these expectations include limited number of patient visits, patients with limited medical vocabulary, and patients who withhold information from their nurses. Again, constraints of time and scope of practice seem to be challenges, but more

awareness and training in the benefits of narrative flow might empower therapeutic relationship encounters.

In addition to the nurse participants of the study, two medical receptionists (Glenda and Nancy) also talked about being involved in therapeutic relationships with patients and talked about taking part in patient care which is not in their job description. Listening to patients' stories and helping them to narrow down the reason for their visit were additional tasks carried out by the medical receptionists. The above-mentioned medical receptionists appeared to be overinvolved and included in patient care beyond the expected competencies described in the Academy of Learning College Ontario website (2013). The role in intake protocols for the medical receptionists appeared to be about being empathetic to patients, gaining their trust, making them comfortable during their visits, listening to their stories, and making sure their experience of the physician visit is positive, likely for the physician as well as the patient. Interactive competencies described by the medical receptionists in the study included attentive listening to a patient's complaints, gaining a patient's trust, being empathetic to patients, being able to multitask, and giving priority to the patient standing in front of them. Some challenges that undergird these competencies included dealing with aggressive clients, as well with as clients who were "angry" and "abusive." Another challenge was dealing with immigrant patients who go to their visit without an interpreter

In summary, for physicians the role of diagnostic encounters is gaining patients' trust and getting the information they need to save patients' lives or improve the patients' quality of life. For nurses, the role of diagnostic encounters is to create the possibility for a therapeutic relationship with the patient and to acquire and deliver information relevant for ongoing treatment and community support. For medical receptionists, the role of intake protocols is to

prepare the patient for the encounters with the next clinician and to provide the patient with attentive, active listening and follow-up interactions.

Research question two was about physicians and nurses beliefs about required/expected interactive competencies in diagnostic encounters. Physicians indicated that technical, clinical, and evidence-based competencies are required (this is supported by the policy documents) and that translation of technical concepts into everyday language is expected in communication with patients.

The interactive competencies expected of both physicians trained in Canada and physicians trained outside Canada (IMGs) appeared to be similar in many areas such as timeliness, having standard technical skills supportive of biomedical approaches, having good verbal and nonverbal communication, and having intellectual-conceptual and quantitative abilities. However, understanding cultural competencies and having high standards of excellence, knowledge, and commitment to clinical care are additional competencies expected of IMGs (see latent content analysis CCC website).

Nurses in this study indicate that using standardized protocols and maintaining a nonjudgmental demeanor is required (supported by policy docs) and that advocacy for and empathy with patients are expected. Medical receptionists indicate that friendliness and an ability to multitask in a courteous and efficient manner are required (this is supported by policy docs.) and that listening to patients, making patients comfortable, and narrowing down the reasons for their visits are expected.

As indicated in the literature, cultural competence can ensure healthcare professionals' preparedness in providing quality care to diverse populations. Therefore, healthcare professionals are required to receive training in cultural competence to effectively address racial disparities in

healthcare (Beach et al., 2005; Betancourt, 2004; Betancourt & Green, 2010).

Similar to the literature, all the study participants acknowledged the importance of cultural competencies in patients' care. Among the physician participants, Dr. Greg and Dr. Carly acknowledged the importance of cultural competence and better patient results. Dr. Adrian also talked about the importance of understanding patients from different religions in addition to different cultures. However, the other two physicians took similar approaches with all their patients. Dr. Bob, for example, acknowledged the challenges of dealing with patients of the opposite sex, but cultural competence for him was about patients who spoke English as a second language. Nurse Crystal emphasized the importance of cultural competence in community nursing and Nurse Wendy talked about it as an important factor contributing to patients' health. As documented in the literature, the role of culture is crucial in regards to individuals' beliefs and responses to illness and healing (Huff & Yasharpour, 2008). Healthcare professionals have to learn more about the effect of culture on communication in the medical setting, particularly in regards to a patient-centered approach that emphasizes joint decision making (Kim, 2002). Differences in belief system, perceptions of appropriate treatment, and expectations about interaction in interviewing obscure effective patient-clinician communication. For example Crystal talked about the emphasis on assertiveness in her approach with patients. However, cultures that discourage assertive behaviour (e. g., Eastern cultures), make it difficult for patients from that culture to engage collaboratively in therapeutic relationships with their clinicians. Knowing how culture influences patients' communication and their engagement in the therapeutic relationship is important for developing culturally sensitive interviewing models to build collaborative medical practice (Kim, 2002).

Similar to physicians and nurses, the medical receptionists also acknowledged the

importance of cultural competence in patients' care. Grace, for example, recommends the importance of bringing an interpreter to their appointments for new immigrants and patients with language barriers. Clinicians should be able to establish effective interpersonal working relationships that supersede cultural differences and make sense of why things happen and connect thoughts through motives or cause (Charon, 2006a). In addition to ensuring technical, quantitative, and academic competencies, communication and cultural competence training programs should be developed to help clinicians understand interactive competencies to help meet the healthcare needs of diverse communities.

As indicated in the literature and shown in the manifest content analysis of the physician policy document, medical training is primarily concerned with developing technical and scientific skills that help clinicians in diagnosing diseases (Mishler, 1984; Timmermans & Angell, 2012). Dr. Greg and Dr. Adrian reflected on the idea that medical school does acknowledge the importance of interviewing skills for physicians but does not provide specific training on physician-patient communication. Dr. Greg explained that the focus for most physicians in interviewing patients is on completeness of the interview such as past history, family history, medical history, social history, etc., rather than an unfolding of an individual patient's complete embodied experience of illness. Dr. Bob, for example, mentioned that his patients often do not provide specific answers to his questions. His checklist approach does not account for embodied accounts of illness, but rather elicits discrete facts from patients who are trying to communicate their distress. The communication disconnect is not only between physician and patient but also between the actual strategies occurring to give and extract information. Communication is not the ground to be assumed but a goal to be sought.

The medical receptionists talked about having excellent communication skills as an

important aspect of their jobs. Some nurses and physicians acknowledged the importance of communication during encounters with patients. The two physicians with the most clinical training and experiences showed interest in further training in communication and cultural competencies and the two physicians with comparatively less clinical experience showed no interest in further training in communication and/or cultural competence. Dr. Bob recommended management training programs for physicians and Dr. Adrian recommended community exposure programs for physicians in their final year of training.

Among the nurses, two participants showed interest in taking further training courses specific to their current fields of practice not focused on communication and/or cultural competencies skills. The other two nurses said they already had enough training and did not show interest in further training. Among the medical receptionists, except one who was going to retire soon, all participants showed interest in further training.

Regarding how might physicians, nurses, and medical receptionists view interactive competencies' influence on the overall healing process. The physicians in this study recognize the value of effective communication and patients' stories; however, they feel that the time constraints and the application of their expertise do not give them the luxury of spending their time this way. The patient's successful outcome is more dependent on physician expertise than on physician communication. The nurses in this study also recognize the value of effective communication and the patients' stories and attempt to incorporate opportunities for meaningful patient interaction within the constraints of therapeutic relationships and time based protocols. The medical receptionists in this study recognize the importance of patient comfort and satisfaction as well as the patients' need to express themselves and their concerns. These

receptionists also understand how handling these patient issues contributes to overall clinic functioning and quality patient outcomes.

Conclusions

While more traditional analyses and conceptual approaches to these data sets might have yielded similar patterns and themes, the narrative frameworks offered by Charon (2005, 2006a) and Mishler (1984/1995) allowed for a more robust examination of how narrative structures function in many levels of medical and clinical education and in clinical practice. Further, they allowed for more exploration of the interactive and communicative competencies that are taken for granted but not necessarily given the attention they warrant. Communication is the goal, not the ground. As part of this goal, implementing Charon's (2005, 2006a) recommendations about member checking with patients and developing better analytical skills during the diagnostic interview would allow clinicians to be time conscious and still give the patient and his/her narrative the attention they both deserve. Further, an acknowledgement of cultural competence as a skill set that clinicians need whether they are immigrant or otherwise would also enhance the patient's interactive experience and could very likely positively influence the healing journey.

The results of the study showed that participants with the least education (medical receptionists) appeared to be more committed to empathy by working narratively in connecting with patients and establishing human relationships as well as in listening to patients' stories and providing support to narrow down the reason for their visit. The diagnostic and intake success stories' regarding patient clinical encounters for other study participants were focused on a timely securing of patient information, with some nebulous acknowledgement of rapport and empathy. However, decision making was based solely on clinicians' understanding of patients'

conditions. As reported in the literature (Charon 2005, 2006a), narrative can bridge the gap between evidence and large scale randomized, controlled studies and the medical art of applying this knowledge to individual patients. In medical practice, aspects of both search for cause and effect and embodied descriptions of patients' unique experience should be sought together. Equal attention should be paid to subjective experiences of illness and objective dimensions of the patient's experience. Clearly, these competencies need more practice and attention before the physician or nurse moves into a professionally oriented practice.

As reported in the literature, measuring medical receptionists' role in therapeutic relationships with patients is yet to be documented (Patterson et al., 2005). This study's results showed that in addition to doing clerical tasks, the medical receptionist participants in the study were involved in patient assessment, monitoring, therapeutic interventions, as well as, in one receptionist's case, directly involved in patient care by assisting with minor surgical procedures.

As shown in the review of literature from Toombs (2001) collection, physicians' illness experiences changed their understanding of their professional role and their relation to their patients. Similarly, literature from Charon (2005, 2006a) indicated that physicians' awareness of their own and their patients' narratives have a similar impact. Narratives can have a healing effect, both in the listening to the stories of others and in telling one's own story; therefore, the illness narrative has to be understood and seen as being part of both the patient's and the clinician's life stories (Charon, 2006a; Goyal et al., 2008). The importance of narrative in empowering patients and contributing in their treatment plan has been largely underemphasized by at least half of the study participants, with some burgeoning awareness present in the remaining participants. Recent work by Arntfield, Slesar, Dickson, and Charon (2013) supports a narrative component in the fourth year curriculum, and preresidency of medical students while

more recent work by Charon (2013) suggests that more awareness of and focus on the interrelational and team-based character of medical practice be included prior to residency in medical education.

The comparative analysis (transcripts, policy document, and CCC website) has disclosed important consistencies relating to narrative elements, educational standards, training programs, and technical and quantitative competencies expected of clinicians. There is a need to create a practical, patient-centered (supportive of embodiment) driven service that places a patient at the center of service and delivery and transforms the current, traditional, clinician control, paternalistic approach to healthcare services. The results of the study show that patient-centeredness is present at the discourse level of representation but needs to be learned and employed effectively at the embodied and enacted levels to improve patient care.

Strengths and Limitations of the Study

The use of narrative design to illustrate participants' perceptions and experiences in their everyday encounters in a rich and descriptive way helps to convey a sense of realness and immediacy to the nature of each individual's experience.

As reported in the literature, there is an emphasis on the need for research that incorporates the voices of clinicians (Eveleigh et al., 2012; Morgan, 2008). Therefore, the insight from this study into the participants' experiences of patient encounters will contribute to the literature on the topic.

The following is a discussion of some particular techniques for establishing trustworthiness suggested by Lincoln and Guba (1985) that added to the strength of the study. Patton (1997) defined credibility as, "a complex notion that includes the perceived accuracy, fairness, and believability of the evaluation" (p. 250). In addition, credibility can be established,

in part, by stating clearly the procedures by which the study was conducted, the data were analyzed, and the conclusions were drawn (Patton, 1990). To ensure credibility, the study was based on multiple comparisons between the participants' (similarities and differences in their patient encounters). Reflections on the experiences of patient encounters among the participants in their own words (verbatim quotes) added to the credibility of this study. Using multiple sources, such as interview transcripts from 13 participants that were selected through purposeful sampling technique, including a wide range of participants from different medical disciplines, specialities, and age groups with different experiences, provided rich description of their experiences in their encounters with patients. Three different sources of data as well as three diverse groups of participants were included in the study that shed light on experiences of physicians, nurses, and medical receptionists in patient encounters.

Multiple data analysis strategies (thematic analysis, Mishler's and Charon's narrative approaches and manifest and latent content analysis) added to the credibility of the study. In addition, the bi-weekly debriefing through meeting with my dissertation supervisor, international and national conference presentations, and doing lectures added to the credibility of the study. Through collaborative sessions with my dissertation supervisor, alternative data analysis approaches have drawn the researcher's attention to flaws in data analysis and helped me become more aware of alternative suggestions and new insights. The process of the research proposal was done through the review of a committee of academics. Peer debriefing sessions with my dissertation supervisor and committee members provided an external check of the research process (Lincoln & Guba, 1985). Constructive feedback from my advisory committee helped with bringing fresh perspective, refined the data analysis methods used, and strengthened the results sections. Conference presentations were done in different narrative inquiry related

sessions, conferences on medical ethics, phenomenology conferences, and the Mapping The New Knowledge conference. Lectures were done for qualitative research methods courses. Reflective commentaries were added on the researcher's background and initial impression of the data collection process (Merriam, 2009). Information regarding the researcher's background, qualifications, and experience has been made explicit to further increase the credibility of the study (Patton, 2002). In addition, the process of recruiting the study participants has also been reflected on. All the audio files have been accurately transcribed to ensure accuracy of the data. Thick descriptions of the phenomenon and findings under study also promoted credibility of the study (Merriam, 2009; Patton, 2002). To ensure the degree of congruency of data, a comparison of the results was made with similar literature.

Like all qualitative studies, the results represent the current study participants' (physicians', nurses', and medical receptionists' experiences) of patient encounters and may not be representative of other physicians, nurses, and medical receptionists. The time commitment required and difficulties in recruiting physicians and nurses also made it difficult to work with a large sample. The use of three data sets and multiple levels of analysis made for a complex study that might be somewhat dense and inaccessible for readers outside the discipline and, hence, might be considered as another limitation of the study. Even though the conceptual frameworks used helped in building texts and invaluable sources from different disciplines, they may also have limited the interpretation of the study based on the concepts reviewed. Further, different researchers may have dissimilar conceptions of the same phenomenon. That said, the levels of analyses and use of theoretical frameworks in the service of analyses contributed to strengthening the overall triangulated strategies (i.e., using analytical and theoretical triangulation in addition to sample and data collection triangulation).

The findings were reported in a thick and descriptive way that can add to transferability of the results to similar situations as described by Merriam (2009) and Patton (2002). However, the degree of transferability will depend on identified similarities between the two contexts. Sufficient contextual information is provided to enable readers to transfer the results of this study to similar situations (Holloway & Wheeler, 2010). Similarly, a broad description of the data is provided to allow readers to have a deep understanding of the arguments made and, therefore, compare the results with other similar studies. All the information on the number of participants, in supporting the recruitment process of the study, the data collection and analysis methods, number and length of the data collection sessions, and geographical locations in which data were collected have been provided.

Other strengths of the study included dependability, which was addressed through a systematic process of data analysis using the QRS software NVivo 10. The process of designing the study, collecting and analysing data was reported in detail. The use of NVivo10 software ensured the steps taken in data analysis were detailed. The in-depth coverage of the research design, data collection, and analysis helped to develop a transparent description of the methods. As reported in the literature, the use of computer assisted software, such as NVivo, can help with establishing an audit trail and enhancing the trustworthiness of the research (Sinkovics et al., 2008; Yin, 2003, 2009). The use of NVivo 10 enabled the researcher to demonstrate the integrity, robustness, and therefore, trustworthiness of the study (Richards, 1999). Further, it helped the research process become more transparent and open to closer scrutiny (Richards, 1999; Sinkovics & Alfoldi, 2012).

Confirmability of the study was strengthened by referencing the results of the study to literature and findings by other authors (Guba & Lincoln, 1989). Further, confirmability was

supported by providing a record of the inquiry process (Lincoln & Guba, 1985). The findings of the study are grounded in experiences and perceptions of the research participants. Triangulation of the study was also supported by inclusion of three diverse groups of participants including physicians, nurses, and medical receptionists. In addition, three different sources of data and forms of data analysis including interviews analysis, website analysis and policy document analysis were used to support the argument made (Creswell, 2013; Merriam, 2009). The researcher's background has been made explicit in the reflexivity section. The reasons for adopting a narrative approach as a best design for the study and details on methodological choices have been explained in detail. When needed, reflective commentaries were made. Different diagrams were provided to show the processes of data collection and analysis.

The followings general aspects of trustworthiness for narrative inquiry suggested by Creswell (2013) were also addressed in the study.

- The study was focused on several individuals' narratives
- The data collected were related to significant issues in clinical patient encounters
- The three different narrative structures suggested by Mishler (1995) helped explore participants' experiences in terms of temporality, textual consistency and application to the larger society/ culture.
- The data were analyzed using three different approaches including open, axial, and selective coding, manifest and latent analysis, as well as Mishler's (1995) narrative structure and Charon's (2005, 2006a) narrative thematics.
- The researcher provided details on reflexivity.

Recommendations and Implications

Despite the limitations noted above, the findings presented in this study represent a first glimpse of the experience of physicians, nurses, and medical receptionists after 2 decades of a patient-centeredness paradigm. Beyond the quality of the patient-physician, patient-nurse, and patient-medical receptionist relationships, the role of other healthcare professionals is also crucial in determining the quality of care provided. Physician assistants, nurse practitioners, medical technicians, and other health professionals can make important contributions to ongoing patient care. Therefore, exploring their perspectives on patient care is recommended for future research. Further, more focused attention on the cultural aspects of patient care would also allow more emphasis to be placed on future research so that “foreign bodies” are not subjected to stereotypical or tokenistic treatment in clinics and other healthcare facilities. To my knowledge, no study has formally addressed patient-medical receptionist therapeutic relationships; therefore, exploring a holistic perspective focused on interdisciplinary approaches will substantially contribute to the body of knowledge surrounding patient care. Further, overt and covert studies can provide a deeper understanding of clinicians in different medical disciplines: physician assistants’, nurses’, nurse practitioners’, and medical technicians’ experiences, challenges and needs. Through application of the results of such studies, medical training programs based on narrative medicine and patient-centeredness paradigms can become more responsive and effective in fulfilling the lived therapeutic needs of patients.

As suggested by Norgaard et al. (2012) and supported by the results of this study, increases in patient satisfaction will be seen when their healthcare providers as a team participate in training courses focused on patient-centered care as opposed to only physician, nurse, and

nurse assistant. Team based preparation would also enhance clinic atmosphere, and would contribute more meaningful attention, representation, and affiliation.

Contributions from this Study

Moving forward in narrative medicine Charon (2006a, 2013) suggests training in patient-centered care not be limited to physicians, nurses, and social workers, but also to a team of professionals involved in patient care including medical receptionists. A medical team-based training will allow for more coordinated patient-centered care and mitigate errors within complex domains. As a group of healthcare professionals including medical receptionists provide care to the same patients, they become a team working with one common goal while relying upon information and action from each other. Therefore, depending on the various healthcare settings, such as a walk-in clinic, family medicine practice, acute care, general hospitals, speciality hospitals, and ambulatory center care, integration of a team of healthcare providers in training programs, such as communication, collaboration and professional development specific to patient-centered care, could enhance system effectiveness and increase patient satisfaction.

Given that more family practice and community based clinics are organized around team based service delivery and diversified distribution of expertise, it may be that while reflection on and awareness of personal/professional narratives can benefit everyone in healthcare delivery, that these competencies may also be more appropriately enacted by thoughtfully considered distribution of these capacities. Since timeliness continues to be the most prevalent stressor for physicians, and, increasingly, nurses, then other healthcare team members will be necessarily called upon to be more involved in the direct contact, interactive and interrelational elements of patient care. This should be a significant focus for future policy which influences not only

physicians and nurses' education and competency, but also clinical team members' education and competency.

The study results also suggest that patient-centered care will be safeguarded when all dimensions of patient-centered care, including attention to embodiment, are included in the core competencies of clinicians. Policy makers need to emphasize competencies based on embodiment as equally valued sources of information as objective ones, as opposed to simply recognizing them. It is crucial that flexible policies with maximum options for clinicians should be in place that can respond to individuals with unknown and less known medical conditions as opposed to tight time bounded outcome based encounters. Patients' satisfaction and good consult results are correlated with good intercollegial communication and collaboration. Clinicians who adopt a friendly and reassuring manner during their consults with patients are appreciated by their patients (Ammentorp & Kofoed, 2010).

As this study's findings and discussion have made abundantly clear, the patient's sense of well-being and being cared about are as important a focus as task and outcomes. How the health care team keeps this insight at the forefront will influence not only the trajectory of the patient's narrative (from the intake protocol through to the treatment and the denouement of the healing journey) but also the quality of all the intertwining narratives involved in patient-centered care.

“The patient will never care about how much you know, until they know how much you care” (Terry Canale in his American Academy of Orthopaedic Surgeons Vice Presidential Address; Tongue, Epps, & Forese, 2005).

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Appendix A

Interview Guide Physicians

1. Can you tell me a bit about yourself?
2. What is a typical week like for you?
3. Tell me about your work experience from the time you first started till present.
4. How would you describe your job?
 - a. What did you learn from doing that?
 - b. What did you like/dislike about your experience?
5. Describe a situation in which you were successful.
6. What do you believe is the purpose of a diagnostic interview?
7. Tell me about some of the challenges you have experienced during diagnostic interviews?
 - a. What major challenge have you had to deal with recently?
 - b. Please describe a situation where you had to see a patient multiple times before making a final diagnosis?
8. If you had to choose your career path over again, what one thing would you change?
9. What accomplishments during diagnostic interviews have given you the most satisfaction in your career?
 - a. How satisfied are you with your communication skills with your patients?
 - b. What are your strengths and weaknesses in interaction with patients?
 - c. How does diversity influence your communication style, if at all?
10. Describe the aspects of your job which contribute to
 - a. Joy, satisfaction, happiness
 - b. Sadness
 - c. Frustration, irritation
11. What methods do you use in identifying patients' health condition and making diagnosis?
12. How has your professional training prepared you for your job? What changes would you like to see happen?
13. Do you have any plans for taking any further training? How much training do you think you will need to become more productive in diagnostic interviews?
14. What qualities do you feel a successful physician should have?
15. How can the support physicians provide bring improvements in patients' health and quality of life?

Is there anything else I should know? Is there anything you would like to add?

Thank you for participating in this interview.

Appendix B

Interview Guide Nurses

Can you tell me a bit about yourself?

1. Tell me about your experience of dealing with patients.
2. How would you describe your typical day at work?
3. What is a typical week like for you?
4. Describe a situation in which you were successful?
5. What skills do you think you need to be successful in your job?
6. What accomplishments in patients' care have given you the most satisfaction?
7. Tell me about some of the challenges you have experienced at work when interviewing patients?
8. What major challenge have you had to deal with recently?
9. Please describe a conflict situation where you had to talk to your manager about it?
10. What are your strengths and weaknesses in interacting with patients?
11. How has your professional training prepared you for your job?
12. Do you have any plans for taking any further training? How much training do you think you will need to become more productive in your work?

Is there anything else I should know? Is there anything you would like to add?

Thank you for participating in this interview.

Appendix C

Interview Guide Medical Receptionists

Can you tell me a bit about yourself?

1. Tell me about your experience of dealing with patients.
2. How would you describe your typical day at work?
3. What is a typical week like for you?
4. Describe a situation in which you were successful?
5. What skills do you think you need to be successful in your job?
6. What accomplishments during intake protocols have given you the most satisfaction?
7. Tell me about some of the challenges you have experienced at work when interviewing patients?
8. What major challenge have you had to deal with recently?
9. Please describe a conflict situation where you had to talk to your manager about it?
10. What are your strengths and weaknesses in interacting with patients?
11. How has your professional training prepared you for your job?
12. Do you have any plans for taking any further training? How much training do you think you will need to become more productive in your work?

Is there anything else I should know? Is there anything you would like to add?

Thank you for participating in this interview.