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**More Than a Diagnosis: Enabling Medical Students to Understand
and Address the Patient's Psychological Needs**

A Capstone Project Submitted in Partial Fulfillment of the
Requirements of the Renée Crown University Honors Program at
Syracuse University

Paige Jarmuz
Candidate for BA Degree
and Renée Crown University Honors
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Honors Capstone Project in Child and Family Studies

Capstone Project Advisor: - Colleen Baish

Capstone Project Reader: - Dr. Elizabeth Nelsen

Honors Director: Stephen Kuusisto, Director

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Abstract

Patient-centered care is a framework for providing medical services in a humanistic, patient-focused manner. Although there are many proposed dimensions, it is simply the perspective of caring for the patient as a person with psychosocial needs, not just a diagnosis. Extensive literature review was completed to gain understanding of the application of patient-centered care in undergraduate medical education, as well as the evidence behind implementing patient-centered methods. Aspects of patient-centered care may be taught in many medical schools but their importance warrants a stronger focus. Incorporating aspects of patient-centered care is not only most ethical, but also is also associated with improved patient outcomes and patient satisfaction. Because measures of patient satisfaction are newly considered in Medicare reimbursements, there are financial implications as well. A wide range of strategies is used to teach patient-centered principles, but no single method is widely accepted or considered best practices. For best results, cultural changes in medical institutions supporting psychosocial awareness are necessary.

Table of Contents

Abstract.....	ii
Executive Summary.....	iv
Chapter 1: Introduction.....	1
The Current State of Medicine.....	1
Defining Patient-Centered Care.....	3
Chapter 2: Communication Skills.....	6
Patient-Centered Communication.....	7
Shared Decision-Making.....	10
Honesty.....	12
Chapter 3: Cultural Competence.....	16
Cultural Humility.....	18
Chapter 4: Empathy.....	22
Chapter 5: Future Research.....	27
Chapter 6: Application of Patient-Centered Care.....	29
Family Advisory Councils.....	29
Patient-Centered Medical Homes.....	31
Hospitality Elements in Health Care.....	32
Chapter 7: Conclusion.....	35
Works Cited.....	37

Executive Summary

The following document is a descriptive analysis of patient-centered care and its integration into the curriculum of undergraduate medical education. Furthermore, implications and strategies for integrating patient-centered care into medical practice are discussed. In order to do this, I conducted an extensive literature review with the support of two health professionals: Colleen Baish, a Child-Life Specialist and Professor of Practice, and Dr. Elizabeth Nelsen, Assistant Professor of Pediatrics at Upstate Medical University. Overall, my goal was to provide evidence that patient-centered care should be further integrated into undergraduate medical education.

Patient-centered care is a humanistic view of the patient as a “unique human being” (Beach, Rosner, Cooper, Duggan & Shatzer, 2007). Rather than a sole focus on the biomedical aspects of practicing medicine, patient-centered care adopts a biopsychosocial perspective (Saha, Beach & Cooper, 2008). In other words, within a patient-centered care model, patients are recognized “in the context of their own social worlds, listened to, informed, respected, and involved in their care ... during their health care journey” (Epstein & Street, 2011).

Because there are many variations on the overall conceptual framework, I chose to focus on a number of important aspects. First, I will define patient-centered communication and explain strategies for teaching it to medical students, and the concept of shared decision-making. In

addition, I will propose the importance of honesty as a key component to patient-centered communication. Second, I describe cultural competence and contrast it with cultural humility. The current minority population in the United States is estimated to surpass 50% by 2056, so it is increasingly important for physicians to treat patients in a culturally mindful manner (Champaneria & Axtell, 2004). Third, I discuss the importance of empathy to the patient-centered clinical relationship and explain a few strategies for teaching empathy to medical students.

Following this discussion, I outline a number of challenges to more widespread implementation and ways in which medical institutions have integrated patient-centered ideals into their culture. This section includes exploration of the culture of the Mayo Clinic, a medical system renowned for its quality of care, and the use of Family Advisory Councils in hospitals to incorporate input from patients and their families.

This capstone is motivated by my own personal experience. Although I am not yet a physician, I have had the opportunity to see patient-centered care (and lack thereof) as a patient, volunteer, and a practicum student. I have spent summers interacting with pediatric patients in the Emergency Department of my local hospital and as a counselor at Double H Ranch, a camp for kids with chronic illnesses. My degree in Child and Family Studies has inspired me to balance the science of medicine, with the personal side, including psychosocial needs and development. Through my experiences, I believe it is necessary to teach

medical students not only the necessary didactic aspects of medicine, but also how to behave as a doctor.

While patient-centered care has grown in acceptance and application in recent years, I argue that it should be further integrated into undergraduate medical curriculum, as well as the culture of medical institutions. Patient-centered care has powerful implications in improving patient satisfaction and medical outcomes. A call to action is relevant now due to the pressures on physicians to cut costs, improve quality, and care for an increased population of insured patients under the Affordable Care Act.

Schools that do not explicitly add an experiential or didactic lesson on aspects of patient-centered care rely on students to obtain knowledge of proper patient care. However, in lieu of deficits in care provided by existing physicians, medical students cannot adequately learn through shadowing alone. A study of clinical clerks “found 98% of students heard physicians refer to patients in a derogatory manner” and “61% witnessed what they believed to be unethical behaviour by other medical team members” (Mahmood, 2011).

Many medical schools have devised unique strategies for teaching future physicians to be empathetic and supportive caregivers. The rationale for implementing a patient-centered culture and teaching it in medical school is multifaceted. First, it is simply an ethical strategy of caring for patients. Tending to others as a physician is a “moral enterprise”

at its core and the doctor-patient relationship provides support during vulnerable and significant times in people's lives (Goold & Lipkin, 1999). However, medical institutions are businesses and thus decision-making is rarely propelled by morality alone. Thus, it is important to note evidence of improvements in quality of care and financial benefits.

Personally speaking, this paper has inspired future work toward further integrating patient-centered care into undergraduate medical education. As a future physician, this work has focused my own idea of the kind of relationship I want to have with my patients. Patient-centered care has the ability to strengthen the physician-patient relationship—an important aspect of garnering trust and providing treatment.

Chapter 1

Introduction

The Current State of Medicine

Medicine today is more complex than it has ever been before. Over a hundred specialties have resulted from our continually growing knowledge of the human body (Association of American Medical Colleges, 2012). Just a hundred years ago, a physician's role was all encompassing, and doctors relied mostly on nurses for assistance. Yet we find ourselves in an era that necessitates partnership with a variety of health professionals, such as nurse anesthetists, physician assistants, respiratory therapists and more. All the while, the intense pressures of limiting costs, meeting the country's demand for specialized care and broadening access to primary care impact the education of future physicians. Medical students are expected to absorb and digest volumes of complex scientific information, along with learning how to communicate with others and carry themselves in a professional manner. Too often, this results in future physicians who are more concerned with obtaining clinical knowledge than learning how to behave as a doctor.

Amid these pressures, it is no wonder that we have lost sight of the earlier days of strong patient-doctor relationships that yielded compliance, healing, empowerment, and support (Goold & Lipkin, 1999). What has happened to the concept of physicians as healers? We may not be able to pinpoint where the path shifted, but future generations of doctors can be taught to revitalize the patient-physician relationship and bring the focus back to the patient. The emphasis on creating a physician of integrity who can communicate and treat patients with empathy pales in comparison when medical schools are concerned about students' scores on science-based licensing exams (Chen, 2013). Concerns with increasing efficiency have led to heightened pressure for time, leading to less time spent on the psychosocial concerns of the patient, less accurate and incomplete data, less trust, less healing, more errors, and more waste (Goold & Lipkin, 1999).

The basic construct of medical education has largely remained static since the early 1900s (Educating Physicians, 2010, p. 10). In years prior, the curriculum comprised only eight months of lectures. Incredibly, there was no patient interaction or laboratory experience, and all students graduated with an M.D. degree, regardless of academic performance (Educating Physicians, 2010, p.11). However, in the early 1900s, schools reconstructed their curriculum to include two years of basic science lectures and two years of supervised clinical experience in a teaching hospital (Educating Physicians, 2010, p.11).

The aim of this paper is to argue the significance of patient-centered care to the physician-patient relationship, and of its necessity in undergraduate medical education. Evidence from the recent literature will support this assertion. I begin with an overview of patient-centered care and its proposed characteristics. In Chapter One, I present the concept of patient-centered communication and discuss strategies to improve the communication skills of students. In Chapter Two, I explain the significance of cultural competence and cultural humility, and explain their difference in perspective. In Chapter Three, I review the research on empathy deficits in medical school years and present case studies that propose remedies. In Chapter Four I explain the gaps in literature that need to be filled in order to expand acceptance of patient-centered care. In addition, I offer examples of patient-centered care integrated into the culture of medical institutions, as care must be improved across all medical institutions to provide a wide-spread effect, not solely in medical education.

Defining Patient-centered Care

Patient-centered care is a humanistic concept that seeks to understand each patient as a “unique human being” (Beach, Rosner, Cooper, Duggan, & Shatzer, 2007). More broadly, it is care that is “respectful of and responsive to individual patient preferences, needs, and values, and ensur[es] that patient values guide all clinical decisions” (Institute of Medicine, 2001, p. 6). Within this model, one must look at the

patient holistically. Patient-centered care is a stark contrast to physician-centered and disease-centered actions in the clinical context (Epstein, Fiscella, Lesser & Stange, 2010). In other words, physicians are flexible in their approach and care is centered on the patient's needs and concerns.

There are many variations on the overall conceptual framework of the patient-centered perspective (Saha, Beach & Cooper, 2008). I propose that it is best understood when the dimensions outlined by Stewart, and Mead and Bower are combined. Stewart's six aspects of patient-centered care are "1) exploring the illness experience, 2) understanding the whole person, 3) finding common ground regarding management, 4) incorporating prevention and health promotion, 5) enhancing the doctor-patient relationship, and 6) being realistic about personal limitations" (Saha et al., 2008). Mead and Bower introduced a similar framework with five dimensions: "1) adopting the biopsychosocial (as opposed to narrowly biomedical) perspective; 2) understanding the patient as a person in his or her own right, not merely as a body with an illness; 3) sharing power and responsibility between the doctor and the patient; 4) building a therapeutic alliance; and 5) understanding the doctor as a person, not merely as a skilled technician" (Saha et al., 2008). While Mead and Bower focused their definition on communication and interaction with patients, Stewart viewed patient centeredness within a broader context of patient care (Saha et al., 2008). More simply, patients are recognized "in the context of their

own social worlds, listened to, informed, respected, and involved in their care ... during their health care journey” (Epstein & Street, 2011).

While the culture of medicine has been described as authoritative where the physician is the end-all be-all, patient-centered medicine views the patient as a consumer (Epstein & Street, 2011). By reframing medical care using patient-centered principles, patient satisfaction and personalization of care take precedence. This doesn't mean acquiescing to patients' requests or leaving them solely responsible for every decision, but rather empowering them as a partner to work collaboratively toward positive health outcomes and improved quality of life (Epstein et al., 2010).

Many agree with early advocates of patient-centered medicine that the moral implications should be reason enough to enact such practices (Epstein Values). The doctor-patient relationship is central during vulnerable and significant times in people's lives; thus, providing care is a “moral enterprise” (Goold & Lipkin, 1999). However, hospitals and clinics are propelled by concerns of finances and outcomes. Only recently have reimbursements been tied to patient satisfaction (Rau, 2011). As part of the Affordable Care Act, Medicare is currently withholding one percent of its payments to hospitals to be allocated as bonuses to hospitals scoring above average on several patient satisfaction measures (Rau, 2011). Further, patient-centered care is noted to yield reduced diagnostic testing costs in primary care, and to reduce the likelihood of physicians and

surgeons being sued (Epstein et al., 2010). With dependable evidence of care improvements and savings, patient-centered care may gain further acceptance nation-wide. Accordingly, in the next chapter I will examine the evidence supporting the incorporation of patient-centered communication skills into medical education.

Chapter 2

Communication Skills

The goals of patient-centered care depend largely on sufficient communication skills (Frampton et al., n.d.; Epstein et al., 2010). The three functions in a clinical interview are to gather information, develop and maintain rapport, and communicate information. These aspects are inextricably linked. For example, a patient who is anxious with a student-physician is unable to voice concerns or understand information clearly. A patient who is not trusting may not fully disclose information efficiently. Therefore the relationship directly impacts the patient's satisfaction and quality of care (Goold & Lipkin, 1999).

Although values of respect and strong ethics are outwardly espoused upon, it has become clear that a "hidden curriculum" exists. The formal curriculum of medical school emphasizes "interdisciplinary practice, collegiality, and patient-centered care," yet the majority of lessons on professionalism occur when students observe clinical faculty and their behavior is in stark contrast to the professional ideals of medicine. A study of clinical clerks "found 98% of students heard physicians refer to patients in a derogatory manner" and "61% witnessed

what they believed to be unethical behaviour by other medical team members”. In light of these findings, it is imperative to emphasize to future physicians that what they are like is just as significant as what they know (Mahmood, 2011). This becomes difficult to implement when inadequate role models may be contributing to an unsuitable learning environment. Conversely, a positive role model has been emphasized as a key contributor to the acquisition of caring skills in students (Maheux et al., 2000).

Patient-Centered Communication

Patient-centered communication is one of the cornerstones of patient-centered care. It is virtually impossible to implement patient-centered care if physicians are not mindful of the ways in which they communicate with patients—especially during history taking and the decision-making process of treatment. This need is reflected in the curricular objectives of numerous medical schools, and in the competencies required for groups such as the Accreditation Council for Graduate Medical Education. Physicians who apply patient-centered communication seek to include the patient in medical treatment in a more humanistic and respectful way and obtain a better understanding of the patient as an individual (Boyle, Dwinnell & Platt, 2005). According to Goold and colleagues, the actual amount of time spent with a physician is less critical than the perception by patients that they are the physician’s sole focus and that they are accurately heard (1999)

Innovative communication skills curriculum. While many schools may incorporate communication into their curriculum, the University of Colorado School of Medicine (CUSOM) has devised a technique that has been incorporated into its three-year longitudinal clinical skills course since 2001. The method—called Invite, Listen, and Summarize (ILS)—is a patient-centered communication technique that emphasizes the skills of open-ended inquiry, empathy, and engagement in gathering data from patients. Students practice their skills with four standardized patients in a series of diverse, videotaped clinical encounters. Interdisciplinary tutors from the community lead small groups to reflect and discuss the interaction after each of the focused lessons (Boyle et al., 2005).

The framework of ILS is quite simple. First, open-ended questions *invite* the patient to explain their story adequately. Within the ILS model, moments to get to know the patient, his or her role within the family, and possible psychosocial dimensions are included in this step, with prompts such as “tell me a little about yourself”. This humanizing question can especially serve to comfort new patients, but also sets the stage for rapport-building. Throughout the exchange, students are reminded to *listen* and to display active listening skills such as “nodding appropriately, maintaining eye contact, and avoiding distractions such as too much charting or computer use during the conversation.” Lastly, students are instructed to *summarize* the patient’s story and perspective. Not only does

this offer an opportunity to verify and reflect the student's understanding, but it also provides a "therapeutic value of a sense of being understood" (Boyle et al., 2005). The literature suggests that strengthening the physician-patient relationship on dimensions such as general communication, overall satisfaction, physician trust, and dialogue regarding adherence, can each contribute to a patient's adherence to treatment (Schneider, Kaplan, Greenfield, Li & Wilson, 2004).

This program is unique in that it is spread throughout the first two years of medical school. Twice a year, small groups meet for four weeks at a time, for four hours per session. As students move through the program, the exercises grow progressively more complex, while the format remains consistent. During the fall of the first year, students focus on the most basic ILS skills. In the winter of first year, the empathic connection is emphasized, with a stronger focus on the patient's feelings, ideas, and values. The second-year curriculum introduces students to difficult scenarios. In the fall, the lessons illustrate an inquiry-based approach to behavior modification issues, which may allow students to understand barriers to adherence and increase the likelihood of change. The final session delves further into challenging patients with four key scenarios: "an angry patient, a victim of domestic violence, an anxious, overly talkative patient, and a patient with reams of Internet material who has an incorrect self-diagnosis." By practicing such difficult situations, which students will undoubtedly encounter in the future, they will be

prepared to approach them constructively and with less anxiety. The course closes each year with two videotaped standardized patient encounters that are reviewed one-on-one with a faculty member. Since the implementation of this program, a few clinical clerkships within the CUSOM have built on ILS skills within their own standardized patient exercises (Boyle et al., 2005).

One key benefit of the program is its use of standardized patients. A majority of medical schools currently use standardized patients to teach the taking of patient histories and physical exam skills, thereby minimizing any implementation cost (May, Park & Lee, 2009). The faculty tutors are not financially compensated, but rather participate simply for personal reward and the opportunity to advance their own interviewing techniques. Tutors “come from a variety of professions, including community and faculty physicians, psychologists, attorneys, social workers, and educators.” To address the issue that some preceptors may not necessarily model the behaviors CUSOM is striving to teach, they have partnered with the largest malpractice provider in the state of Colorado to facilitate an ILS workshop for their preceptors. In exchange for their participation, preceptors receive points toward a reduced malpractice premium (Boyle et al, 2005).

Shared Decision-Making

A key aspect of providing the best care to patients is including them in the decision-making process among treatment options. Patients

need to be involved in determining the care most compatible with their preferences and values—whether the intervention is considered standard or not. For example, in chronically ill geriatric populations, some patients may choose to extend life expectancy at the cost of decreasing quality of life; others may prioritize quality of life. During shared decision-making, both parties share information: the clinician offers options and describes their risks and benefits, and the patient expresses his or her concerns or goals. Each participant thus earns a better understanding of the significant factors and shares responsibility in the treatment decision (Barry & Edgman-Levitan, 2012). Addressing decision-making in this collaborative way may pose a challenge to physicians, as their advice may be in direct conflict with the patient’s values. For example, a patient may object to a blood transfusion due to religious preferences and his decision must be respected despite its opposition with standard medical practice.

It is essential to collaborate throughout the decision-making process, as neither party is fully equipped to unilaterally evaluate options. Within the field of psychology, patients are notoriously fallible in their predictions of the impact and “duration of negative emotions” in response to loss or change. In other words, they overestimate the decrease in quality of life that they will experience. Psychologists have described this gap for paraplegia, visual impairment, heart disease, asthma, dialysis, and living with a colostomy. Given this gap in understanding, it is the duty of the

physician to quell patients' concerns and reframe them in a realistic light (Halpern & Arnold, 2008).

Shared decision-making has the ability to truly improve outcomes for patients with chronic illness. In a study focusing on adherence to asthma controller medications, shared decision-making yielded greater medication adherence and significantly better clinical outcomes (i.e., improved lung function, low rescue medication use, improved asthma-related quality of life, and health care use) in the year following, when compared with unilateral clinician decision-making. The target population was composed of adult patients whose asthma was not well managed, as determined by evidence such as overuse of rescue medication, or a recent asthma-related emergency room visit or hospitalization. Within the shared decision-making model, both the clinician and patient were cited as sharing pertinent information, expressing treatment preferences, weighing the options, and agreeing on the treatment (Wilson et al., 2010).

A shared decision-making approach contrasts starkly with the historically unidirectional approach of generations of doctors past. Thus, in order for shared decision-making to be fully integrated into widespread practice, it ought to be taught explicitly within the undergraduate curriculum. Two Australian universities tested medical students, physiotherapy and occupational therapy students in an hour-long small-group intervention composed of a facilitated critique of a five-step framework, strategies, and a pre-recorded role-play. The brief intervention

was found to be effective in improving students' ability, attitude toward, and confidence in, facilitating shared decision-making (Hoffmann, Bennett, Tomsett, Hons & Del Mar, 2013). Because this is a newer concept, few studies have measured the long-term outcomes.

Honesty

Considering its documented importance to the physician-patient relationship, I propose that honesty be included as a core component of patient-centered communication. Medical errors are inevitable, but injurious consequences can be lessened or avoided through apology. Ethical standards established by the American College of Physicians and the American Medical Association require the disclosure of errors, and the Joint Commission on the Accreditation of Hospital Organizations obliges the disclosure of unanticipated outcomes to patients. Though a simple response, an apology has the power to restore trust, reduce negative emotional reactions like anger, and reduce antagonistic responses. For an apology to be effective, responsibility must be taken—this is suggested to increase the impact of an apology over similar expressions of sympathy. Equally important is that the expression of apology be sincerely extended. Otherwise, patients can perceive insincerity and react with indignation toward the physician (Robbenolt, 2009).

Possibly the most commonly referenced barrier to disclosure and apology by physicians is the fear of litigation, although a correlation between the possibility of litigation and willingness to disclose has not

been identified. Generally speaking, physicians are apt to considerably overestimate the chance of being sued. Moreover, research has indicated that the majority of injured patients do not seek prosecution against the physician in question. There is compelling evidence that apologies tend to decrease blame and make injured patients less likely to file lawsuits and more inclined to settle when they do. Studies of litigants find that patients are compelled to investigate what happened and prevent future injury—both desires can be fulfilled by a proper apology that includes a plan of action for the prevention of similar errors in the future. In fact, in a study of error disclosure by surgeons to standardized patients, only 8% assured the patient the case would be investigated to prevent injury in the future (Gallagher, Waterman, Ebers, Fraser & Levinson, 2003).

Factors besides the threat of litigation serve as barriers to disclosure. Gallagher and colleagues propose that “the norms, values, and practices that constitute the culture of medicine” may outweigh the role of liability in discouraging disclosure and apologies (Gallagher et al., 2003). Within medicine, there is an overwhelming expectation for self-regulation and perfection—from oneself, peers, and patients—that can hamper the likelihood of apology and public accountability. Yet more generally, the vulnerability of admitting that an error has occurred and holding oneself responsible for it can be embarrassing and damaging to one’s pride, regardless of profession. It is difficult to preserve one’s sense of

competence, while also accepting that one has brought forth suffering in a patient (Robbennolt, 2009).

Finally, a perceived lack of skill in disclosing errors and apologizing for them may hinder many physicians. Some medical schools have incorporated training on error disclosure and apology into the curriculum (Robbennolt, 2009). Halbach and Sullivan led a study of third-year medical students at New York Medical College in Valhalla, New York, during their family medicine clerkships. Students completed a four-hour curriculum that included interactive discussion, relevant literature, a videotaped conversation with a standardized patient, and a small-group debriefing session conducted by a family physician. 89% of students agreed or strongly agreed that “the opportunity to present an error to a patient increased my confidence about discussing this issue with patients.” Targeting students during clerkship appears appropriate as 28% of them had already “witnessed a colleague make a medical error” (Halbach & Sullivan, 2005).

Communication may be the defining factor to the success of the physician-patient relationship. Incorporating improved listening skills, shared decision-making, and honesty into student practice will support improved patient outcomes. With patients of different cultures, communication skills can prove to be more complex, as I will address in Chapter 3.

Chapter 3

Cultural Competence

As American communities become even more diverse, it is increasingly important to be mindful of cultural factors that may play into the treatment options and psychosocial needs of patients. The current minority population in the United States is estimated to surpass 50% by 2056. The proportion of minority physicians and medical students, however, has experienced a commensurate increase (Champaneria & Axtell, 2004). Cultural differences between physician and patient can prove to be an obstacle to effective communication—leading to patient dissatisfaction and poor adherence to treatment plans (Teal & Street, 2009). Furthermore, the Institute of Medicine has determined that racial and ethnic minorities in the United States receive poorer-quality health care and have substandard health outcomes compared to their white counterparts. These disparities seem to stem from the quality of physician-patient communication and attitudes toward racial/ethnic minority patients (Beach et al., 2007). However, a culturally competent physician can proactively identify and resolve sociocultural differences through patient-centered communication (Teal & Street, 2009). Cultural competence has

been described as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals that enable effective work in cross-cultural situations” (Paez, Allen, Carson & Cooper, 2008).

According to Teal and Street, the four crucial components of culturally competent medical communication are strong communication skills, “situational awareness, adaptability, and knowledge about core cultural issues.” *Situational awareness* refers to heeding patient cues and expectations, which serves to address confusion and resolve misunderstandings due to physician-patient cultural divergence. *Adaptability* concerns a physician’s ability to be flexible in managing a variety of patients and tailoring his or her communication to accommodate the unique needs and characteristics to yield equitable care. The main premise of understanding the core cultural issues is to be able to identify the social determinants of health, as well as assessing “situations, interactions, and behaviors that have potential for cross-cultural misunderstanding.” Such issues “include beliefs about gender roles, physician authority, physical space, family roles, beliefs or practices about death, religious beliefs, and explanations of disease” (Teal & Street, 2009).

Recognizing core cultural issues can enable the physician-patient partnership to overcome obstacles to care, such as “limited English proficiency, low health literacy, fears (mistreatment, avoidance of stigmatizing or grave diagnoses and deportation), beliefs that preempt

treatment (e.g. mistrust, and aversion to medications, invasive treatment and preventive care), lack of knowledge (understanding of health, management of acute and chronic illness, and Western healthcare delivery norms and practices), lack of resources (e.g. insurance, funds for out-of-pocket expenses and transportation) and inability to leave their place of employment to attend medical appointments” (Paez et al., 2008).

Medical schools have answered the need for cultural awareness with two general strategies: cultural immersion programs and cultural competence curricula. Cultural competence curricula use a case-based, small group design to discuss “the core cultural issues and health beliefs of various ethnic groups, complementary and alternative medicine, language barriers, substance abuse, racism, and cross-cultural interviewing skills” (Champaneria & Axtell, 2004).

A review of the recent literature shows little evidence of a positive correlation between cultural competency training and improved patient outcomes, yet high quality research in this area has been limited (Lie, Lee-Ray, Gomez, Bereknyei & Braddock, 2010) Further research may be required to determine whether certain types of training may be superior to others in producing results, and therefore, be implemented as best practices. I assert that regardless of any outcome improvements—or lack thereof—acting in a way that treats patients of all cultures with respect and humility should be a priority in patient care.

Cultural Humility. While cultural competence is commonly integrated into medical school curriculums, recent literature features the concept of “cultural humility” to complement cultural competence. The literature on cultural humility defines a number of fundamental elements, including self-reflection on professionals’ personal assumptions and beliefs; seeking to understand patients; partnership building; and the recognition that cultural humility is a life-long process (Chang et al., 2012).

The very language of cultural competence suggests a sense of final accomplishment, as if upon completion of a course, one is definitively prepared to act in a culturally appropriate manner in every situation for the remainder of his or her life. Could one ever truly be competent in a culture besides one’s own? Furthermore, fixating on the attributes of cultural groups can unwittingly encourage physician dependence on stereotypes as the foundation for intercultural interactions (Teal & Street, 2009). Cultural humility, on the other hand, maintains the perspective that cultural awareness is a dynamic and life-long process of learning from the patient. Culturally appropriate medical training requires more than “responding to a set of static cultural customs, values, and beliefs” (Chang, 2012). Rather, the multifaceted dimensions of culture that can be intertwined and ambiguous must be considered for the diverse population of the United States. Due to intermarriage and differing extents of acculturation, culture exists in a full spectrum. Through cultural competency training models,

professionals may use Chinese culture as a guide for how a Chinese patient may think, feel, or respond; yet intrinsic diversity within Chinese-American immigrant groups may be overlooked. A model of cultural humility counters the over-simplification of the patient experience (Chang, 2012) and recognizes that culturally competent communication is a skill that improves incrementally as a physician sees patients from a variety of backgrounds over time (Teal & Street, 2009).

At an interpersonal level, the emphases of patient-centered and culturally competent methods overlap. Both systems feature an alignment of educational materials, information, and services to meet the individual needs and preferences of patients (Saha et al., 2008). In a sense, because culture frames the lifestyles and beliefs involved with patients' risk of health conditions and their response to illness (Chang et al., 2012), I assert that patient-centered care ideals will produce culturally appropriate care as a byproduct. Patient-centered communication is characterized by communication that "elicits and understand the patient's perspective and social context" (Teal & Street, 2009). Further, Beach et al. propose that patient-centered care could reduce the occurrence of stereotyping through the notion that each patient should be viewed as "a unique human being" (2007).

Thus culturally mindful care should be a byproduct of any patient-centered interaction. In fact, a study at the Johns Hopkins University School of Medicine examined students' interactions in standardized

patient encounters. While interacting with African American standardized patients, students with patient-centered attitudes performed significantly better than students without patient-centered attitudes in interpersonal skills, history taking, and counseling. Yet all students performed similarly with white standardized patients (Beach et al, 2007). This study suggests that ethnic differences may be bridged by the integration of a patient-centered care model.

There is an incredible amount of room to lessen the impact of ethnic differences on health outcomes. Disparities have been noted across the spectrum of health, for both adults and pediatric patients, including in mortality rates, health status, chronic diseases, special health care needs, quality of care, and organ transplantation. Mortality-rate disparities have been documented for children in all 4 major US racial/ethnic minority groups when compared to mortality of white children, including from acute lymphoblastic leukemia, and after congenital heart defect surgery (Flores & The Committee on Pediatric Research, 2010). A study comparing pain management received by pediatric patients in the Emergency Department presenting with severe (7-10 points) abdominal pain found that non-Hispanic black patients were less likely to receive analgesia than non-Hispanic white patients (Johnson et al., 2013).

Given the varied ethnic backgrounds in the United States, cultural humility is increasingly important. The status quo of accepting health

disparities as a reality must end. We instead need to address them head-on by educating students.

Chapter 4

Empathy

In order to fully integrate patient-centered care into practice, a physician should be empathetic. The Association of American Medical Colleges underscores the value of empathy in their Learning Objectives for Medical School Education, “physicians must be compassionate and empathetic in caring for patients” (Stepien & Baernstein, 2006). Because empathy is such an ambiguous concept, researchers have defined it in three ways. Some researchers have described empathy as a cognitive attribute that primarily involves understanding of another person’s concerns. Others have described empathy as an affective characteristic, suggesting that it predominantly requires feeling another person’s pain and distress. A third group defines empathy as both cognitive and affective. In a clinical context, empathy primarily acts as a cognitive attribute (Bayne, 2011).

It is important here to note the distinction between sympathy and empathy. While empathy aims to understand the patients’ experiences, a sympathetic physician is more concerned with feeling patients’ experiences. In other words, empathy is the ability to “sense the client’s

anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it” (Rogers, 1957). While empathy has a positive impact on personal growth and clinical outcomes, sympathy is correlated with career burnout and compassion fatigue (Hojat et al., 2009). Although many medical programs have incorporated empathy training to one degree or another, there is insufficient literature determining a standard practice for competent instruction.

A positive relationship between physicians’ empathy and diabetic patients’ clinical outcomes has been established. It is thought that empathy sets the foundation for mutual understanding, communication, and trust within a strong physician-patient relationship. In turn, patients’ needs are better aligned with treatment plans, leading to greater adherence. Patients of physicians with high empathy scores were 56% more likely to have good control of their hemoglobin A1c levels than were patients of physicians with low empathy scores (Hojat, Louis, Markham, Wender, Rabinowitz & Gonnella, 2011).

In recent years, research has consistently documented a decrease in empathy in medical students. At Jefferson Medical College in Philadelphia, two classes of medical students were studied throughout undergraduate medical education. In their third year, 78% of students experienced a significant decline in empathy scores. This timing was unexpected, as the third year traditionally marks the beginning of clinical clerkships, so students are not as focused on didactic learning. Between the third year

and graduation, there is little change. The erosion of empathy has been attributed to numerous factors, including a lack of strong role models, a high volume of knowledge to master, and inadequate sleep. However, as previously mentioned, the hidden curriculum of modern medicine reinforces and models emotional detachment (Hojat et al., 2009).

Unfortunately, ameliorating the many possible factors contributing to a deterioration of empathy is beyond the scope of this discussion. The cognitive nature of empathy, however, implies that it may be taught as a skill within medical education. Yet some programs choose not to include structured opportunities for empathy training, expecting instead that observing physicians within clerkships and residencies will foster empathy. This omission could be—in part—due to the view of humanistic objectives as ancillary by the general culture of medicine, when compared to goals of learning about disease, anatomy, and treatment (Bayne, 2011). On the other hand, many different curricular interventions have been used to teach and reinforce empathy. Some schools have taken a creative arts approach to the issue, including writing essays reflecting on students' experiences or adopting the patient's point of view, and facilitating dramatic role-playing.

A variety of programs have used first-hand or vicarious experiences to increase empathy in students. Many programs choose to have students directly encounter the patient's point of view, but vary widely in length of time. Mullen and colleagues of Glasgow University

Medical School facilitated student visits in the homes of chronically ill patients. Each student had one visit and interviewed the patient about their experience (Mullen, Nicolson & Cotton, 2010). As part of its 6-week primary care clerkship, the Weill Cornell Medical College facilitated student participation in house calls with a geriatrics team. In these experiences, students observed the physical and psychosocial effects of disease in a personalized context (Yuen, Breckman, Adelman, Capello, LoFaso & Reid, 2006).

Other programs choose to provide simulated experiences—often focused on certain disorders or conditions—to enable students to gain insight into on patients’ perspectives. Bunn and Terpstra had third-year psychiatry clerkship students listen to 40-minute simulated auditory hallucinations through personal headphones. While listening to this simulation, they participated in simplified cognitive tests of memory, concentration, and other tasks. They later were asked to walk around the medical center and attempt to interact with peers as they would normally. A paired sample t-test indicated a statistically significant increase in empathy in the test group (Bunn & Terpstra, 2009).

According to a widespread systematic review of curriculum focused on empathy, the strongest gains in empathy were within a qualitative and quantitative study in Virginia led by mental health professionals. Small groups of third-year students in a family medicine clerkship participated in didactic instruction and experiential practice.

Facilitators demonstrated effective verbal and non-verbal skills (i.e., open-ended questions, summarizing, and active listening) and led discussions of possible empathic responses to examples of patient statements. Within the group, students were also asked to reflect on their observations of physicians and themselves with patients in the past week. This allowed for an opportunity to note differences between empathic and non-empathic interactions, as well to examine challenges to providing empathic care. Many students expressed frustration with patients who showed disrespect or disregard for students' time and efforts. Participants reflected on the perceived restrictions of utilizing empathic care in the midst of "long hours, pressure from supervisors, and the sheer number of patients to be seen." Broader changes may be needed to achieve larger gains in empathy across generations of physicians (Batt-Rawden, Chisholm, Anton & Flickinger, 2013).

The training in the Virginia study lasted two weeks, combined with pre- and post-tests with standardized patients. Standardized patients used the Consultation and Relational Empathy (CARE) scale to most accurately gauge the empathy that a real patient would sense in the interaction. After the training program, student scores on the CARE measure increased significantly. Unlike many interventions, this study utilized mental health professionals who could use training techniques from the counseling field. Because such lessons are integral to psychology, the medical professions

could benefit from collaboration with the mental health professions (Batt-Rawden et al., 2013).

From the literature it is clear that empathy aids in supporting a strong physician-patient relationship in addition to being an aspect of patient-centered care. Considering that empathy deterioration is said to continue into the residency years, it is important to determine whether effects of related trainings can be sustained over time. Further studies on empathy within attending and fellow physicians may reveal a deficit as well.

Chapter 5

Future Research

To advance the agenda of expanding acceptance and application of patient-centered care in medical education and medical institutions, further research may be necessary. A number of studies that have been subject to methodological flaws, including small sample sizes, single institutions, and a lack of control groups or long-term follow-up (Batt-Rawden et al., 2013). It is imperative that future studies involve multiple schools and include randomized, controlled, long-term trials to evaluate the effectiveness and longevity of interventions. Patient-centered curriculum additions have been well received by students at institutions where this has already been implemented (Batt-Rawden et al., 2013; Boyle et al., 2005).

Many studies confound behaviors with outcomes, leading to misleading results. If a patient is satisfied with the physician's communication skills, yet his or her diabetes control worsens, has patient-centered care been accomplished? While clinical outcomes are important to medical practice, researchers need to emphasize the proximal outcomes that may alleviate a patient's anxiety associated with disease and uncertainty (Epstein & Street, 2011).

Also, a patient isn't always the best judge of whether an interaction is patient-centered. Sometimes patients visit their doctor in search of a prescription, when it may be medically unnecessary. Submitting to a patient's request may lead to patient satisfaction, yet physicians who prescribe inappropriately should not be described as patient-centered. It is evident that patients often overestimate the extent to which they have been informed about and understand their illness. The discrepancy between high patient satisfaction with care, and poor understanding and participation in care, is strongest for populations with poor literacy and fluency, cognitive impairment, and social disadvantage. Meanwhile, these populations may arguably have the greatest need for patient-centered communication (Epstein & Street, 2011).

Chapter 6:

Implementation

Many medical institutions are applying patient-centered principles to various aspects of patient care in order to improve the patient's experience. First, Family Advisory Councils provide hospitals with insight to the patient and family's perspective. Second, Patient-Centered Medical Homes provide a strategy for coordinating care to improve patient outcomes. Lastly, hospitals such as the Mayo Clinic incorporate elements of hospitality to create a patient-focused atmosphere.

Family Advisory Councils

Because the needs and desires of patients are the main focus of patient-centered care, many facilities and institutions have moved beyond the status quo to construct Family Advisory Councils (or Family Advisory Boards). The Family Advisory Council (FAC) has proved to be an effective mode of obtaining patient and family input the development of institutional policies and programs. Support from FACs can range from "specialty councils" to general changes aimed at improving patient and family satisfaction. For example, Children's Mercy Hospital in Kansas City, Missouri, developed its Latino Advisory Board in 2008 in response

to changing demographics. The Latino Advisory Board has facilitated projects for bilingual signage, Spanish radio health messaging, and Spanish orientation videos for patients and families. Some pediatric hospitals recognize that teens have different needs than other patients, and have therefore created specialty councils for that population. The Teen Advisory Committee at Children's Hospital Boston, for example, has designed orientation videos for teen patients, created a web site, assisted in conducting a research project on teen involvement in decision-making, and helped design an inpatient teen activity room (Ahmann & Dokken, 2012).

In both residency and medical school, family and patients are often used as educators. According to the Association of American Medical Colleges, 80 of the 142 medical schools in the United States and Canada disclosed using patients and families as teachers in undergraduate medical education (Earp, French & Gilkey, 2008). One group of family faculty at the University of Pennsylvania School of Medicine developed curricular materials for a course called "Doctoring 101" and served as teachers of the required course. In this course, students learn to understand illness from the perspective of patients and families by examining topics such as delivering difficult news, living with illness and disability, and death and dying. Family members have even partnered with nursing faculty to co-author articles in publications such as *Pediatric Nursing* (Johnson et al., 2008). At the Children's Hospital of Philadelphia, parents involved in the

Family as Faculty team use their experiences to give employees a variety of insights, from how to discuss a diagnosis in a clear, compassionate way, to the day-to-day implications of their child's disease (Heller & McKlindon, 1996). Widespread collaboration with patients and family members may further increase patient satisfaction and yield unparalleled learning opportunities for students.

Patient-Centered Medical Homes

In recent years, the principles of patient-centered care have converged to create a concept called the Patient-Centered Medical Home. This model aims to administer comprehensive primary care with an emphasis on partnerships between individual patients, their personal physicians, and the patient's family. Within the medical practice, the patient has a consistent relationship with one particular physician, who is responsible for addressing all of the patient's health care needs and appropriately coordinating care with other professionals when necessary. The payment structure of the patient-centered medical home (PCMH), shifts toward reimbursing physician communications outside of the face-to-face visit, reflecting the value of physician and non-physician patient-centered care work, such as coordinating services among the practice and consultants, ancillary providers and community resources. Improved access to care is provided within the PCMH through expanded hours and new modes of communication between patients and the practice staff, such as secure email and telephone consultation. Perhaps most importantly,

medical home practices are driven by “a compassionate, robust partnership between physicians, patients, and the patient’s family” to realize superior patient-centered outcomes (Johnson et al., 2008).

The changes brought about by the patient-centered medical home are an apt response to the inadequate primary care foundation of the U.S. health system. “Only two-thirds of American adults report having an accessible primary care provider, while nearly three-quarters have had difficulty getting an appointment, receiving telephone advice, or getting off-hours care without going to an emergency room.” Patients with regular access to a primary care physician are more likely to receive suggested preventative services and obtain recommended treatment before more significant and costly problems develop, and they have fewer emergency department visits and hospital admissions. While it has not yet been determined what components of the PCMH propel positive patient outcomes, the literature suggests that due to an increase in the receipt of preventative services and better management of chronic conditions, the patient experience is improved. As a result, PCMHs have the capacity to reduce the overall cost of care without forfeiting quality (Davis, Abrams & Stremikis, 2011).

The Affordable Care Act supports the adoption of PCMHs nationally by offering states the opportunity to increase compensation to primary care clinics designated as “health homes” for Medicaid patients with chronic conditions. An analysis completed by the Commonwealth

Fund and Lewin Group projected that widespread implementation of the medical home model in Medicare and Medicaid could reduce national health spending—relative to currently estimated levels—by an estimated \$175 billion through 2020 (Davis et al., 2011).

Hospitality Elements in Health Care

In recent years, the health care industry has taken inspiration from hotels to incorporate elements of the hospitality industry to address a notable increase in patient and family expectations, and regulatory and financial incentives. Research supporting this change cites an enhanced physical environment as being supportive of healing and contributing to consumer decisions and perceptions of service quality. Because outcomes in medicine are often intangible and difficult for non-clinicians to estimate, patients often look to the physical environment of a hospital or clinic for cues about the quality and capabilities of the institution. In fact, research conducted in waiting rooms found that patients surveyed in more physically attractive areas not only gave greater assessments of quality of care, but also were more willing to recommend the facility than patients surveyed in unattractive waiting rooms. Because of the excellent outcomes associated with hospitality in medicine, partnerships have been established with key leaders in the industry such as the Ritz-Carlton Hotel Company, Four Seasons Hotels and Resorts, and the Walt Disney Company for training in service processes and management (Wu, Robson, Hollis & Tanner, 2013). For example, the Bon Secours Virginia Health Systems

partnered with the Ritz-Carlton Leadership Center to shift their cultural focus onto service excellence and has reported increased quality, financial and patient satisfaction outcomes (The Ritz Carlton Leadership Center, 2014).

Efforts to contain the costs of care can constrain a hospital or a practice's ability to incorporate hospitality elements, yet they are necessary to provide a competitive edge (Wu et al., 2013). The Mayo Clinic, for example, is arguably the most powerful brand in the health care industry, due to word of mouth and excellent patient loyalty, with very little advertising. When interviewed for a Harvard Business Review publication, patients consistently depicted their care as being more concerned with their needs rather than the doctors' schedules, the hospital's operations, or any other factor related to Mayo's internal processes. Furthermore, the culture and guiding principles of the Mayo are centered on William Mayo's belief that "the best interest of the patient is the only interest to be considered". Every detail, from the hiring process to the design of its facilities, reflects the organization's values. All new employees—whether janitors, accountants, or nurses—go through an orientation process aimed at reinforcing the patient-first mentality and aiding all staff in understanding how their jobs affect patient's well-being. Yet it is not only the patients that benefit from the Mayo's patient-centered culture. Employees take pride in Mayo's mission and are aligned with its values, contributing to lower staff turnover. At Mayo, the annual turnover

among hospital nurses is only 4%, compared to 20% for the industry as a whole (Berry & Bendapudi, 2003).

Many calls for patient-centered care have stressed infrastructural changes, such as electronic health records (Epstein & Street, 2011). Yet such reorganization will not be adequate if undergraduate medical education does not instill the values of patient-centered care in their graduates. To provide health care institutions with a wealth of patient-focused, empathetic physicians with strong communication skills, principles of patient-centered care must be emphasized in medical education. Furthermore, if hospitals as clinics do not implement cultural shifts toward patient-centered care, the pressures on physicians may undo any humanistic education gained in medical school.

Chapter 7

Conclusions

Patient-centered care may be the most ethically sound approach to improving health outcomes and the patient experience. One's health is one of the most personal aspects of life, especially when it is being threatened. Thus, patients need to be able to not only trust a physician's skill, but also be able to trust the doctor as a person. The patient must feel that the physician has his or her best interest in mind, even when it doesn't benefit the physician's wallet or ego.

While patient-centered care has grown in acceptance and application in recent years, there is still progress to be made for further implementation and research support. Now is the time to expand the patient-first perspective. Changes due to the Affordable Care Act are putting pressure on physicians to care for an increased population of insured patients. Hospitals and practices are struggling to cut the costs required to sustain the current expensive, yet low-quality health care system.

Granted, improving psychosocial care for patients is not a simple task. The issues of the current health care system that require

improvement are the same ones putting pressure on physicians, inhibiting their focus on patients.

Yet there is growing evidence of the benefits of implementing patient-centered care practices. When patients are cared for by empathetic physicians armed with strong communication skills, they are more likely to adhere to their treatment and to have better health outcomes. Now that the Affordable Care Act has tied Medicare bonuses to patient satisfaction, there are financial implications as well.

As I have outlined, there are many strategies to integrate these concepts into the curriculum at institutions nationwide, each with varying degrees of success. Further research needs to be completed to establish the best practices of teaching patient-centered care in an undergraduate medical education setting. However, from studies describing substandard professionalism and physician-patient relationships it is clear that role modeling alone is not providing medical students with an adequate lesson on patient care.

Furthermore, it may not be enough to solely teach the ideals of patient-centered care to medical students. I assert that widespread institutional and cultural changes may be necessary to support the continuation of patient-centered practices throughout one's career, and to counter the mounting financial and time pressures of the medical field.

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