THESIS/DISSERTATION APPROVED BY

May 7, 2018
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Perceptions of Trust and Care in the Patient-Provider Relationship: A Mixed Methods Case Study of a Nurse-Practitioner Clinic in Rural Nebraska.

By

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A THESIS

Submitted to the faculty of the Graduate School of the Creighton University in Partial Fulfillment of the Requirements for the degree of Master of Arts in the Department of Cultural and Social Studies

Omaha, NE

April 27, 2018

Abstract

Recent Nebraska legislation has relaxed regulations on the scope of practice for nurse practitioners (NPs) in an attempt to reduce the healthcare provider shortage. This move centered on the idea of NPs operating rural primary care clinics without the previously limiting oversight of a medical doctor. A medical anthropological approach to assessing this legislation's impact requires the study of cultural preferences for the patient-provider relationship in Nebraska. While medical anthropology has studied patient-provider relationships, further study is required in rural areas to assess local populations for preferences in different types of healthcare providers. The trend toward greater NP utilization is one example of an increasingly important patient-provider relationship. Therefore, the patient-provider relationship needs to be reassessed on the local level for cultural norms and expectations influencing this relationship. In this study, a mixed-methods approach was taken to assess the local perceptions of NPs and the patient-provider relationship utilizing a quantitative survey and qualitative interviews of patients at a NP-run clinic in Elk Valley, Nebraska. In this setting, the following variables arose from the interview process and were assessed for their impact on the development and maintenance of the patient-provider relationship: 1) Provider credentials and perceived competency, 2) Trust, 3) Provider actions, 4) Provider characteristics, and 5) Perceptions of health and wellness. A lifeworld perspective of these variables influenced by the work of Jürgen Habermas allows for the discussion of subjective, societal, and objective interpretations of the patient-provider relationship.

Acknowledgements

I would like to express my great appreciation to Barbara Dilly, Ph. D., Alexander Roedlach, SVD, Ph.D., Laura L. Heinemann, Ph.D., M.S.W., and Helen S. Chapple, Ph.D., RN, MSN for their mentorship, direction, and support not only during the writing and editing process, but throughout the entirety of the master's program. This committee has provided me with great insight as well as the flexibility to make this work my own.

I would also like to acknowledge the Master's in Medical Anthropology program through the Department of Cultural and Social Studies at Creighton University. The faculty have shown dedication to passing on their immense wisdom and practice to their students. Not only has this program made me a better researcher, but it has made me a better person.

I give special thanks to Dr. B. APRN and her staff at the 'Whole Care Clinic' for their generosity and kindness. The experiences I had at this clinic will stick with me throughout my life, and the lessons I learned will inform my development as a prospective healthcare provider.

Finally, I would like to think my wife, Jessie. Her support and love throughout the entirety of the Master's in Medical Anthropology degree as well as the thesis writing has been unwavering. She provides me with the ambition to achieve my goals.

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> "Just feeling like they care is so important. One time, I noticed a spot on my leg that wouldn't heal. I got really scared to do anything about it after it had gotten so bad, I didn't want to call or come in. I wanted to see if it would heal on its own. The next time I came in I did finally show her, and I was expecting her to scold me. But she didn't. She was very sincere and gave me her cell phone number and told me to call her anytime if it was something that serious. I thought this was really important to show that I can trust her and that we had a good relationship."
>
> - Thirty-seven year old diabetic woman

Introduction

The state of Nebraska passed legislative bill 107 (LB 107) in 2015, enacting greater freedom for the scope of practice for nurse practitioners (NPs). In rural areas of the U.S., nurse practitioners have become a ray of hope for underserved rural communities. As of this writing, at least 22 states have passed legislation allowing the full scope of practice for NPs (see Figure 1); with others allowing a reduced practice in comparison to full practice (Nurse.Org 2017). At full practice, legislation allows NPs to run standalone clinics without what was deemed 'unnecessary' oversight by a cooperating physician (American Association of Nurse Practitioners 2015). Reduced practice for NPs requires the NP to have some kind of a collaborative agreement with a cooperating physician for at least one aspect of their practice. States with restricted practice require direct oversight for at least one action performed by an NP (see Figure 1).

In medical anthropology, the patient-provider relationship has been studied for many years (for example, see Kleinman 1980), however, the recent push for increased utilization of nurse practitioners as primary care providers (PCPs) should re-capture interest in this topic. Due to this increased use of NPs in rural areas, this study seeks to assess local perceptions of the patient-provider relationship from the patients' perspective

at an NP operated clinic. The importance of this relationship warrants a culturally relevant and localized approach to studying the effects of rural healthcare policy. To study this relationship, then, a mixed-methods case-study was performed at one NP operated clinic in Northeast Nebraska. While many factors affect this relationship, five major themes were characterized from these interviews. These include 1) Provider credentials and perceived competency, 2) Trust, 3) Provider actions, 4) Provider characteristics, and 5) Perceptions of health and wellness. Patient-provider relationships can impact trust in healthcare providers, continuity of care, as well as healthcare seeking practices. This is especially true for rural patients who are increasingly utilizing NPs in the role of a PCP.

This increased utilization of NPS as PCPs marks a pivotal point in U.S. healthcare policy's move towards higher quality, lower cost care. This transition has de-emphasized the patient-provider relationship in favor of efficiency and effectiveness; placing greater emphasis on quantity and pre-assigned quality measures. As described by Rylko-Bauer and Farmer, "both patients and physicians are managed through cost-containment techniques that put strict controls on use of medical services and on patients' choice of doctors and medical options and that offer financial incentives to doctors and hospitals to cut costs and services" (2002, 478). Additionally, U.S. healthcare policy has moved toward a greater focus on primary and preventative care. This is seen as beneficial since "when quality primary care becomes available, communities can develop new faith in their local health systems" (Drobac et al. 2013, 160). This provides an opportunity for NPs to fill the primary care gap in the face of greater physician specialization. However, when legislative changes regarding NPs occur, the reasons behind such moves are often

largely based on cost-effectiveness analysis in the face of a looming provider shortage. Because of this, legislative changes may fail to adequately consider the local sociocultural realities as perhaps the greatest impactors on the efficacy of such changes. In this context, then, it is important to assess these sociocultural realities affecting the care NPs can give from the perspective of patients. This study of an NP operated clinic in rural Northeast Nebraska aims to determine the characteristics influencing the development and maintenance of the patient-provider relationship and how this relationship can impact overall health and wellness of patients. These variables of the patient provider relationship will be brought into discussion with Habermas' theory of the lifeworld allows for a deeper understanding of the different influences on this relationship.

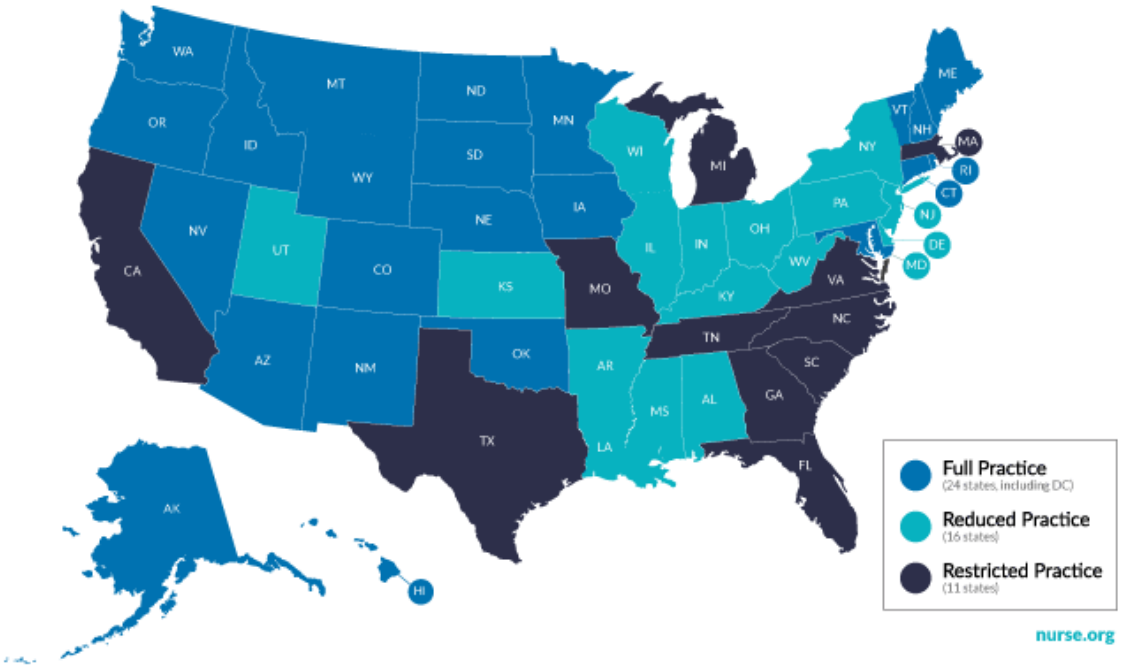

Figure 1: U.S. Breakdown of Legislation on NP Scope of Practice (Nurse.Org 2017).

Study Context

Contribution to Literature: Why is the patient-provider relationship important?

Improvements to the U.S. healthcare system require a greater understanding of the complexities of the patient-provider relationship. Studying the impacts of patient-provider relationships on health-seeking behaviors (and, eventually, health outcomes) will be vital to the continued social legitimacy of the health professions. Without a focused attempt to study this relationship, the cultural distance between patients and providers will continue to grow and cause problems, as shown in the 'Characteristics of the Patient-Provider Relationship' section of the results. Ignoring the meaningfulness of the patient-provider relationship can jeopardize the quality of care received by patients. This is especially important in a country where the people are perhaps becoming more diverse (and cautious) in their healthcare beliefs. Examples of such cautious behavior include the pushback on genetically modified organisms in foods and resistance to vaccinations. In these examples, and many others, a more developed relationship between patients and providers (on both the individual level as well as on a community or national level) can help patients feel more confident in their healthcare seeking behaviors.

Healthcare seeking behaviors of a particular group of people can both influence and are influenced by patient-provider relationships. These healthcare seeking "behaviors become critical for understanding how patient-provider relationships unfold and how subsequent use of services evolves" (Boyer and Lutfey 2010, S80). For example, the frequency of healthcare seeking may not be as often as the provider asks for, and this can often lead to the patient being labeled as non-compliant. In this case, the provider has not developed the relationship well enough to determine why the patient did not follow-up as

frequently as suggested. On the other hand, the relationship with a particular provider (as well as the generalized relationship between the lay population and healthcare providers) can also affect healthcare seeking behavior. A proposed common trajectory for healthcare seeking is "(1) selecting a source of care; (2) preparing to obtain care, or organizational accommodation; and (3) getting to care, or geographic accessibility" (Haggerty et al. 2014, 94), and disruptions in healthcare seeking practices can be problematic. As shown in the results section of this study, there are people who will forego healthcare because of a previous experience causing them to generalize one poor relationship to all healthcare providers. Trust is one example of a factor in both the development and maintenance of the patient-provider relationship. Trust, however, can affect the relationship in different ways; for example interpersonal trust as opposed to societal/structural trust.

Trust, then, must be assessed in the study of the patient-provider relationship and why this relationship is important. In Kleinman's discussion of explanatory models, he asserts negotiation between shared explanatory models as "the single most important step in engaging the patient's trust, preventing major discrepancies in the evaluation of therapeutic outcome, promoting compliance, and reducing patient dissatisfaction" (1978, 257). Trust, in Kleinman's perspective, spawns from the negotiation of the lived experiences of the patient and provider. This negotiation, of course, may take time and patience from both sides, but it provides the basis necessary for mutual trust.

While Kleinman's perspective as described above is beneficial for the development of a relationship between patients and providers in the clinic, society places a certain degree of trust in healthcare providers (Mechanic 1996). Although the movement towards patient autonomy and informed consent has come a long way from

unnecessarily paternalistic patient-provider relationships, Grimen argues this may not always benefit trust in the patient-provider relationship. This is partially due to the "knowledge gap [being] probably greater in health care than in any other consulting profession" (Grimen 2009, 18). With increasing technology and the continual increases in medical knowledge, Grimen argues this gap is actually increasing. In addition, "patients have often only extreme alternatives to trusting the competence, technology, and professionalism of health care staff" (Grimen 2009, 18). This continues to be the case as providers spend less time with patients. As Kleinman argued, patients receive explanations that are often "limited and in terms either too technical or too abstract for patients to make much sense of" (Kleinman 1980, 288), so a clinical informed consent process may still leave the patient with unanswered questions. These factors likely contribute to "the growth of internet health sites and heightened public skepticism about medical authority" (Smith-Nonini 2006, 236).

It is this background that supports the necessity for the study of the patient-provider relationship to determine local patient preferences; for example, the cultural distance they wish to have with their provider. This study hopes to add to the current trends in U.S. healthcare policy regarding the primary care movement and promoting higher quality care delivered at lower costs. It also seeks to call attention back to the relationship between patients and providers as a means of improving health outcomes (though health outcomes are not assessed in this study). In addition, this study seeks to add a case study analysis discussing the importance of patient-provider relationships as well as how NPs fit into the rural primary care framework of high-quality, low-cost care.

It is beneficial, then, to understand more about the area of study to be able to make determinations.

Study Context

Within Northeast Nebraska, there are few cities exceeding five or six thousand persons. This area of Nebraska has an average percentage of the population living in a rural area of 77.5% (County Health Rankings 2016), making the area predominantly rural. For reference, the state average of the population living in rural areas is 26.9%. Though rurality can be defined many different ways, this study will define rurality consistent with the US Census Bureau. In this classification, urban areas "have cores of populations of 50,000 or more" while "urban clusters have cores with populations that range from 2,500 to 49,999" and "all other areas are designated as rural" (Hart and Casey 2012, 29). Within this definition, the local hub Elk Valley (a pseudonym for the name of the town where this study took place) is categorized as an urban cluster. For the sake of this study, patients were assumed to be coming from across Northeast Nebraska, and not just Elk Valley; though place of residence was not a variable for any analysis (see Figure 2 for a diagram of the potential study population). As the surrounding region is largely rural, as shown above, rurality was generalized to include Elk Valley and those patients coming into the clinic. However, it is important to note there are likely many populations within

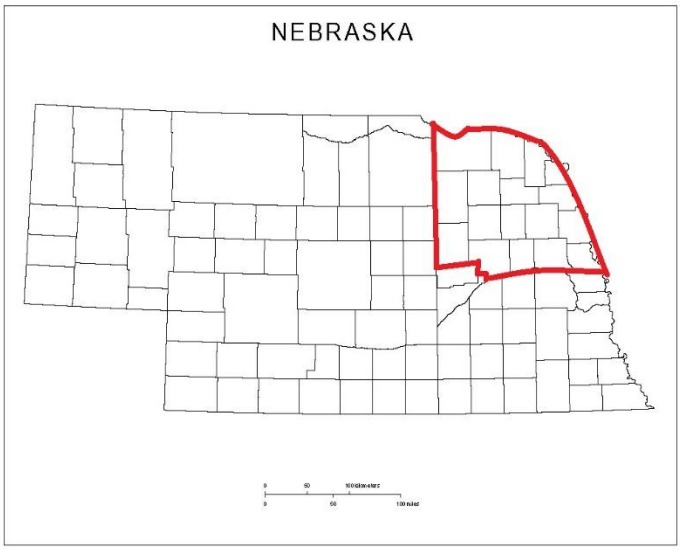

Figure 2 Map of Nebraska. Denotes the potential study population in red. (Wikimedia Commons contributors)

this region who may not identify with a rural lifestyle. These perceptions are assumed to have little effect on the outcomes of this study, as even those populations will likely acknowledge living in a largely rural area.

Although the provider shortage is general across rural Nebraska, rural parts of Northeast Nebraska contain some of the poorest physician densities in the state (County Health Rankings 2016). The provider shortage in rural areas is only worse with mental health and dental providers. However, NPs and PAs can help to reduce the shortage in primary and mental health care and are being increasingly utilized in such ways. Due to low provider densities in the smaller surrounding towns, many people travel to Elk Valley for healthcare appointments. Here, the effects of the new legislation for NPs can be seen in standalone NP clinics. Prior to the 2015 legislation, the Whole Care Clinic (a pseudonym) had been run by a single NP for about ten years. During this time, though, the NP contracted with an overseeing physician. This practice can be both costly and burdensome for NPs. With LB 107, this requirement (and therefore the practice at the clinic) had changed.

The Whole Care Clinic was midway through a major remodel when I first stepped through its doors. Through the construction it had a faint feel of many clinics I had been to before; I recognized the waiting area, the exam rooms, and nurses' station. As I was interested in patient-provider relationships, what most struck me initially was the lack of exam tables (only one of all five exam rooms contained an actual exam table). In their place were sit-down tables; presumably intended to induce less stress and invite a more conversational interaction. This touch was one example of the many ways this clinic had a different feel compared with many other clinics in the area. As the construction came to

a close, the incorporation of non-biomedical complementary and alternative medicines became more clearly incorporated into the structure of the clinic. These treatments will be referred to throughout as complementary and alternative therapies; as these therapies are in addition to or in place of biomedical therapies, and the study context presumes the use of biomedical treatments.

Dr. B. APRN's background in energy work informed the physical structure of this clinic as well as the treatments available to patients. Her work in this geographic area gave her insight into the patient population, including insight into the amount of patients that might be interested in different types of complementary and alternative treatment options. These complementary and alternative treatments provided different options to improve the overall wellness of patients without being limited to only biomedical treatment options. In an attempt to not alienate patients who were not interested in these complementary and alternative treatments, the clinic was primarily split into two wings. The two 'wings' of the clinic were set up to for what might seem to be very different purposes to those unfamiliar with non-biomedical complementary and alternative treatments. However, the overall goal of the clinic was clear: to help the patient feel well, regardless of the methods they choose to utilize. Down the first hallway were the 'exam rooms' with the sit down tables where Dr. B. APRN would do her visits. Circling around the nurse's station gets you to the non-biomedical side of the clinic. Here were the beds for healing touch (the type of energy-healing practiced at the clinic), a light therapy system, and eventually a dry spa. In the lobby, essential oils, essential oil diffusers, Himalayan salt lamps, and other items were sold in connection with the clinic.

The clinic itself is connected to a local grocery store actually owned by Dr. B. APRN's family, where the staff frequently visits for mid-morning or mid-afternoon snacks. The space had been converted years ago from a laundromat. Surrounding the clinic, the few blocks on either side of the clinic houses a high concentration of fast food restaurants; directly across the street sits a doughnut and pastry shop. This follows a general trend for rural areas of poor healthy food access (Morton et al. 2004), though Elk Valley has comparatively greater options than many of the surrounding rural towns. In this setting, all data collection for the case study took place.

Methods

Data Collection Methods

A mixed-methods approach was taken for this study. Both a closed-ended questionnaire and an open-ended interview were utilized to gather data on healthcare practices and perceptions of the patient-provider relationship. The focus of the study was on the patient's relationship with NPs. Because of this, patients showing up for their clinical appointments were prioritized over patients showing up for other types of appointments held in the clinic, though these appointments were not outright excluded from the study (for example, healing touch or appointments with the allergy nurse, etc.).

In the spring of 2017, a total of fifty-one patients participated in this study. After an informed consent discussion, patients were given a short questionnaire regarding demographics and previous experiences with this and other healthcare providers (see Appendix I: Quantitative Questionnaire for Patient-Participants for a copy of the questionnaire). In addition, patients participated in a short, semi-structured interview with open-ended questions with the primary investigator. This interview process was aimed at

finding factors affecting the patient-provider relationship as well as comparisons between different types of providers. Interviews were typically between fifteen and thirty minutes. Both the interviews and the surveys were completed in the privacy of the examination rooms, and pseudonyms are used for all participants, patients and providers alike, to protect their confidentiality. Pseudonyms were utilized due to the largely rural population in order to prevent others from the area being able to identify a participant based upon their story and the fact that they went to a certain clinic during the study period.

The interview process took place in the time immediately before or after (instead of during) the patient's actual appointment with the NP in order to investigate the participant's perceptions of the relationship and how this relationship affects their health. The decision-making behind this design relied on the validity of the emic perspective of patients. The emic perspective can be defined as the "participant's point of view" (Salzman 2001, 51). Taking an emic perspective, then, these perceptions were assumed to be a valid and reliable tool for analyzing the relationship from the patient's perspective, as their subjective interpretation is based on these perceptions as opposed to a third party's interpretation of them. This study aimed to determine what is necessary for the patient to feel comfortable and cared for, and how the importance of the relationship may impact the healing process.

Interview questions inquired about participants' previous experiences with healthcare providers as well as their experience with the provider at this specific clinic. Interviews were mostly completed before the visit with the provider, though the reality of the clinic sometimes required the interviews to be broken into a pre-visit and post-visit format. This did not affect the focus of the interview process. Since the interview process

was semi-structured, the same questions were not always asked for each patient, and if a patient got to talking about something it was common for additional questions to be asked based upon the direction the conversation was going. In general, participants were asked about perceptions of NPs as well as characteristics they did and did not want in their provider. In addition, participants were asked to describe any barriers they perceived to developing or maintaining the relationship in order to assess participant's ability to relate to the provider. Doing the interviews in an open-ended fashion allowed for the reduction of bias on the part of the investigator by allowing patients to decide what factors were important to the relationship (see Appendix II: Interview Schedule for Patient-Participants for the semi-structured listing of prepared questions).

Data Analytic Strategies

The qualitative interviews were transcribed from detailed hand-written notes. Data recording was done through the use of detailed hand-written notes as opposed to the use of an audio recorder due to the medical setting as well as an attempt to reduce any type of patient discomfort with an audio recorder use in the consultation room. Quotes were taken down verbatim when possible and are utilized throughout this study when appropriate. While it is possible some subtleties of the relationship were missed due to utilizing hand-written notes as opposed to an audio recorder, promoting the ability of participants to talk freely without the use of an audio recorder was assumed to provide an overall benefit to the study while still assessing the main factors of the relationship. The transcribed notes from all interviews were then compiled and examined for themes utilizing grounded theory. This approach allows for "the discovery of theory from data" (Glaser and Strauss 1967, 1). This means the data was allowed to speak for itself. Open coding was performed to generate a comprehensive listing of variables developed from

the patient interviews. This data was then grouped and the themes were then counted as variables. The grounding theory approach allowed for variable introduction as a result of the data analysis, with reduced bias that can come with deductive approaches. At this point the transcribed notes were re-examined and similar variables were grouped together in order to create the final and most meaningful variables.

Quantitative data were collected in two ways: 1) quantitative data from the closed-ended questionnaire and 2) from the open-coding process creating variables. This allowed for method triangulation to greater inform the understanding of what was deemed important by participants (Denzin and Lincoln 2011) (in addition, a literature review was completed to assist in identifying themes). Quantitative data gathered from the questionnaire were entered into and analyzed with IBM SPSS Statistics V24. After the qualitative data from the interviews were analyzed and categorized, this data was also entered into SPSS to be analyzed together with the questionnaire. Once all data were in SPSS, data analysis was done using frequency analysis, T-Tests, and Fisher's Exact Test. Fisher's exact test was utilized for statistical comparisons as it allows for the comparison of small sample sizes (categories of less than 5). Fisher's exact test was utilized to assist in finding relationships between whether patients discussed a variable or not. Since the interviews were open-ended, many variables had 'missing values' as patients were allowed to talk about what was important to them. For analysis, these missing values were counted as negative indications. For example, participants indicating they wanted to feel as though their providers listened to them were coded as a "Yes" value for this variable. Participants not bringing this up were then coded as a "No" value to assist with analysis, and the Fisher's exact test, then, was used to compare whether the subject came

up as an important contributor to the relationship. While the utility of this test may be limited in these instances, these tests serve to be suggestive of characteristics that may jointly affect an aspect of the relationship and require further study for validation.

Participant Demographics

The survey consisted of a section on participant demographics. Questions on gender, age, ethnic background, education, and income were asked. Of the fifty-one participants who participated in this study, 61% identified as female, 29% identified as male, and the remaining 10% did not indicate a gender. This does over-represent the female population of the area by about 10%; estimates show a nearly 50:50 males to female ratio in the area (U.S. Census Bureau 2017).

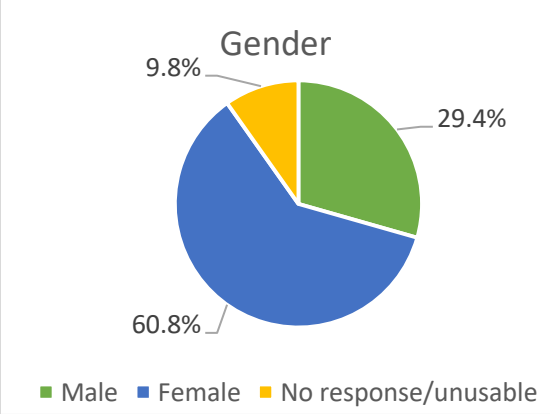

Figure 3: Gender Distribution of Study

The median age of participants was 57 years, with an average of 54 years (the range was between 22 and 79 years of age). Criteria for inclusion required the participant to be at least 19 years of age. In comparison to average ages of the state and surrounding counties, this study participants are older than the surrounding counties and the state

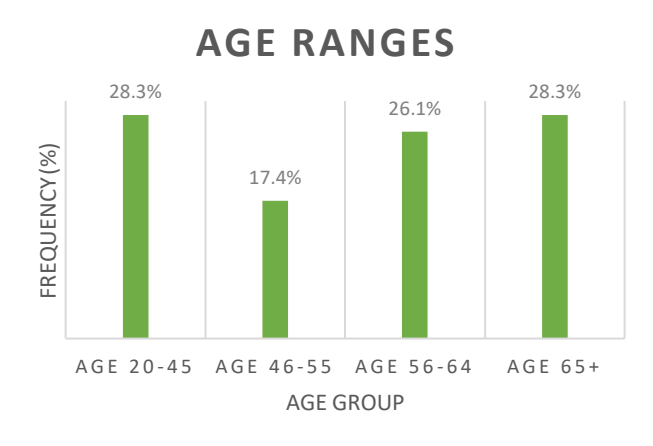

Figure 4: Age Distribution of Study

of Nebraska as a whole. The median age for Nebraska is 36.2 years, and the median age for the county where the study took place was 36.8 years (U.S. Census Bureau 2017). The rural counties surrounding Elk Valley all have higher median ages (in the 40s) but are still lower than the study population. This geographic area follows the general trend of older rural populations in the U.S. compared to urban populations. This aging has been attributed to "three demographic factors: the outmigration of the young, the aging-in-place of the resident adults, and the in-migration of elders from larger cities" (Gessert 2008, 17).

When asked about racial/ethnic background, the study was largely consistent with the area as the majority of participants identified as Caucasian, though the study did not aim to present a representative sample of local populations. In all, 86.7% of study participants identified as Caucasian (see Figure 5), while 2016 U.S. Census estimates an 87.6% 'white' population. Within the sample of minority participants, however, Figure 5 shows disproportionate representations of different ethnic groups. This study over-represents African Americans and under-represents both Native American and Hispanic/Latino populations (U.S. Census Bureau 2017).

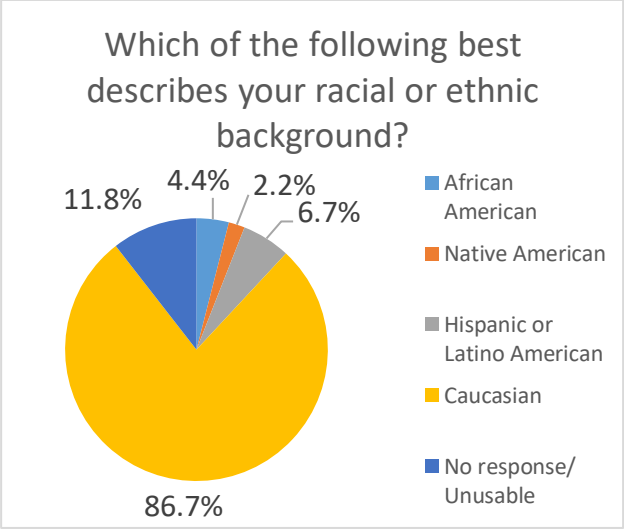

Figure 5: Ethnicity Distribution of Study

Participants were also asked about their annual income to help assess socioeconomic status. While over one quarter of the participants did not disclose their income, the remainder reported a broad array of annual income. The median income range was between $35,000 and $49,999 for the study (see Figure 6). This is comparable to the region's median annual income of around $50,000; although the income brackets were broken down differently for this study than for the U.S. Census (U.S. Census Bureau 2017).

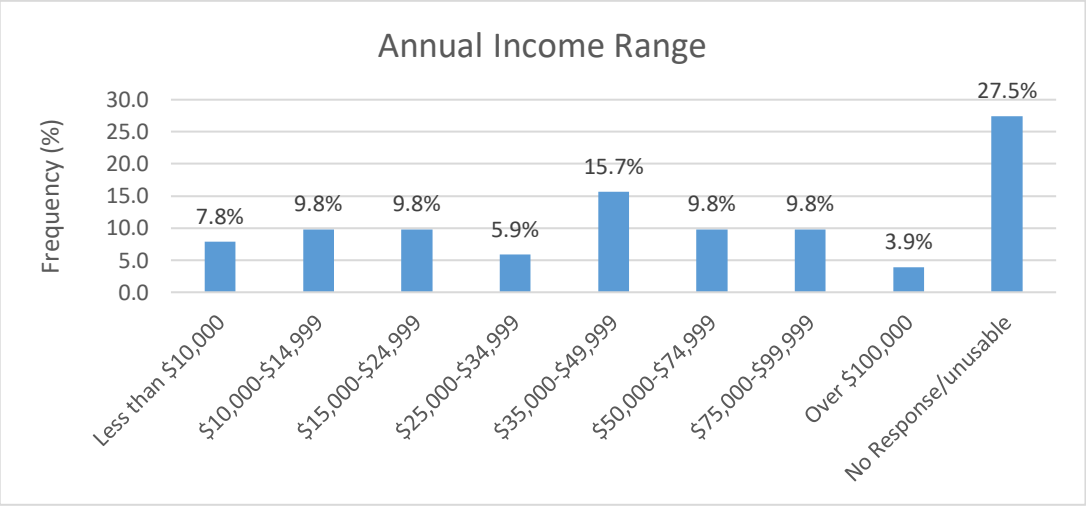

Figure 6: Annual Income Distribution of Study

Of the 51 patients in the study, the majority rated their general health as 'Good' (54.9%, see Figure 7), whereas a total of 23.5% of participants rated their health as 'Fair' or 'Poor'. Comparing this to County Health Rankings data (average of 12.8% for Northeast Nebraska counties) the study has poorer health ratings than the general population. Though, it should be noted, County Health Rankings includes an 'Excellent' category not included in this study (County Health Rankings 2016).

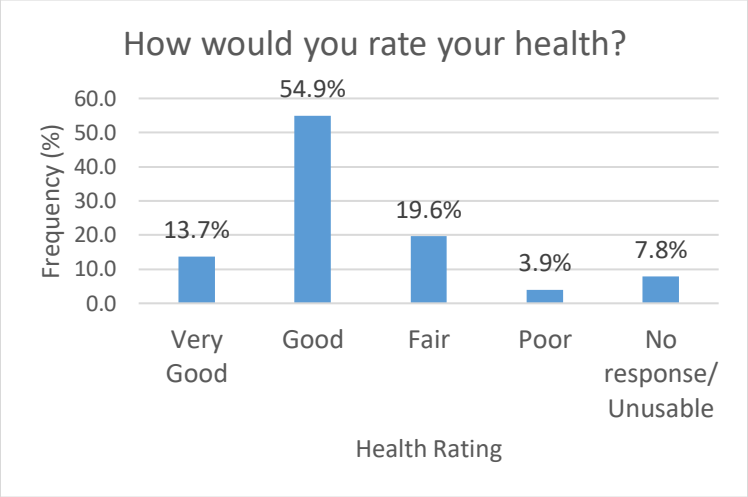

Figure 7: Overall Health Ratings

Results

Healthcare Seeking Behaviors

In order to study the patient-provider relationship, it is necessary to determine the healthcare seeking behaviors of the study participants. Healthcare seeking behaviors, "become critical for understanding how patient-provider relationships unfold and how subsequent use of services evolves" (Boyer and Lutfey 2010, S84). In this study, healthcare seeking behaviors were characterized by the average yearly frequency of healthcare visits as well as the types of providers being visited (see Table 1). Though attention could be given to other sociocultural influences on healthcare seeking behaviors, this was beyond the scope of this study. Therefore, participants were asked questions to gauge the ways they access healthcare services.

Participants were asked about their visits to this clinic. In total, 80.4% responded having been to this clinic and seen this provider before. The remaining 19.6% were split evenly between those patients who were new to the clinic and those who did not provide a response to the question. Further, 43.2% of participants recognized this provider as their

primary care provider (PCP). A similar percentage (41.2%) indicated this provider was not their PCP, while the remaining 15.8% were either unsure or did not respond. Though this study was done at a NP-run clinic, this finding shows there are ample patients willing to utilize NPs as their PCPs.

In order to further gauge healthcare seeking patterns, participants were asked to describe whether and how frequently they visited a listing of different types of healthcare providers. Table 1, below, shows the raw number of participants who indicated visiting each specific type of provider. The rows in Table 1 represent an estimate by the participant of the number of times the participant visits each type of provider in an average year. Consistent with the analysis above, due to this being a NP-only clinic, the study population likely over-represents the frequency of NP visits. However, this study was not meant to represent the general population. Further study, then, should include direct comparative analysis of the utilization and relationships between patients and NPs, MDs, and other provider types within similar geographic and sociocultural environments.

This study, however, was more interested in showing some of the different ways patients are obtaining healthcare. As shown in Table 1, most patients in this study regularly saw more than one type of health provider. Only three participants (5.9%) indicated having visited only NPs and not any other kind of provider. Therefore, the workings of a team-based approach was being utilized for most patients. The 'Other' provider category was meant to incorporate non-medical providers (listed suggestions included 'chiropractor, healing touch practitioner, acupuncturist'), but was left open to interpretation. This was important to provide a preliminary assessment of their healthcare seeking behaviors, their healthcare beliefs, and their trust in different types of providers.

The type of provider a patient visits may be a representation of the treatments they choose to undergo (for example, compare a chiropractor's approach to a sore back to a physician's approach within the biomedical model). As patients navigate their healthcare options, their choice in the providers they visit are going to be impacted by their trust in the providers themselves and the type of healthcare they deliver. As healthcare beliefs in the U.S. change, it is vital for providers to work within a team-based care model by forming treatment plans in collaboration with other providers from whom the patient may seek care. Exclusionary rhetoric between these providers is unhelpful to this goal as it complicates the patient's navigation through their healthcare decisions.

Table 1: Frequency of Study Participants Visiting Types of Providers

Number of times visited yearly (estimate)	Nurse	Nurse Practitioner	Physician's Assistant	Medical Doctor	Specialist	Other	Totals
0 (times per year)	0	1	1	0	3	2	7
1	1	2	3	3	3	1	13
2	2	7	7	9	6	1	32
3	2	4	1	3	2	2	14
4	1	2	4	2	3	3	15
5	0	3	0	1	0	1	5
6	0	4	1	2	1	1	9
7	0	0	0	0	0	1	1
8	0	1	0	0	0	1	2
10	2	1	1	3	0	3	10
12	1	3	0	1	2	2	9
15	1	0	0	0	0	1	2
26	0	0	0	0	0	1	1
52	1	0	0	0	0	1	2
Total	11	28	18	24	20	21	-

One way of measuring patient's perceptions of their relationship with providers included a question about how concerned they felt their providers were about their health and wellness. In all, 76.5% stated feeling as though their providers were either concerned or very concerned with their health. This shows patients generally feel as though their providers are appropriately concerned about the health of their patients.

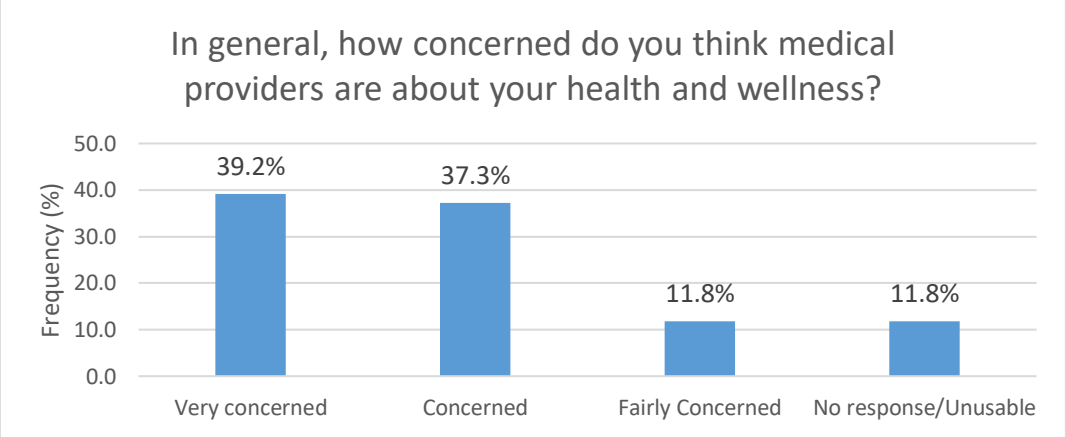

Figure 8: Provider Concern for Patient Health

Participants were also asked further questions into their understanding and affinity for meaningful patient-provider relationships. When asked how well patients related to their providers, only 3.9% indicated they did not relate well. This number was higher, however, for those people who indicated generally not liking to go to the 'doctor's office'. The term 'doctors' was a common colloquialism inclusive of many healthcare providers associated with a biomedical approach including MDs, DOs, PAs, NPs. In all, about 9.8% of participants expressed this opinion. An aversion to visiting healthcare providers can affect the relationship these patients develop with any type of provider. This was evidenced by those participants independently indicating an ability to generally relate well to providers being significantly less likely to independently indicate disliking going to the 'doctor's' office in general.

Patients typically had difficulty describing their reasoning for a generalized dislike for visiting providers, however a few did help shed a little light on the subject. One woman, aged 43, wasn't sure how to describe barriers to developing a relationship, but noted, "I hate doctors anyway, but if I want to control my diabetes I need to come in." She also commented, "I don't like it when people make me for who I'm not, instead of who I am. Don't try to change me." This hints of a fear of being judged or pressured into big life changes and not be able to have control over who she is. Of all patients, 7.8% independently indicated such distaste with a feeling of judgment from a provider. However, the above quote also describes this dislike of going to the 'doctor's office' in terms of an underdeveloped relationship. The above quotes help show the impact of not getting to know someone's reality before making assumptions on treatment plans.

A 70 year old woman also described a previous experience with a provider who heavily influenced her future patient-provider relationship building. "Five years ago, I had stage 4 uterine cancer. But he came out and said, go buy a lotto ticket, because it was going to be okay. But then, he put a cut in my large intestine [as a complication of surgery] and left me bedridden for 8 months." This patient stated "I've had good and bad, but I'm not a doctor person", so when something does go wrong with her health, it really comes as a shock. This suggests how, when she does need to visit a healthcare provider, she does have fear acting as a barrier to the relationship, whether the fear is recognized by her or not. Some fears that can be identified throughout the case of this 70 year old woman include a fear of poor health being found when the patient assumes they are in good health; a fear of a poor outcome as a result of attempted treatment; as well as a generalized fear of 'doctors' in not knowing if the provider interaction will be positive.

Carrie, a 32 year old woman, spoke further on the topic of uncertainty in the positivity of the interaction between patient and provider. She attributed this to characteristics she had come to expect from a visit at the 'doctor's office'. She described, "I don't like it when doctors are being short, abrupt, and not hands on" and she was critical of having to feel as though she was "an inconvenience to the provider" due to her being "rushed in and rushed out."

Table 2: Fisher's Exact Test for Relationship between How One Generally Relates to Providers and Whether They Generally Like Going to Healthcare Providers.

			Don't like going to Drs. in general		
			Not Mentioned	Yes	Total
How does patient relate to providers in general? (Well/not well)	Not Well/No response	Count	14_a	4_b	18
		Expected Count	16.2	1.8	18.0
		% within How does patient relate to providers in general? (Well/not well)	77.8%	22.2%	100.0%
		% within Don't like going to Drs. in general	30.4%	80.0%	35.3%
		% of Total	27.5%	7.8%	35.3%
		Standardized Residual	-0.6	1.7	
	Well/Very Well	Count	32_a	1_b	33
		Expected Count	29.8	3.2	33.0
		% within How does patient relate to providers in general? (Well/not well)	97.0%	3.0%	100.0%
		% within Don't like going to Drs. in general	69.6%	20.0%	64.7%
		% of Total	62.7%	2.0%	64.7%
		Standardized Residual	0.4	-1.2	
Total		Count	46	5	51
		Expected Count	46.0	5.0	51.0
		% within How does patient relate to providers in general? (Well/not well)	90.2%	9.8%	100.0%
		% within Don't like going to Drs. in general	100.0%	100.0%	100.0%
		% of Total	90.2%	9.8%	100.0%
Fisher's Exact Test (p)		**0.047**			

It is useful, then, to study the effects the relationship can have on patients. This study attempted to do so by asking participants whether relationship matters to them. Of all respondents who commented on this issue, 94.6% of participants stated the relationship was important to them and their health, while only 5.4% of participants actually indicated the relationship did not matter to them or their health (see Table 3, below).

When asked to share more details about why the relationship matters to them, one 53 year old woman commented, "I wouldn't come otherwise, I have to trust them… It gives me a sense of belonging. I need to know that they have my best interest at heart." While another participant, a 48 year old man, stated, "You need to be comfortable with them [healthcare providers], you need to know they listen to you." These sentiments were echoed in many other patients. These patients needed to feel a sense of trust and comfort established with the provider for them to feel confident in the goals and values said to be similarly understood on both sides of the relationship.

Table 3: Does the Relationship Matter?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	2	3.9	5.4	5.4
	Yes	35	68.6	94.6	97.3
	Total	37	72.5	100.0	
Missing	No Response/Unusable	14	27.5		
Total		51	100.0		

Patients were realistic about this relationship, as well. As one 65 year old man put it, the "relationship is important. I understand that we won't skip off into the sunset together, but you [as the patient] should know that you are more than just the 2:30

appointment." While some patients outwardly expressed this sentiment of not trying to idealize the relationship when speaking of it in general terms, the importance of the relationship was often later apparent in other comments they made. Beneath the surface, then, many patients want to have their individual differences acknowledged and feel as though their provider is willing to give them not only enough time for the appointment but also provide them with a sense of comfort and trust in the dedication to the wellbeing of the patient. As the above examples have shown, healthcare seeking behaviors are affected by the perceptions and experiences with patient-provider relationships. What, then, are the characteristics that either positively or negatively influence this relationship?

Characteristics of the Patient-Provider Relationship

Since the relationship has been deemed an important factor by patients, it is important to explore the influences playing into the success, or failure, of this relationship. From a medical anthropological standpoint, it is vital to understand the cultural norms and expectations influencing this relationship. For this reason, this study was focused on the relationship in the predominantly rural Northeast Nebraska. In this setting, five key variables were identified and assessed for their connection to the development and maintenance of the patient-provider relationship.

Because of the focus this study takes on NPs, there was utility in assessing patients' perceptions of provider credentials as well as how this relates to their perceived competency, the cultural distance between patients and providers, and what this means for the development and maintenance of the relationship. Other variables were developed as a result of the coding analysis of the qualitative interview process. One of the most common variables participants brought up was the issue of trust and how this relates to

the relationship. Relating to this, participants emphasized the importance of the actions of providers in building and maintaining the relationship. Similarly, certain provider characteristics identified by participants in the interview process were frequently listed as influencing the relationship. Another major contributor to the relationship was based on participants' comments surrounding compatibility between patients and providers regarding perceptions of health and wellness.

Credentials, Competency, and Cultural Distance

Further understanding of local perceptions of NPs as providers is necessary in order to examine the ability of NPs to provide low-cost, quality care to rural areas. Recent public discourse regarding NPs has been trending towards a positive outlook, as "existing research suggests that NPs can perform a subset of primary care services as well as or better than physicians. Expanded utilization of NPs has the potential to increase access to health care, particularly in historically underserved areas" (Schiff 2012, 11). However, dissenters argue against freeing the restrictions on NPs with concerns over educational differences between NPs and MDs.

Opposition to LB 107 (the legislation allowing the full scope of practice for NPs in Nebraska) came largely from physician advocates and lobbyists with the chief concern being the amount of training that NPs have in comparison to physicians. Other comments revolved around career paths and whether allowing NPs to have more similar responsibilities to MDs (not to mention reduced time and financial commitments) would deter students from going to medical school. This opposition is not incomprehensible. It makes sense that medical students may be more hesitant about committing to over seven years (counting residency) to end up with nearly similar responsibilities when it could be

done in about three or four years, for a much lower cost, and an arguably less stressful lifestyle. This back-and-forth has resulted in some hostility between these types of providers as they are now set as competitors in the U.S.'s commodified healthcare system (see Figure 9). By studying patient provider relationships, we can begin to understand the importance for the medical community to re-evaluate the ideologies responsible for the PCP shortage and how this affects patients. Factors to be re-evaluated as they relate to rural primary care include an increase in healthcare costs, rural brain drains (Fuchs and Jotkowitz 2012), as well as a sociocultural distance between patients and the healthcare system by idolizing Western biomedicine and ignoring sociocultural 'explanatory models' (Kleinman 1987).

The sociocultural distance between patients and providers has particular application within this context. Rural NPs, just like any other PCP, have a certain degree of cultural distance between themselves and their patients, and this distance affects the patient-provider relationship. Cultural distance can be described as the degree of concordance of values "that exist between two persons or statuses" (Kadushin 1962, 519-520). While cultural distance can be beneficial for the introduction of new health practices (for example, a step back from local dietary patterns can help with the introduction of new dietary practices, possibly providing healthier options while still being appetizing), it can also cause a varying degree of problematic situations. These can range from a simple misunderstanding of phrase that results in an embarrassing encounter to the extreme consequences shown in examples such as Fadiman's (2012) ethnographic account of a Hmong family's interactions with the healthcare system. Those who have years of RN experience—including direct patient experience in comforting and

addressing patient concerns—bring this experience to their practice as NPs. This background is important for the patient-provider relationship for NPs because the "social distance between physician and client is problematic, but nurses emphasize empathy, caring, and identification with the client" (Dougherty and Tripp-Reimer 1985, 224). This is supported by participants of this study who commented on the ability for NPs to relate better to patients (see Credentials, Competency, and Cultural Distance section in this study). From a cultural distance standpoint, one may hypothesize a perception of NPs as having less of a problematic cultural distance (rather: a beneficial cultural proximity) between patient and NP as compared to the cultural distance encountered in the patient-physician relationship. Greater study needs to be done to assess the trends between the relatability of different provider types, and whether a greater cultural proximity can be beneficial to the relationship. However, this study views the cultural distance between patients and providers as largely problematic. Since people from rural areas "are much less likely to go to or finish college", and many rural workers have "relatively few prospects for dynamic income growth or potential change in social status," the cultural distance between rural patient and provider can strain their relationship (Florence et al. 2012, 61-63). Many medical professionals, though, are removed from rurality for long portions of time during their training, allowing for the possibility of medical trainees from local areas losing touch with the rural lifestyle (or not ever forming an appreciation for benefits to rural practice for trainees not from rural areas).

Currently, NPs have the unique opportunity to live in the area they hope to serve during their advanced training as many of these programs are largely online. This has been deemed important due to the historical benefits of "the existence of long-term social

relationships" between patients and providers (Betz and O'Connell 1983, 87). For those wishing to stay in the rural setting, the opportunity is present to be able to make a difference and advance their career all while still have familial and local ties. MSN (Master of Science in Nursing) and DNP (Doctor of Nursing Practice) programs do not require the uprooting of these familial or local ties during the years of training. Going forward, it is important for rural nurses (and possibly other healthcare providers) to have similar opportunities to be able to make a difference. Being able to train rural individuals from within these communities has the potential to help the health and well-being (and likely the economy) of rural areas. This provides an advantage for NPs to be preferentially utilized in the face of the structural issues medical schools have been unable or unwilling to reverse.

A.	**Midlands Voices: Nurse practitioners ease shortages** This is an opinion article from the Omaha World Herald from the perspective of a psychiatric nurse practitioner in Nebraska (Phillips 2016).
B.	**When a nurse is your health-care provider, you're at risk.** This shows an opinion article from the New York Post critical of legislation favoring freedoms for NPs (McCaughey 2015).
C.	**[Update] Dr's Post on Nurse Practitioners Goes Viral, Claims Someone Else Posted.** This shows a reply to a controversial series of posts (statements that have since been retracted and blamed on a hacking) from a social media website in strong opposition to the move (Gibson 2017).
D.	**Doctors and nurse practitioners have to stop fighting** This is a blog post from KevinMD.com with a call to end the provider-provider fighting (Ackerman 2017).

Figure 9: Examples of Public Discussion on Nurse Practitioners.

In general, though, NPs have been well received by healthcare systems and patients by improving local provider densities at lower costs, particularly in rural areas. The truth of the matter is NPs are a growing profession in this country, and NP programs seem to have the ability to continue increasing enrollment at a much higher rate

compared to many medical school programs. This problem is particularly important for rural residents who face increased specialization and urbanization of the provider workforce. In light of this trend toward greater utilization of NPs, qualitative research is critical to understanding how patients judge the competency of NPs; after all, the patients are the direct users of these healthcare providers. Patients in this study generally indicated being less interested in the credentials of the provider and were instead more interested in making sure they felt cared for and got their needs met. While only 7.8% of participants independently stated this in their interview, many echoed the sentiment throughout the interview process. Participants fell into two groups on the issue: they either thought the credentials did not matter, or they thought NPs can actually relate better than other types of providers. Though the scope of this study was limited to one provider type, the acceptance and preference of NPs is noteworthy and may serve as a justification for greater utilization of NPs in primary care.

Margaret, a 70 year old woman, was one patient who indicated the care she received was more important than the provider's credentials. She stated, "I don't know that the letters behind the name make a difference. She [Dr. B. APRN] has an understanding, not just because of her training but because of her experience, probably as a nurse. Some people are picky, but life is too short for that." Many patients echoed this approach to the relationship; while some went further, arguing NPs can relate better than other providers. Linda, age 76, noted, "Nurse practitioners can get to know [patients] more with both the medical and socioeconomic background. The nursing background tells NPs that they have to get to know your patients' socioeconomic background." According to Linda, then, the relationship between patients and NPs has a more

appropriate cultural distance than the relationship between NPs and MDs/PAs. In a similar comment, Jamie, 34, added,

> "It's easier to relate to nurses or nurse practitioners. I say that I have a doctor but I'd rather see the NP. I feel more comfortable and I feel like they have more time and patience. Initially I wasn't sure about NPs and PAs, but they're actually listening to you and caring. They don't seem to be rushing you. My feeling is that doctors rush you."

As shown in the quotes above, many patients at the Whole Care Clinic felt they were able to have more of a say in their care. As Harry, 44, noted, "NPs can be more thorough, [and] able to ask the patient what might work better." Many patients had similar comments appreciating Dr. B. APRN's acknowledgment and understanding for life getting in the way of being a perfect diabetic patient, for example. In fact, 18% of patients independently indicated an appreciation for when providers make the patient part of treatment option or otherwise consider cultural and socioeconomic situations. Dr. B. APRN's ability to work diligently to find appropriate treatments for patients helped build up the confidence and trust her patients have in her.

Trust

Perhaps the most significant factor patients brought up was their trust in this relationship. Patients recognized the importance of being able to entrust the provider with being truthful and honest. In the open-ended interviews, the trust as a foundation for the relationship was brought up independently by participants 33.3% of the time.

A patient's trust in their provider can affect both the conversation as it occurs in the office visit as well as their healthcare seeking behaviors in the long term. For instance, Janet, a middle-aged woman stated

> "Trust is very important, if you can't trust, I don't go there. My husband- he doesn't know [if he trusts his doctor]. So I said why do you keep going there? I think men are different. He won't see my doc, maybe because he thinks she should be in the kitchen, I don't know. The way she [Dr. B. APRN] acts, I know I can call her anytime. And that helps build trust. If I call and they are not there then I can't trust."

In this example, Janet points out she would seek care elsewhere if she felt she could not trust her provider. She is not alone in feeling this sentiment. About 10% of participants brought up this same issue and were willing to find another provider if they felt they had a poor relationship.

In addition to those who are willing to seek another provider in the instance of a poor relationship, there is also a proportion of the population where the risk of such discontinuity of care is dangerously high. Patients who indicated they do not generally like going to healthcare providers were significantly more likely to feel as though a single poor experience shakes future relationship building with healthcare providers (see Table 4, $p=0.015$).

Those participants who were already not comfortable going to their healthcare provider, then, were more likely to become even more uncomfortable in the event they felt not listened to, ignored, or otherwise not treated fairly. This characteristic is particularly problematic when viewed in terms of trust. Davies and Rundall echoed this sentiment when they stated, "trust may take a long time to build but is fragile and easily damaged or even destroyed. Once it has been lost, trust may be difficult or even impossible to regain. It is vulnerable even to small breaks of faith, or suspicions of such" (2000, 612). Because of this, there are important implications for healthcare seeking behaviors and, potentially, the overall health of patients who are already apprehensive about accessing care.

As shown in the previous section on provider credentials, the amount of cultural distance between patients and providers can have major implications for the relationship. The cultural distance between patients and providers is represented well by the differences in comprehension of the increasingly technological and academic advances within Western medicine. These advances, what Betz and O'Connell (1983) call 'professionalization', can affect individual and public trust in professionals such as medical providers in both positive and negative ways. Betz and O'Connell argue such professionalization leads to increased cultural distance because "while clients respect the professionals' expertise, they do not assume that the 'expert' decisions are made always with the clients' best interest in mind" (1983, 84-85). Therefore, the development and maintenance of the patient-provider relationship is highly dependent upon trust. Within the context of this study, it is important to be cautious in not strictly advocating for more NPs as PCPs. On the contrary, more staffing for rural PCPs are needed across the board. In a team-based approach to rural primary care, then, the cultural distance critique above should invite providers to be more relatable to patients regardless of their credentials.

Table 4: Fisher's Exact Test for Relationship between Whether Patient Generally Likes Going to Healthcare Providers and the Effect of One Poor Experience on Future Relationship Building.

			Single poor experience shakes future relationship building		
			Not Mentioned	Yes	Total
Don't like going to Drs. in general	Not Mentioned	Count	42_a	4_b	46
		Expected Count	39.7	6.3	46.0
		% within Don't like going to Drs. in general	91.3%	8.7%	100.0%
		% within Single poor experience shakes future relationship building	95.5%	57.1%	90.2%
		% of Total	82.4%	7.8%	90.2%
		Standardized Residual	0.4	-0.9	
	Yes	Count	2_a	3_b	5
		Expected Count	4.3	0.7	5.0
		% within Don't like going to Drs. in general	40.0%	60.0%	100.0%
		% within Single poor experience shakes future relationship building	4.5%	42.9%	9.8%
		% of Total	3.9%	5.9%	9.8%
		Standardized Residual	-1.1	2.8	
Total		Count	44	7	51
		Expected Count	44.0	7.0	51.0
		% within Don't like going to Drs. in general	86.3%	13.7%	100.0%
		% within Single poor experience shakes future relationship building	100.0%	100.0%	100.0%
		% of Total	86.3%	13.7%	100.0%
Fisher's Exact Test (p)		**0.015**			

Acts of Care

As described in the epigraph, when the provider did not scold the patient for being scared to call in for a non-healing wound, trust in the relationship can be developed via acts of care. These actions are, therefore, integral to the relationship. In fact, patients who listed trust as a positive trait were significantly more likely to also list wanting a provider who would "go the extra mile" or exceed their expectations of care (p=0.045). Kathy, age 63, recalled another provider who "called me after I left. She also walked me out of the clinic to my car when I was having vertigo, and eventually convinced me to have my

husband come pick me up. [It is important] when they go the extra mile." Patients notice the ways providers' actions show how much they care, even when the actions are more subtle than taking time out of their day to walk you to your car and arrange for a safe transport home. This shows how acts of care can influence trust in a provider and positively benefit the relationship.

By far the most prevalent perceived act of care for patients is the act of showing the provider is listening, paying attention, and not prejudging the situation. In all, 54.9% of patients brought this up during the interview process. Angela, a 39 year old woman, commented,

> "She just listens better, I like that the room is like this instead of the treatment room [rooms include a table with 4 chairs; only one room has the exam table]. It shows that she wants to just sit down and have a conversation. She always says that there is no shame here, which I like, but I want to meet her expectations, feel like I don't want to let her down. She is very conversational."

Angela not only acknowledges the structures of the room making the visit seem more conversational in nature, but she also makes the connection between the willingness and ability to have this conversation and the benefits of the patient-provider relationship. To her, feeling as though she is being listened to leads to a greater desire to have better health; allowing her to improve the relationship with this provider she sees as important to her health.

In addition, 19.6% of participants stressed the importance for providers to take the patient seriously and believe the patient's truth. A destigmatized and respectful approach is clearly vital to the relationship. For example, Hannah, a 22 year old college student, described a time when she had persistent pain after a back injury due to collegiate athletics. She noted, "When they completed the MRI, it didn't depict the pain that I had.

And I just thought, a medical professional's job is to treat the patient, and you can't always treat a patient based on a picture." Her truth was dismissed, and she searched for care elsewhere; where she eventually went in for a spinal fusion. Hannah's example invites a criticism of the paternalistic model to the patient-provider relationship. In this model, "the physician presents the patient with selected information that will encourage the patient to consent to the intervention the physician considers best. At the extreme, the physician authoritatively informs the patient when the intervention will be initiated" (Emanuel and Emanuel 1992, 2221). This case exemplified a paternalistic relationship as it devalued and overpowered Hannah's illness experience.

In less extreme examples, patients are pushing back against overly paternalistic relationships by desiring greater input on their treatment plans. In the interview process, 17.6% of patients independently stated they wanted some degree of say in their treatment plan. Resistance to pharmaceutical drugs (specifically, the term 'pills' continually came up) was notable in about 10% of patients; perhaps due to the nature of this particular clinic. This resistance was largely justified in one of two ways (1) the patient tried to use more natural and/or alternative therapies to achieve the same health benefits, or (2) patients felt they were 'strong' enough to get through an illness without taking pills, especially chronically. The latter justification is likely influenced by the largely rural culture often generalized as having to be self-reliant; having to 'tough-it' through illnesses and hard times (Crosby et al. 2012, 4).

When participants did have to undergo some type of treatment plan or further testing needed to be done, they tended to want to know their provider was willing to advocate and care for them. For many patients, it was important they felt as though their

provider cared about them outside of the scheduled office visit. This is an indicator of the relationship patients wish to have with their providers; many want to know their provider cares about them not just because they have a scheduled appointment. Patients understand this as a continuity of care issue. The most common way this was manifested was in the provider offering a way to be reached in the event of an emergency for advice; typically by giving their cell phone numbers to patients. In the open-ended interviews, 62.7% of participants indicated an appreciation for either being recognized outside of the clinic, being offered the provider's cell phone number and told to call anytime they need to, asking about 'personal life' (as patients termed it), or other ways of going the 'extra mile'.

An additional factor adversely influencing the relationship was described as the overuse of medical language. In all, 13.7% of participants mentioned this failure to speak in layperson's terms when describing treatment options or the clinical course of a disease. Figure 10 (below) shows the educational distribution of patients in this survey. While nearly 80% of participants have at least some college, the technical terminology of clinical medicine can be easily lost on even those patients with a healthcare

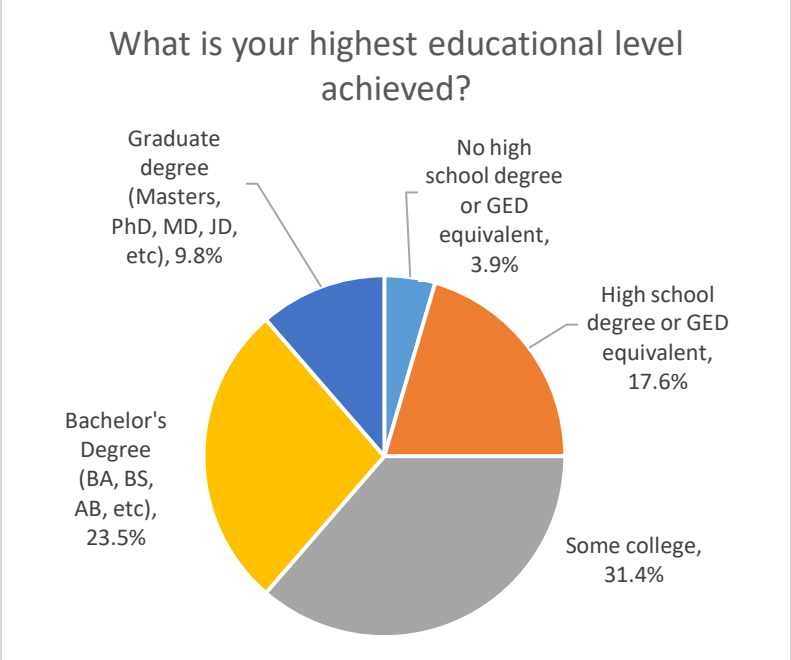

Figure 10: Educational Level of Participants by Highest Degree Achieved

background. One patient stated “talk [to me in] English, not ‘Medical-ese’. Although I have a medical background and I am a psychologist, don’t talk to me like a doctor.” However, there is a definite balance to be struck to make sure patients are receiving the information they need. Another participant, a 57 year old woman recognized how “it is important that they don’t talk down to you. It is important to talk to me in simple terms, but also acknowledge that we are intelligent and want to be acknowledged.”

Being able to use layperson’s terminology for as much of the discussion as possible is vital, according to the study findings. Not only does this allow the patient to feel as though they are more involved in their treatment plan, it also lessens the perceived cultural distance between patient and provider and can increase trust in the relationship. Schnittker supports this assumption with the hypothesis: “sociodemographic differences in physician trust can be explained largely by differences in physicians’ behavior” (2004, 220). Therefore, in a largely rural setting, patients could develop distrust in their healthcare providers due to this unfamiliarity with medical terminology.

An additional factor impacting trust in the relationship is the chronically low provider densities in many rural areas. As a demographic, then, rural patients may have less trust in the accessibility of providers, and, if they are accessible, how long any particular provider will stay in the area. Carrie, the 32 year old woman, provided an example toward this claim when she stated “we get used to a doc’ and then they move on.” In this study, 13.7% of participants independently indicated a similar frustration at the frequency of their healthcare providers moving. This typically came as a comment similar to the one above from Carrie.

Acts of care such as those described above—exceeding care expectations, proper communication (including when the provider is listening as well as how they speak to patients), believing the patient's truth, allowing patients to be part of the treatment option, speaking to patients in layperson's terminology, and having provider consistency—show how the development and maintenance of the patient-provider relationship should be a continuous priority for healthcare providers across the board. Participants thought it important for providers to build relationships with their patients so individual differences can be acknowledged in 31.4% of the open-ended interview process. One danger of not taking the time or effort to build the relationship lies within cultural cues that may hint at patient preferences. For example, Kurt, a 60 year old man with an outgoing personality, clarified "it is important to read a person correctly and carefully. Some people you can joke with and others you have to be business-like." This was important to him because he used humor as a way to become more comfortable with the situation and build a relationship beyond the clinical reason for his visit. He proudly shared, "I had one doc tell me that he is going to make my appointments the last one of the day, because I always give him something to think about on the way home." This type of camaraderie is important for many patients, especially as the topics discussed in the patient-provider visit can be uncomfortable or stressful.

Provider Characteristics: What do patients want?

Participants knew the development of the patient-provider relationship was at least partially dependent on specific characteristics making the provider more relatable. These characteristics can include the provider's communication skill, personality, as well as their age and gender. Below are discussions about the characteristics identified by

participants as having relatively high impact on the relationships. A full listing of these characteristic variables can be found in Table 5 (page 42). Importantly, the reported frequencies of these characteristics come from the semi-structured qualitative interviews with patients. In such interview processes, patients may not have been asked the same series of questions, they may have had differing understandings of the questions being asked, and they may have not listed an exhaustive list of the characteristics important to them. Therefore, these numbers are meant to represent those who deemed each characteristic important enough to mention. This structuring was a vital way of finding out what characteristics were valuable from the patient's perspective, without having the researcher select the characteristics to be studied and introduce the biases of such a design.

Communication Skill

In addition to the opposition to the overuse of medical language described in the section above, 37.3% of participants think it is important for their healthcare provider to be able to communicate well, be easy to talk to, and be good at reading people. Hannah, the 22 year old student, made note of this when she commented, "[Dr. B. APRN] reaches people on a social level- she is professional yet she is able to communicate well to patients. I don't think I would be able to learn and understand if I would be shown complex diagrams or things like that. For me, easy conversation is much better to understand what is going on." Therefore, being able to build the relationship and find the patient's preferred communication style is of value for healthcare providers.

Time

In the patient-provider relationship, patients will often require something hard to come by for physicians: time. Unfortunately, "the medical profession responded to the shortage of doctors by shortening the time doctors spent with patients" (Betz and O'Connell 1983:84-95). However, during the open-ended interview 41.2% of participants independently brought up an appropriate amount of time spent with patients as a desirable trait for providers. As described above, many of these participants may not have a conversational understanding of medical terminology, and may require careful explanation in order to gauge the most appropriate treatment option. Doris, a 55 year old woman, highlighted this when she said, "I like to be listened to, and some people can't describe exactly what is going on or how they feel. So I want someone to take the time to figure it out." Pushing through appointments quickly can leave the patient with unanswered questions and force them to try to find this information using other sources or simply wait until symptoms are more severe. A more extreme example came from Eunice, a 64 year old woman, who explained a scenario from her husband's visit to a different provider:

> "He'll ask a question about something to do with getting medicine or a shot and how to deal with it then the doctor would say, 'I'm the doctor, that's for the nurses to handle. I don't have time for that.' –I think he's kind of arrogant, or that he thinks he's special. My husband might not notice, but a woman notices. I think, 'well la-dee-da you're the doctor, I'll talk to Linda the nurse, she talks to me and does everything anyway'."[1]

[1] While unrelated to time, here, it is of interest to note Eunice's distinction between expectations based on the patient's gender. During the open-ended interview process, 19.6% of patients indicated a preference in the gender of their provider. Of these, all but one indicated a preference for a same-gendered provider as the patient. Only 6% of participants indicated a preference in the age of their provider, spread equally across those preferring younger, those preferring older, and those preferring similar ages to the patient.

Eunice's story shows how poor experiences can come from an individual lack of patience or structural inability to spend appropriate amounts of time with patients. A frustration with the lack of time spent with their provider was common among many patients. In all, 37.3% of participants independently indicated the importance of having adequate time for appointments or being able to get into the clinic soon enough.

Empathy

Perhaps more important to the relationship, though, is provider empathy towards patients. In all, about 35% of participants emphasized the importance of empathy or feeling as though the service to patients is prioritized. The 22 year old student, Hannah, shared, "I know it can be annoying to listen to patients all day, and that it takes a special person, but empathy and excitement is really important." Each patient is coming in with their own story they want heard. This, perhaps, plays in to the high percentage of participants who wanted to feel as though they were listened to. Acknowledging one's story gives them validation of the importance of their symptoms; it helps them feel as though their experience, their life, matters to more than just themselves. For patients, this also instills confidence in the provider working within the patient's best interests.

Additionally, empathy is interconnected with patience, trust, and judgment. Helen, a 56 year old woman, highlighted empathy as a necessary factor when she commented, "Empathy; care about how I feel and what is going on in my life. It shows that I can ask them questions without embarrassment or feeling stupid. It is easier to talk to these two [the NP and allergist she sees here] because I trust them and I know them. You have to trust your doc or nurse or whoever you are seeing." Empathy, then, can lead to better active listening, less judgment felt by patients, and greater trust in the

relationship. Having empathy also makes it possible to perform the appropriate acts of care for any particular patient.

Table 5: Frequency of Provider Characteristic Preferences in Open-ended Interview

Trait Description	Trait Frequency
Positive Traits	
• Feeling the provider is listening/paying attention/not prejudging	55%
• Desirable demeanor/personality/ friendly/ attitude/ sense of humor	49%
• Patience/ Willing to answer questions/ give enough information	43%
• Communicates well/easy to talk to/ good at reading people	37%
• Empathy, Caring, Service to patients/ compassionate, warm-hearted	35%
• Trust/ Truthful/ Honest	33%
• Build Relationships/ Acknowledge individual differences	31%
• Take Patient seriously, believe me/my truth, Respect patient/ not stigmatic	20%
• Going the extra mile	18%
• Make patient part of treatment/option/consider culture/socioeconomics	18%
• Remembering things about patients	16%
• Professional/responsible	14%
• Proper Referrals	12%
• Being hands on/ doing physical exam. Not just on computer	12%
• Good 'Bedside Manner'	10%
• Thinking/ willing to try outside of 'medical box	10%
• Open	8%
• Accepting Insurance/allowing time to pay	8%
• Becoming/ being part of the community	8%
• Excitement/positivity/enjoyment of what they do	4%
• Spiritual	4%
Negative Traits	
• Short/ Abrupt, Brash, Arrogant, rude	18%
• Standoffish/ unconcerned/ Scolding	16%
• Paternalistic relationship/ dictatorial	16%
• Overuse of medical language/ not speaking in layman's terms	14%
• Feeling like inconvenience/ annoyance/ defensive	12%
• Feeling Judged about numbers or behaviors	8%
• Scare Tactics	6%
• Not acknowledging the family/concerns of the family	4%

Perceptions of Health and Wellness

The variables displayed in Table 5 allows for the comparison of patient and provider perceptions of the relationship. However, discrepancies between patient and provider perceptions of health and wellness need to be discussed to determine the overlap of values and goals and whether this is enough an effective relationship. This was of particular importance in this clinic due to the complementary and alternative treatments offered as complements to or substitutes for biomedical treatments. While this discussion warrants multidisciplinary attention, medical anthropology is well positioned because "a strong tendency within the sub discipline, within both its 'critical' and 'interpretive' camps when such labels mattered, was the critique of biomedical universalism through the invocation of culture as local knowledge" (Cohen 2012, 73). In relation to this study, patient perspectives of health and wellness must be greater incorporated into the current healthcare institutions as local knowledge. With renewed vigor, then, medical anthropology should continue to lead the way in the validation of complementary approaches of health and wellness based on local, sociocultural definitions in the U.S.

About 10% of participants indicated in the open-ended interview process an appreciation for the provider being able to think outside of what was termed the 'medical box' and being willing to try some complementary and alternative treatments. In addition, 39.2% of participants indicated they appreciated the multiple options for treatments including treatment options offering more than just a pill. Some of these patients described aversion to what they termed 'pill-docs'; providers who, according to them, only cover up symptoms by "saying, 'oh just take a pill for this'" according to Angela,

the 39 year old woman. Dan, a 42 year old man, was one of these patients. He commented

> "I have a bad back and I use the chiropractor and massage. I think there are benefits of yoga and tai chi, or alternatives to pushing pills and I think that is great. When I was going through my back therapy, I could've gotten hooked on drugs because of the doctor that was pushing pain pills. He kept asking, 'well are you sure, I can get you more pills'. Some people can get hooked on it so easily. I appreciate the alternative things, if it is a professional thing."

Dan's example mirrors many other patients in this study who are becoming less and less willing to take pills for longer periods of time; particularly with pain pills. Because of this trend, as well as this clinic's overt inclusion of complementary and alternative treatments, this clinic served as an ideal place to study the value of these complementary and alternative perspectives and the effects these can have on both patient health and the patient-provider relationship.

One way patients described this complementary approach to health and wellness was by referring to it as a holistic (or a whole-person) approach. In fact, 19.6% of all participants independently indicated during the open-ended interview process the desire for their provider to have a holistic approach to health. When asked about this clinic, Helen shared, "they all care about what you're going through. It's not just your health, they're looking at the whole person." Additionally, 21.6% of participants in the open-ended interviews sated they wanted a balance between biomedical and complementary and alternative treatments. Angela indicated her "balance of Western and Eastern therapies. I had some stomach problems a few years ago, and after everything it was only fixed when I saw an Eastern medicine provider in Omaha. But, I realize that if you need an antibiotic, of course, take one." This blending of biomedical and complementary and alternative treatments (or Western versus Eastern medicine, as Angela puts it) is common

among patients. In addition, the decision for what types of illnesses necessitate either type of treatment option is culturally influenced.

As shown in Table 6 one third of the participants (33.3%) in this study had participated in complementary and alternative therapies, with another 17.6% of participants stating they were willing to try such alternative therapies or other non-strictly biomedical approaches. Together, this means 51% of all participants readily indicated being at least willing to utilize these complementary and alternative approaches. Of all participants, 21.6% indicated a preference for a balance between biomedical treatments and complementary and alternative therapies. On the other hand, about one fourth of patients were unwilling to try complementary and alternative therapies not supported by biomedical science. For example, when asked about complementary and alternative treatments, Larry, age 48, stated, "Personally, I don't agree with that stuff, I come here for diabetes. But, I'm not getting it pushed at me." Jason, a 37 year old man who came into the clinic with his wife, was similarly concerned about complementary and alternative treatments. He said, "We are Christians, and I don't know enough about the theology about it and don't want to do something that goes against my faith." Importantly, though, these preferences and even objections to the other treatments offered at this clinic did not deter most patients from coming back.

Throughout the interview process, the decision by the clinic to incorporate these complementary and alternative therapies was largely a non-issue, even for patients who do not participate in such therapies. Many patients in this study believed the amount of care they felt, as well as the competency they perceived, outweighed any slight discomfort they might have had on the issue; if they give it any thought at all. Because of

the relationships the staff at this clinic try to build with their patients, discomfort with extra things offered was minimal. Additionally, patients indicated the staff used good discretion on when they offered these complementary and alternative therapies to patients. They understood these treatments were not for every patient.

Table 6: Participant Utilization of Complementary and Alternative Therapies

		Frequency	Percent (%)
Valid	Unwilling to utilize complementary and alternative therapies	13	25.5
	Willing to try/not opposed to but have not	9	17.6
	Have utilized complementary and alternative treatments in the past or are currently doing	15	29.4
	Currently utilizing a different complementary and alternative medicine not offered at this clinic	2	3.9
	Total	39	76.5
Missing	No Response/Unusable	12	23.5
Total		51	100.0

Acknowledging the division of patients who will and will not be accepting of complementary and alternative therapies is an important approach to a complementary approach to healthcare. This is evident in Larry's comments above. However, Melissa, a 38 year old woman, showed that opinions can change as she described how she began utilizing alternative therapies. She stated, "My first time I thought it was weird when I heard about it at a talk. But then the second time I thought, 'hmmm, this is the way it should be'. I think the non-biomedical options are great and if it works, I'm open to it. I think more people should try it, but some people are closed-minded in what it should or shouldn't be." So how can these or other alternative treatments become included as complements to biomedical therapies? Through this case study, one area requiring further

assessment is whether NPs have a greater ability and likelihood of incorporating complementary and alternative therapies as complements to biomedical treatment when they are relevant.

The hypothesis, in this case, is contrary to the sentiment of NPs being less educated in biomedical science in comparison to a physician; a comparison not relevant to this analysis. Rather it focuses on their ability to integrate whole-person care into biomedical science without narrowing health to include only the biomedical approach. NPs may be better suited to incorporate complementary and alternative treatments when necessary due to a greater emphasis on the patient preferences and a less paternalistic patient-provider relationship. A provider's reliance on biomedical science can create another level of separation between a patient and their provider, if those patients are open to or currently practicing alternative or complementary medicine. Not only are patients and providers often separated by socioeconomic status and education, but they also may have fundamentally differing perceptions of health and wellness, and this can cause discomfort and strain in the relationship, as well as discontinuity of care. This is of particular importance for rural areas, where the next available provider may be towns away or only come into town once a week.

Discussion: Lifeworlds of the Patient-Provider Relationship

It is particularly useful to understand the patient-provider relationship in terms of Jürgen Habermas's theory of the 'lifeworld' and communicative action. Habermas described the lifeworld as a "culturally transmitted and linguistically organized stock of interpretive patterns" (1987, 124). Lifeworlds represent variances in experiences of the world and the ways in which these experiences are interpreted. A discussion on patient-

provider relationships, then, can be understood as a coming together of lifeworlds. Habermas's theory of lifeworlds includes a hierarchy of three ways an individual can relate to the world. These are the objective lifeworld, the social lifeworld, and the subjective lifeworld (Habermas 1987). Due to the results of this study being largely focused on the factors influencing the patient-provider relationship, this theory can be utilized to place the study findings into context. Study variables suggested by the participants as influencing the patient-provider relationship can be interpreted based upon their theoretical relation to the realms of the objective, social, and subjective lifeworlds.

The objective realm includes the "totality of entities about which true statements are possible" (Habermas 1987, 120). This represents those entities that are able to be have a truth claim made about them. An example of this is an event; a claim can be made about a patient having a specific surgery and can either be true or false in representing that reality. The social world encompasses "the totality of legitimately regulated interpersonal relations," including obligations "supposedly shared by all the members of a collective" (Habermas 1987, 120). It is in this world where sociocultural factors play a major role in the perceived possibilities for truths. In relation to the patient-provider relationship, this world defines what is perceived and accepted to be an illness, the ways patients and providers will attempt to be healthy (including both preventive medicine and disease treatment options), and similar factors designated by sociocultural structures. The subjective realm, then, includes the "totality of experience to which a speaker has privileged access and which he can express before a public," and "that other actors attribute to the speaker's own subjective world" (Habermas 1987, 120). This represents the lived reality and rationalization of the experiences of an individual who may or may

not be representative of a broader sociocultural perspective. In terms of the patient-provider relationship, the subjective realm includes the patient or the provider's experiences and individualized perspectives of health. Previous sections have aimed at categorizing the influences and impacts of the relationship. This section sets out to determine how different aspects of the patient-provider relationship are influenced by a lifeworld-focused analysis of healthcare relationship perceptions. These 'aspects' of the patient-provider relationship to be discussed include the person-person relationship, the patient-provider relationship, and the client-business provider relationship (see Figure 11).

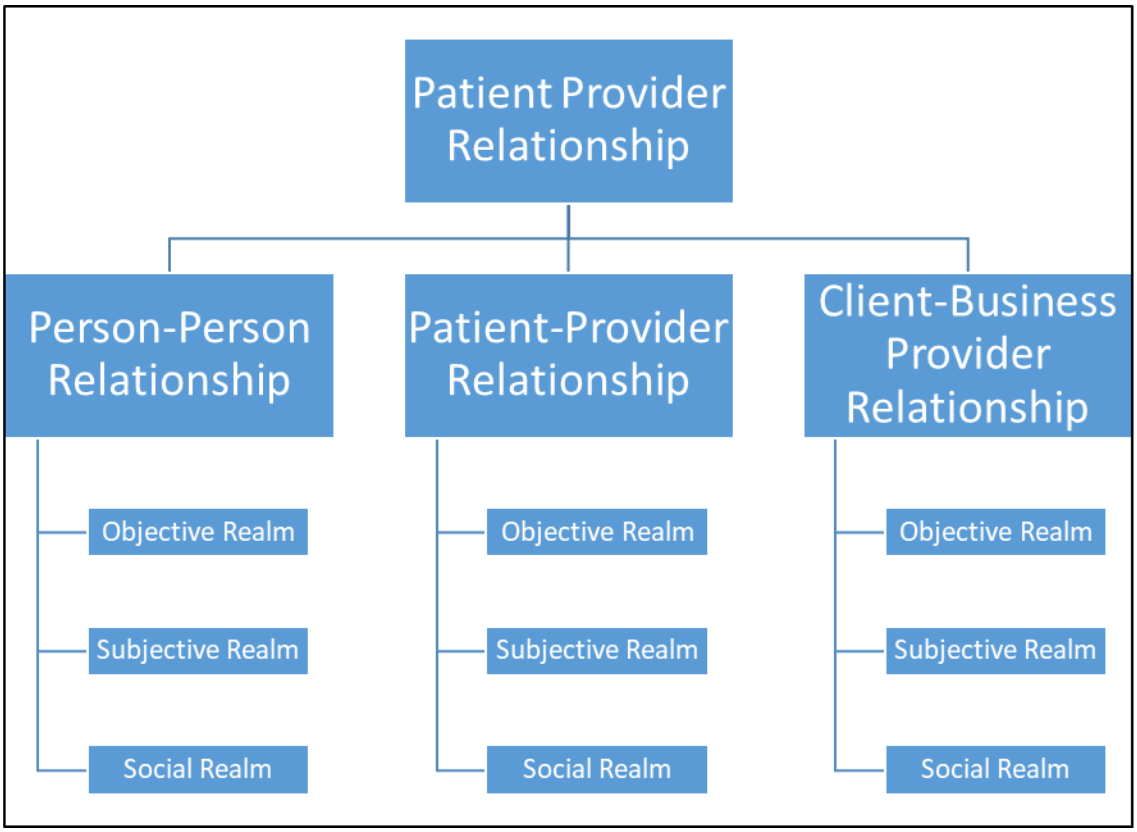

Figure 11: Lifeworlds within the Patient-Provider Relationship

World of the Person-Person Relationship

The person-person relationship represents the interpersonal aspect of the patient-provider relationship. This part of the relationship refers to the bond formed (or lack thereof) between two people. As the patient seeks healthcare they are, on a very fundamental level, forming and maintaining an interpersonal relationship. In this relationship, very personal details will be shared and often done so in a one-sided fashion. Additionally, suggestions for treatments can have major impacts on acute and chronic health conditions. Therefore, the development and maintenance of the person-person relationship is a vital first step in establishing trust, comfort, and a sense of understanding between the patient and the provider. These characteristics are examples of the subjective realm, as each patient has individualized experiences and perspectives influencing their needs from the relationship.

As an example, one of the characteristics of person-person relationship warranting further description is interpersonal trust. This type of trust "has deep roots in socialization, personality development, and primary relations, it is often closely associated with strong affect, and it develops gradually in the course of repeated interactions through which expectations about a person's trustworthy behavior can be tested over time" (Mechanic and Schlesinger 1996, 1694). In addition, according to Russell, interpersonal trust can be "built, sustained or damaged through face-to-face encounters with health providers and is more likely to increase with long-term doctor-patient relationships" (2005, 1397). While some have tried to quantify this relationship (for example, see Anderson and Dedrick 1990), sociocultural differences in definitions of trust can complicate operationalization and standardization of such a measure.

For interpersonal relationships, “trust in persons is an intimate form, deriving from earlier experiences with family and other caretakers. Trust forms early in life based on emotional bonds and amplified cognitively over time” (Mechanic 1996, 173). In light of this, previous experiences can shape the type of characteristics a patient seeks from providers. For example, the ways participants discussed the issue of trust in the relationship showed the interpersonal relationship was often based upon personal characteristics making the provider easier to communicate with and receive empathy from. This is also supported by Mechanic as trust is described as a function of “personality traits, the characteristics of the person or entity to be trusted, and the context in which the interaction occurs” (Mechanic 1996, 173). Trust, then, “is dynamic and fragile, easily challenged by a disconfirming act or by a changing social situation” (Mechanic 1996, 173).

Personal characteristics of providers, then, can have major impacts on trust and can impact the relationship. Habermas’s objective realm, in the setting of healthcare, can be exemplified by the effects of trust on healthcare seeking behaviors (see Figure 12). The social world can be utilized to describe the social influences of preferred characteristics in trusting another person (see Figure 12, for example). The subjective realm also comes into play as patients have individual preferences of these characteristics based upon their own experiences with providers (see Figure 12). These provider characteristics can be based on behavior or attitude, but can also be based on physical characteristics. One such physical characteristic that can impact the perceptions of the relationship is that of gender discordance in the relationship. In this study, the only provider characteristic significantly varying by the participant’s gender included women

being significantly more likely to mention being conversationally short, rude, or abrupt as a negative trait as compared to men (29% compared to 0%, respectively, p=0.021). Additionally, patients indicating some kind of a preference in the gender of their provider were significantly younger than those who did not (43 years compared to 57 years, respectively, p=0.006).

More personal traits varied significantly by age than by gender. The average age of participants was significantly younger for those who indicated communicating well or being easy to talk to as a positive trait as compared to those who do not (48 years compared to 59 years respectively, p=0.012). Additionally, participants indicating a single poor experience poorly affects future relationship building were significantly younger than those who did not (42 years compared to 57 years, respectively, p=0.013). These patients (those indicating a single poor experience poorly affects future relationship building) were also significantly more likely to want to be taken seriously, as opposed to those who did not list they wanted to be taken seriously (40% compared to 7.3%, respectively, p=0.021). Of the characteristics with the possibility of giving a participant a poor experience, participants listing standoffish or unconcerned as a negative trait were significantly younger compared to those who did not list this trait (41 years compared to 57 years, respectively, p=0.004).

The above are merely examples of the ways patients want their provider to relate to them on a personal level. With respect to Habermas's theory of the lifeworld, this study shows some of the factors of the social world and their influence in the patient-provider relationship on both an interpersonal and structural level. For example, in the largely rural context of this study, these personal relationships may have greater

significance in the healthcare seeking patterns of patients (see Figure 12). In this sense, then, provider densities are an example of Habermas's social world. Within a culture, there are norms that influence how provider shortages can be remediated. Although this is a multifactorial issue, healthcare structures have been unable to adequately broaden the provider variety or availability for many rural areas. There are some providers who come to the area and utilize the student loan repayment programs, however, then leave the area not long after their service commitment. Additionally, due to low intrinsic interest in rural practice as well as increased structural frustrations coming with rural practice, many providers utilize loan repayment programs and subsequently move on with their careers elsewhere. This is bound to happen, of course. However, in rural health it is particularly problematic and is viewed as a revolving door by patients. As Reb, a 68 year old woman, stated after losing a long time PCP, then only having the other provider there for a few months, "it was uncomfortable to have multiple providers move through in a short time. Now, every time I see a new doctor I ask 'are you *sure* that you are going to stay'." This discontinuity of care is a structural insufficiency and can affect the relationship building for patients in these areas. The major driver behind the NP expansion in places like Nebraska is the hope for NPs to help fill the rural provider gap. However, further research regarding these intended effects is needed to assess the reality on the ground.

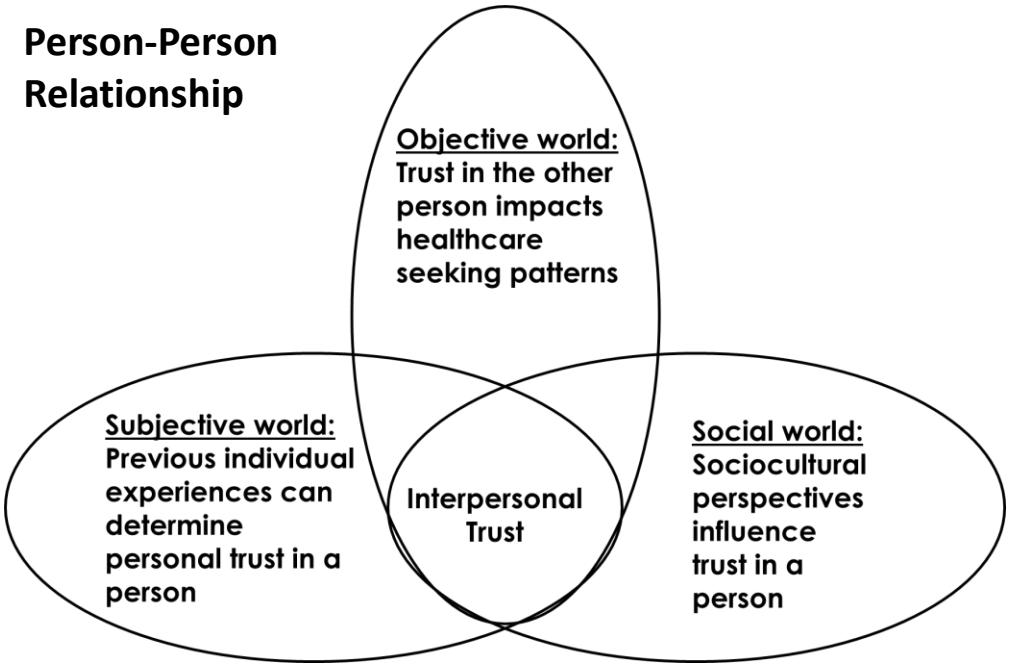

Figure 12: Interpretation of Person-Person Relationship with Habermas's Lifeworld

World of the Patient-Provider Relationship

A second lifeworld developing from this study is the patient-provider relationship. The patient-provider aspect of the relationship represents the caregiving and care-receiving aspect of the relationship. The patient-provider relationship is a type of social trust. Mechanic and Schlesinger define social trust as "more remote, influenced by media exposure and general reputation more than by firsthand knowledge. It is also likely connected with broader forms of confidence in social institutions generally" (1996, 1694). In this sense, the world of the patient-provider relationship includes both the individual patient and provider, but it also includes larger sociocultural influences impacting how care is provided, the power dynamic of the relationship, and healthcare seeking practices of patients.

The above points toward an example of the objective realm within the patient-provider relationship lifeworld is the concordance or discordance of outcome

expectations between patients and providers. The analysis found in the Credentials, Competency, and Cultural Distance section of the results discusses the ways the credentials of the provider can affect the patient-provider relationship and different types of providers may generally have reduced cultural proximity due to their training outside of the area. The objective realm of the patient-provider relationship, then, can be exemplified by the differences in outcome expectations for any treatment or disease process and how these are affected by differences in cultural distance between patient and provider (see Figure 13).

In the subjective realm of the patient-provider relationship, a patient's trust in a provider can be defined "as a person's belief that the physician's words and actions are credible and can be relied upon" (Anderson and Dedrick 1990, 1092) (see Figure 13). Further, Huw and Rundall describe how high levels of trust can benefit patients:

> "A reduced burden on the patient (less need to check); reduced shopping around for health care (fewer second opinions; trust in physician advocacy); better patient loyalty; fuller patient disclosure; improved two-way communication; better treatment compliance; improved patient satisfaction; improved outcomes (arising, for example, from better compliance with treatment and an increase in the placebo effect); greater patient reassurance and reduced anxiety; and potentially less litigation. Finally, without trust there can be little caring, and caring is central to health care." (2000, 613-614)

As the patient seeks healthcare, their experience is interpreted and given meaning to by the provider. Having a high degree of trust in this relationship can make the relationship much more beneficial for all parties. However, misinterpretations due to insufficiencies in this relationship can lead to discontinuity of care and poor health outcomes. For example, of study participants, the amount of people indicating not generally relating well to providers were significantly more likely to also not like going to the doctor's office in general (22.2% compared to 3% who are comfortable enough going to the

doctor's office in general p=0.047). This also has very real effects on healthcare seeking patterns. Patients not generally liking going to see a healthcare provider were much more likely to indicate a desire for good communication from their provider when compared to those who did not indicate a dislike for going to healthcare providers (100% compared to 30%, respectively, p=0.005). Of these same patients who dislike going to providers, they were significantly more likely to feel as though the care they receive in the relationship is more important than the perceived competency of the provider (40% compared to 4%, respectively, p=0.043).

Within the social realm of the patient-provider relationship, society's discussion on medical authority also plays a role in the relationship (see Figure 13). In this study, women were significantly more likely to indicate a desire to be made part of the treatment option compared to men (29% compared to 0%, respectively, p=0.021). This difference is likely due to the effects of historical gender roles of women. They may be more likely to be upfront about wanting this in the relationship because they have not had this type of power balance in the past. However, participants who were women still felt it important to describe their interest in being adequately included in treatment decisions as indicated by the interview process. This represents a shift in the patient-provider relationship away from paternalism and toward a more deliberative model (Emanuel and Emanuel 1992).

In addition, this preference for a move away from paternalism was telling. The average age of participants was significantly younger for those who indicated a preference for taking the patient seriously and respecting the patient when compared to those who did not indicate this preference (45 years compared to 57 years, respectively,

p=0.012). This was also true for patients indicating scare tactics as a problematic tool in the relationship (35 years for opposing scare tactics [n=3] compared to 56 years for those not commenting [n=43], p=0.013, sample sizes were included to show small sample for those opposing scare tactics). While only 6% of participants indicated a distaste for scare tactics, this introduces a topic that should be of interest in studies of patient-provider relationships. Motivational preferences of patients can only truly be understood by building the relationship and having discussions upfront about how patients react to different motivational approaches such as scare tactics. This study suggests the possibility of a trend toward an aversion of scare tactics utilized on younger participants.

Younger participants in this study were also significantly more likely to use this provider (a nurse practitioner) as their PCP compared to those who do not use this provider as their PCP (49 years compared to 61 years, respectively, p=0.003). A study of the ways society has been socialized towards greater acceptance of NPs, then, would be a worthwhile endeavor, as many patients are transitioning toward greater NP utilization.

As this was a NP operated clinic, many of the patients had purposefully sought out the care of a NP as opposed to a medical doctor or physician's assistant. This trait was significantly related to other factors as well. In fact, the amount of people indicating midlevel providers (nurses, NPs, and PAs) relate better were significantly more likely to list good communication is a positive trait as opposed to those not indicating midlevel providers as relating better (67% compared to 28%, respectively p=0.037). Additionally, participants who preferred the midlevel relationship were significantly more likely to dislike being standoffish or unconcerned as a characteristic of the provider compared to those not indicating midlevel providers as relating better (42% compared to 8%,

respectively, p=0.012). When talking about a holistic view of health, patients preferring these midlevel providers were significantly more likely to want a holistic or whole-life understanding from their provider than those not indicating a preference for midlevel providers (42% compared to 8%, respectively p=0.042).

Since patients who preferred midlevel providers were more likely to prefer a more holistic view of health, this particular clinic provided an interesting case study. Participants who wanted a balance of biomedical and complementary and alternative treatments were—understandably—significantly more likely to want to be taken seriously than those who did not want this type of balance (50% compared to 15%, respectively, p=0.027). This greater emphasis on a balance may represent a pushback against the pharmaceuticalization of health and a greater interest in more natural alternatives. This balance often came in the form of patients wanting more than just a pill for their complaints. In fact, these people were significantly more likely to want to build a relationship than those who did not (63% compared to 28.6%, respectively, p=0.031).

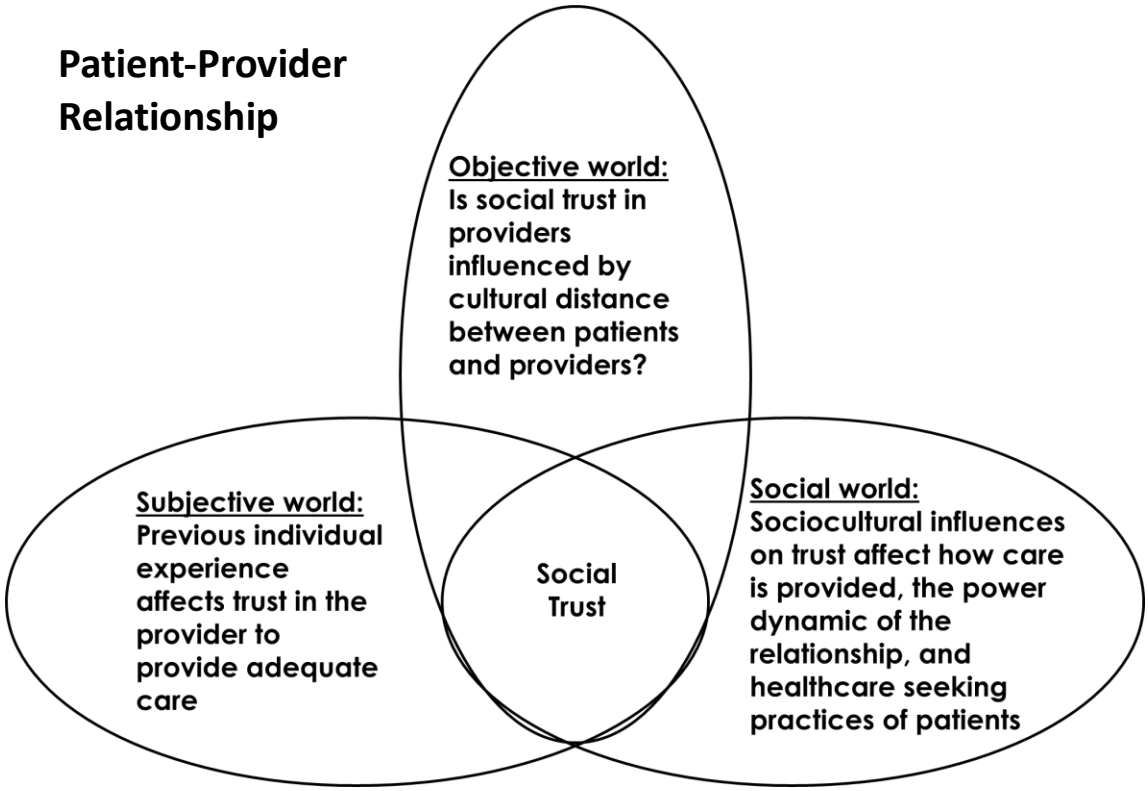

Figure 13: Interpretation of Patient-Provider Relationship with Habermas's Lifeworld

World of the Client-Business Provider Relationship

In addition to the interpersonal and the patient-provider relationships established through the interview process, the client-business provider relationship was another facet of the relationship having become apparent through these interviews. The client-business provider relationship describes the relationship between the patient and the provider through the lens of the provider as a business. The business side of medicine plays a sizeable role in both the interpersonal relationship as well as the patient-provider relationships as they are described above. This was termed the client-business provider relationship. This aspect of the patient-provider relationship represents the corporate-client actions such as scheduling, billing, and even some structural issues such as provider access.

Within the client-business provider relationship, individual experiences and perceptions on paying for healthcare, dealing with billing and insurance companies, and even scheduling appointments can be examples of the subjective realm. Patients have their own unique experiences with these events, including their stresses, frustrations, and shame. The objective realm of the client-business provider relationship can be represented, then, by the effects of these above variables on the patient provider relationship. One way to measure these would be through the use of patient satisfaction surveys (see Figure 14).

The subjective realm of the client-business provider relationship was an important factor in patients' comfort with individual healthcare providers or healthcare institutions in general (see Figure 14). This aspect specifically dealt with the business side of healthcare impacts the patient-provider relationship. Simply acknowledging the business relationship is one way the patient-provider relationship is defined. For example, women were significantly more likely than men in this study to acknowledge how the business relationship influences the patient-provider relationship (26% compared to 0%, respectively, $p=0.040$). Women were more likely, in this case study, to notice some providers have limited time to see patients and recognize this helps them see more patients in a day and increase their revenue. As Sandra, a 34 year old woman, bitterly commented, "fifteen minutes with a patient isn't quality of care, that's just a business." In addition, participants in this study thought midlevel providers helped reduce these wait times. The amount of people who indicated midlevel providers (again defined as nurses, NPs, and PAs) related better were significantly more likely to want adequate time for

appointments and easier scheduling as compared to those not indicating midlevel providers relate better (67% compared to 28%, respectively, p=0.037).

These patients (those believing midlevel providers related better) were also significantly more likely to be appreciative of a money saving measure this clinic utilizes for their lab service. The Whole Care Clinic performs a wide array of lab draws for each patient and sends them to labs who have the policy of not charging patients more than what is covered by insurance. Patients who indicated an appreciation for the lab charges were significantly younger, on average, than those who did not indicate an appreciation (37 years compared to 56 years, respectively, p=0.028).

An interpretation of the social realm for the client-business provider relationship can include sociocultural impacts on provider type, provider availability, and the acceptance of complementary and alternative healthcare methods as acceptable business models (see Figure 14). The overall acceptance of NPs as PCPs is an example of the social realm changing to allow for greater access to healthcare for rural areas.

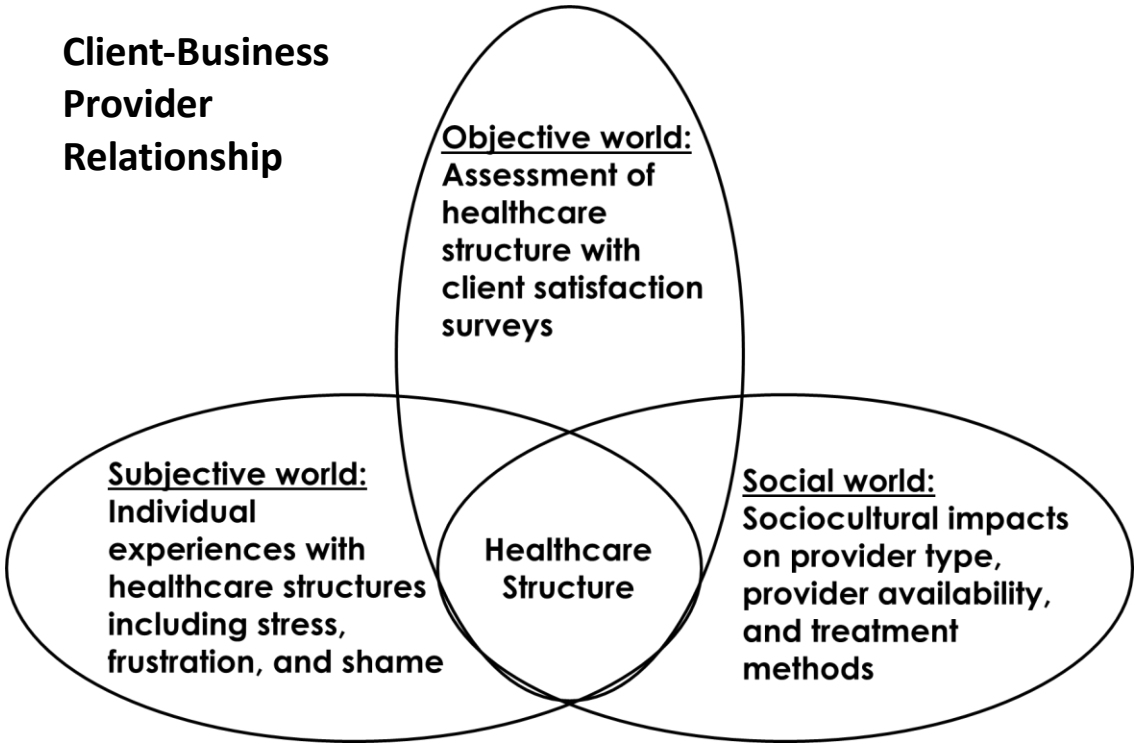

Figure 14: Interpretation of Client-Business Provider Relationship with Habermas's Lifeworld

Conclusions and Further Study

In the context of a rural NP operated clinic, patients perceive provider credentials as less important to the ability of a provider to serve the patient when compared to having the traits necessary to help the patient feel as though they are being cared for. This is suggestive of a need for increased attention to be given to the motivations and altruisms of healthcare provider applicants and graduates.

Building these relationships between patients and providers can allow for increased trust in the patients relationship to both the individual provider and the healthcare system in general. In the absence of such trust, the development or

maintenance of the patient-provider relationship can cause major access barriers for rural patients. Trust, though, is but one factor contributing to the relationship. Interconnected with perceptions of trust are provider characteristics and provider actions that determine the appropriateness of the continuation or further development of the patient provider relationship.

This study stresses the importance of taking time to build the patient-provider relationship, and this was particularly apparent in the preferred characteristics of the provider as indicated by patients. Characteristics such as a provider's communication skills, the amount of time they are able to spend with patients, and the amount of empathy they show towards patients have proven, for many patients, to be determinants of the ability of a provider to care for patients.

While characteristics are important, the ways providers show they care through their actions are perhaps equally as important. Showing they are listening, providing care above and beyond what was expected, and taking patients seriously are some examples of acts deemed important to the success of the relationship.

Fundamental to the development of this relationship is the ability of patient and provider to come to an agreement on their perceptions of health and wellness, and how this will impact potential treatment options. From an anthropological perspective, the ability to take an emic perspective in the relationship is a vital for both working and prospective healthcare providers.

Placing these variables into context utilizing Habermas' theory of the lifeworlds allows for an analysis of the patient-provider relationship. Using this perspective, the

patient-provider relationship can be understood through the person-person relationship, the patient-provider relationship, and the client-business provider relationship lifeworlds. An important next step for further research on the subject of patient-provider relationships is to further elucidate the effects of the patient-provider relationship on both short-term and long-term health outcomes. This will be particularly important in rural contexts due to the chronically low provider densities, as many patients lack alternative options.

While patients agree the patient-provider relationship is important, there is relatively little focus by healthcare providers on concrete ways of building these relationships. Any attempts by providers (or the healthcare system as a whole) to incorporate changes to benefit the relationship require careful planning and a multidisciplinary approach due to the multifaceted nature of the patient-provider relationship. Medical anthropologists must play a role in this refocusing of medical providers toward relationship building; both in the study of current trends and deficiencies in the relationship as well as suggested changes to healthcare policy and education. While these relationships can help build trust in both individual providers as well as healthcare institutions, this study shows how greater relationships can also help providers be more caring and accepting of complementary and alternative perspectives in treatment plans. Based upon the clinic of focus in this study, then, an area of further study is whether such integrated clinics inclusive of complementary and alternative therapies are able to provide more culturally relevant care, as well as whether this type of care can improve paradigms in pain therapies in the midst of the opioid epidemic.

This study also suggests NPs may have a greater ability to relate to patients when compared to other healthcare providers. Further study, then, should include more detailed ethnographic research into the interplay between cultural proximity and the patient-provider relationship. In other words, what degree of sociocultural separation is beneficial for the patient-provider relationship, and how does this vary by region and across culture?

With the increasing frequency of NP utilization as PCPs, Nebraska and many other states have the opportunity to not only study how such a change can affect healthcare access and provider distribution, but to also study the types of relationships patients are having with providers. Within the context of this study, it is important to be cautious in not strictly advocating for more NPs as PCPs. On the contrary, more staffing for rural PCPs are needed across the board. In a team-based approach to rural primary care, then, an increased focus on the development and maintenance of the patient-provider relationship should invite providers to be more relatable to patients regardless of their credentials. Greater study, then, needs to be done to determine how providers of all backgrounds should attempt to relate to patients and what role this relationship plays in the health of their patients.

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Appendices

Appendix I: Quantitative Questionnaire for Patient-Participants

Alternative Healthcare Relationships Survey

Thank you for agreeing to participate! Your responses are very valuable to this study.

1. Have you been to this clinic or seen this provider before?

   Yes No

2. Is this your primary care provider?

   Yes No Not sure

3. Which of the following do you see at least yearly, and about how often do you visit each healthcare provider?

Check if Yes	Type of Provider	Enter number of times per year you visit each provider
☐	Nurse	About ☐ times per year
☐	Nurse Practitioner	About ☐ times per year
☐	Physician's Assistant	About ☐ times per year
☐	Family practice physician (with an M.D.)	About ☐ times per year
☐	Specialty Doctor (Cardiologist, Psychiatrist, etc.)	About ☐ times per year
☐	Other provider (Chiropractor, healing touch practitioner, acupuncture, etc.)	About ☐ times per year

4. In general, how concerned do you think medical providers are about your health and wellness?

   Very Concerned | Concerned | Fairly Concerned | Not Concerned at All | Not Sure

5. How would you rate your health?

   Very Good Good Fair Poor Very Poor

6. Gender (Please Circle): Male Female Chose not to disclose

7. What is your age? _____

8. Which of the following best describes your racial or ethnic background?

   ___African American
   ___Asian American

___Native American
___Hispanic or Latino American
___Caucasian
___Other: (please describe _____)
___Choose not to disclose

9. What is your highest educational level achieved?
___No high school degree or GED equivalent
___High school degree or GED equivalent
___Some college
___Bachelor's degree (BA, BS, AB, etc.)
___Graduate degree (Masters, PhD, MD, JD, etc.)

10. Which of the following best describes your annual income?

___ Less than $10,000
___$10,000 to $14,999
___$15,000 to $24,999
___$25,000 to $34,999
___$35,000 to $49,999
___$50,000 to $74,999
___$75,000 to $99,999
___over $100,000

Appendix II: Interview Schedule for Patient-Participants

Patient Interview Schedule (Semi-structured)
Pre-encounter questions:

1. Can you describe your relationship with healthcare providers, in general? Nurses? NPs? Family Practice Doctors? Physician's assistants?
2. How well do you relate to them? How well do they relate to you?
3. What personalities or traits do you want in your provider?
4. What is your overall impression of the nurse practitioners that you have seen compared to other providers? How frequently do you see a nurse practitioner?
5. Have you tried the healing touch practice that this clinic offers? If yes, how do you think this alternative therapy helps build a relationship with the practitioners and others?

Post-Encounter Questions:

6. How would you describe your relationship with *this* specific provider?
7. What is different between this provider, and other providers that you have had in the past?
8. (If patient is not a new patient to the clinic) Why do you continue to visit this clinic when other options are available?
9. This provider is a Doctor of Nursing Practice, what does her background as a nurse and a nurse practitioner mean to you? How do you think this affects your relationship with her?
10. What, if anything, do you think stands in the way of you creating a good relationship with your provider?
11. Do you feel as though your healthcare providers care about you outside of the exam room/clinic?
12. Of the staff here, who do you feel closest to? Why do you think so?