2020

Doctor-Patient Communication: The Experiences of Black Caribbean Women Patients With Diabetes

Rosanne Paul-Bruno

Doctor-Patient Communication: The Experiences of Black Caribbean Women Patients With Diabetes

by
Rosanne Paul-Bruno

An Applied Dissertation Submitted to the
Abraham S. Fischler College of Education
and School of Criminal Justice in Partial
Fulfillment of the Requirements for the
Degree of Doctor of Education

Nova Southeastern University
2020

Approval Page

This applied dissertation was submitted by Rosanne Paul-Bruno under the direction of the persons listed below. It was submitted to the Abraham S. Fischler College of Education and School of Criminal Justice and approved in partial fulfillment of the requirements for the degree of Doctor of Education at Nova Southeastern University.

Candace H. Lacey, PhD
Committee Chair

Charlene Desir, EdD
Committee Member

Kimberly Durham, PsyD
Dean

Statement of Original Work

I declare the following:

I have read the Code of Student Conduct and Academic Responsibility as described in the *Student Handbook* of Nova Southeastern University. This applied dissertation represents my original work, except where I have acknowledged the ideas, words, or material of other authors.

Where another author's ideas have been presented in this applied dissertation, I have acknowledged the author's ideas by citing them in the required style.

Where another author's words have been presented in this applied dissertation, I have acknowledged the author's words by using appropriate quotation devices and citations in the required style.

I have obtained permission from the author or publisher – in accordance with the required guidelines – to include any copyrighted material (e.g., tables, figures, survey instruments, large portions of text) in this applied dissertation manuscript.

Rosanne Paul-Bruno
Name

October 6, 2020
Date

Abstract

Doctor-Patient Communication: The Experiences of Black Caribbean Women Patients With Diabetes. Rosanne Paul-Bruno, 2020: Applied Dissertation, Nova Southeastern University, Abraham S. Fischler College of Education and School of Criminal Justice. Keywords: Blacks, diabetes, doctor-patient communication, patient experience, verbal communication, nonverbal communication, patient-centered care, doctor-patient relationship, concordance, empowerment, self-efficacy, value care

This applied dissertation was designed to examine the verbal and non-verbal communication experiences of Black Caribbean diabetic women patients with their doctors, in order to provide a better understanding of the essential aspects of doctor-patient communication and their experiences as they managed their condition. Black Caribbean women have been disproportionately impacted by medical conditions such as diabetes. It has been a documented fact that minorities experience disparities in the health care system at different levels and doctor-patient communication is no exception. Poor doctor-patient communication has been known to hinder patients' health outcomes, and therefore warrants such studies to increase the understanding of specific behaviors to improvement patient satisfaction and health outcomes.

The researcher developed an interview instrument/questionnaire using an expert and lecturer in Research and Graduate Studies in Public Health to validate it. The interview questionnaire which included semi-structured questions was used to conduct face-to-face, one on one interviews with 12 Black Caribbean diabetic women patients to investigate their experiences and perceptions of doctor-patient communication behaviors.

An analysis of the data revealed that while some Black Caribbean diabetic women patients experienced favorable doctor-patient communication many were discontented with their doctors' communication behavior. The aspects of doctor-patient communication which most positively influenced doctor-patient communication satisfaction was not only dependent on whether or not desired value care was met but also included concordance, patient-centered care, and relationship building communication. When doctor-patient communication expectations were unmet, patients responded negatively by either being noncompliant which resulted in negative health outcomes, and in other cases decided to change to a more relatable doctor who met their doctor-patient communication needs.

Table of Contents

Appendices

Chapter 1: Introduction

Statement of the Problem

The problem under investigation in this study was the implications of poor patient-provider communication behaviors between Black Diabetic Patients and Healthcare Providers. Although effective communication is necessary to foster a good doctor-patient relationship, which in turn would result in positive patient outcomes and patient satisfaction, patients continue to report that doctors lack the necessary communication skills. In fact, this was confirmed through study findings that suggested that there are still unmet needs relating to doctor-patient communication (Eun-Jung et al., 2016). Nowhere are issues with verbal and non-verbal expression more crucial than in health care because breakdown in communication places humans at risk; and no risk is greater than that faced by people who are sick and in need of health care, because it may be a life and death situation.

Phenomenon of interest. Lack of effective communication is the biggest deficiency where doctor-patient relationship is concerned and this contributes to health care disparities; hence the importance of effective patient-provider communication. This was reiterated in study findings that suggested physician attitudes, such as stereotyping, and implicit bias about race, even if unconscious, negatively affect the doctor-patient relationship in ways that may contribute to health disparities (Blair et al., 2013).

Addressing communication problems in healthcare is of particular importance in an attempt to alleviate healthcare disparities, which has a negative effect on patients' outcome. Despite advancement in healthcare little progress has been made in reducing racial disparity in quality of care among minorities such as African Americans (Williams

& Wyatt, 2015). Statistics has indicated that care has not been administered in same proportions among the races; there has been a disparity in the health of blacks, in the areas of healthcare utilization and outcome (Cook, Kosoko-Lasaki, & O'Brien, 2005). Minorities receive a lower quality of healthcare than Whites, according to research conducted by Aruguete and Roberts (2002).

Effective doctor-patient relationship is important when giving medical care to patients, as it has the potential to either negatively or positively impact patients' outcome. For this reason, this dissertation focused on the verbal and non-verbal communication experiences of diabetic Black patients with their doctor, identifying the challenges encountered in communication, and the specific factors influencing their experience.

Background and Justification

The 2012 *National Healthcare Disparities Report* (NHDR) affirmed that "healthcare quality and access are suboptimal, especially for minority and low-income groups" (p. 2) and although the overall quality of healthcare is improving "access is getting worse and disparities are not changing" (p. 2). The problem of Health inequalities is not exclusive to the United States, but in fact, it is a concern that affects and "exist in most countries around the world" (Mercer et al., 2016, p. 117). They further described this inequality in healthcare with the term 'inverse care law' whereby "the availability of good medical care tends to vary inversely with the need for it in the population served" (p. 117).

There are disparities across a wide range of diseases; however, among the diseases where there is noticeable disparity, diabetes is of particular concern. Rose and Harris (2015) made reference to minorities vulnerability to experience sub-optimal care, for instance, they receive poorer quality diabetes care from doctors, get less positive verbal and nonverbal socioemotional support, and are less involved during consultation.

According to Beckles and Chou (2013) “in 2011 an estimated 26 million persons aged >20 years (11.3% of the U.S. population) had diabetes” (p. 99) and has been increasing “with minority racial/ethnic groups experiencing the steepest increases and most substantial effects from the disease” (p. 99). They are suffering from diabetes complications such as neuropathy, retinopathy, vascular, and kidney diseases.

The 2012 *National Healthcare Disparities Report* called for urgent need to improve the quality of diabetes care and healthcare in general in the southern states. With Florida being among the states which fall in the bottom quartile in quality of care as stated by the NHDR, and one of the States with the largest total (3.2 million) number of Black residents as stated by CDC, this validated the need for this study in Palm Beach County, Florida.

The Black population was selected to be studied because, not only has there been low participation in past studies due to their distrust for the healthcare establishment and providers, which may have stemmed from the Tuskegee Study of 1932-1973, but furthermore, they were not being asked to participate in healthcare studies (Cook et al., 2005). By having Blacks participate in healthcare studies, this has the potential to improve their trust in their healthcare provider and the healthcare system; and simultaneously, healthcare providers are able to gain an understanding of patients’ experiences and perceptions, which is an asset in improving patients’ care, and ultimately aids in minimizing health disparities in Blacks.

Deficiencies in the Evidence

Anything that hinders patients' health outcomes, such as poor doctor-patient communication, is a serious impediment and warrants particular attention. For this reason, researchers have encouraged future studies that increase the understanding of specific behaviors that lead to improvements in health outcomes (Kaplan, Greenfield, & Ware, 1989).

A Study by Cook et al. (2005) affirmed that cultural incompetence by healthcare providers is one of the factors which contribute to problems of communication, establishment of trust and satisfaction. The authors concluded that there is room for improvement in communication, and identified language barrier as a factor that potentiates problems when seeking health care services. It was mentioned that there is an immediate need for further research "to describe the effective nonverbal behaviors for physicians in diverse cultural settings" (Aruguete & Roberts, 2002, p. 802).

Despite evidence on the importance of effective doctor-patient communication in patient outcomes, in particular non-verbal communication, "physicians typically view non-verbal communication as a non-critical aspect of care" (Stepanikova et al., p. 580). As a result, there is urgent need for further studies on not only verbal, but also non-verbal communication skills, in an attempt to improve the delivery of care in an increasingly culturally diverse patient population. This study was guided by past studies such as Mazzi et al (2016), which called for more studies to be conducted on patient experiences and preferences, and Eun-Jung et al. (2016), which went further by suggesting that studies be conducted with different populations.

Audience

This study benefits all levels of healthcare providers (doctors, nurses, pharmacists, medical assistants, and those involved with the management of social services), by raising awareness of doctor-patient communication problems, particularly in the black population, in an effort to improve their standard of care. The study can also serve as a guide in assisting policy makers in the development of interventions to alleviate disparities in the quality of healthcare provided to minorities, which in turn would be beneficial to the patients themselves and their families.

Definition of Terms

The predominant terms used in this dissertation are blacks, doctor-patient communication, communication problems, culture, diabetes, empathy, Health disparity, healthcare disparity, and verbal and nonverbal communication.

Blacks. For the purpose of this study Blacks refer to individuals having origins in any of the Black racial groups of Africa based on self-identification, such as African; African American; and Afro-Caribbean, for example Bahamian, Haitian, and Jamaican. (U.S. Census Bureau, 2011). They share similar ethnicity and physical characteristics.

Doctor-Patient communication. Doctor-Patient communication is the act of exchanging or transmitting information between the doctor and the patient. (Merriam-Webster Dictionary, 2017). Communication is the ability to articulate language and to prompt effective interactions. It is what is seen, heard, observed, felt, imagined and understood. Communication can either be in verbal or nonverbal forms.

Communication problems. For the purpose of this study communication problems refer to failure in effective information exchange and interaction, both verbally and nonverbally, leading to misunderstanding (Merriam-Webster Dictionary, 2017), misinterpretation and dissatisfaction. It can occur between individuals in any relationship such as doctor and patient.

Culture. Culture is the way of life of a particular people or society demonstrated in their ideas, beliefs, customs, attitudes, and behavior (Cambridge dictionary, 2018).

Diabetes. Diabetes is a chronic noncommunicable disease which affects many organ systems in the body, and is characterized by abnormally high blood glucose due to the body's inability to produce or respond to the hormone insulin (Medline Plus, 2017).

Empathy. Empathy is the ability to place oneself in another person's position to understand and feel what the person is experiencing (Cambridge dictionary, 2018).

Health disparity. Health disparity is the preventable difference in the rates of disease occurrence, disabilities, and opportunities to achieve optimal health that exist in socially disadvantaged racial, ethnic, and other population groups (CDC, 2017).

Healthcare disparities. Healthcare disparities are inequalities in the availability, accessibility, and quality of health and healthcare among different population groups (U.S. National Library of Medicine, 2017).

Nonverbal communication. Nonverbal communication includes body language such as posture, gesticulation or mannerism, courtesy, facial expression, eye contact, voice tone, showing empathy and concern, one's general attitude and aura (BusinessDictionary, 2017).

Verbal Communication. Verbal communication is a spoken form of expression, consisting of the use of words in a structured way (BusinessDictionary, 2017).

Purpose of the Study

The purpose of this phenomenological study was to examine the verbal and non-verbal communication experiences of Black diabetic patients with their doctors at a Health Care Center in Palm Beach County, as they managed their condition. The study explored the phenomena of doctor-patient communication, leading to a better understanding of the essential aspects of Doctor-Patient communication, and the experiences of Black diabetic patients.

Chapter 2: Literature Review

In this study, the experiences of Black patients with diabetes were examined, in terms of doctor-patient communication. Besides the already well-documented doctor-patient communication problems that exist in the general population, minorities such as Blacks face even added challenges in doctor-patient communication; challenges that are notorious for this specific population. Studies have shown that healthcare providers hold conscious and unconscious negative stereotypes of minority patients; and racial identity is a predictor of how one is perceived, which consequently influences the way they are communicated with (Burgess, van Ryn, Dovidio, & Saha, 2007).

Some of the popular misconceptions that are commonly shared about black patients are their lack of education and noncompliance. This type of stereotyping facilitates prejudice and discrimination, which further affects communication. Consequently, patients may claim ill-treatment base on the doctor’s attitude towards them through demonstrated verbal and non-verbal communication behaviors, which ultimately affects how doctors are perceived (Kee, Khoo, Lim, & Koh, 2018).

Theoretical Perspective

The theory based on the problem of communication between Black patients and their health providers is grounded in the theory, A Theory of Justice. This theory was originally developed by Rawls (1971) and was primarily used to study philosophy, politics and society. The theory of Justice indicates that “justice is the basic structure of society, or more exactly, the way in which the major social institutions distribute fundamental rights and duties and determine the division of advantages from social cooperation” (Rawls, 1971, p. 6). The theory of justice supports the principle of freedom and equality; and the fact that it encourages equal opportunity, it would therefore involve healthcare. Justice is one of the basic ethical principles that guide the fundamentals of the practice of the medical profession.

This research incorporated the social constructivism and social justice interpretive framework approach. The social constructionist approach reflects how people create a personal meaning, and how they understand and interpret the experiences of everyday life in the world they live and work, in order to understand their historical and cultural settings; whereas, social justice approach provides an understanding of social justice issues or topics such as racism, unequal power relations, and inequities. These two approaches were reflected in this phenomenological study of doctor-patient communication experiences. By the use of open-ended questions, participants were allowed to fully and freely express their views and describe their own experiences through interaction with others, in this case their doctor; while simultaneously addressing social justice issues by providing a picture of inequalities and expectations with regards to doctor patient communication (Creswell, 2013).

The Joint Commission (2010) commented on the growing body of research, which documents that, a variety of patient populations, which includes Blacks, experience poorer health outcomes, and lower quality care based on race. In order to attempt to alleviate the documented disparities in healthcare that minorities experience, there are several areas in communication between Black patients and providers where improvement is needed. However, to address and minimize this documented racial disparity, which can and has negatively influence clinical decision-making and behavior, its existence must first be recognized; hence the necessity to start a movement to bring about cultural change.

Communication

It is often said it is not what you say but how you say it; and this is what determines the effectiveness of communication. There is a general consensus, through evidence presented in research, that challenges exist in doctor-patient interactions, whereby patients experience unexpected, unacceptable interactions which leaves a feeling of disappointment (Sadati, Lankarani, & Hemmati, 2016). The ability to communicate effectively is a required skill throughout life in order to coexist favorably, and according to Mazzi et al (2013) and Ha and Longnecker (2010), in the health care setting, it can actually determine a doctor’s competence. Effective doctor-patient communication is essential in other to establish a good doctor-patient relationship, which in turn would result in patient satisfaction, treatment adherence or compliance, and positive patient outcome. In addition to the positive influence on the therapeutic act, it also helps minimize the risk of malpractice complaints, which are mostly caused by communication errors (Ioan et al. 2017). Important elements that determine effective and satisfactory communication during consultation include, among others, being friendly, treating patient as a person and equal, not being judgmental or insensitive, and showing open and appropriate nonverbal behavior (Deledda et al., 2013). On the contrary, suboptimal doctor-patient communication impacts trust, compliance, disease outcomes, and mortality (Elliott et al., 2016).

Research findings identified insufficient or poor communication from doctor to patient about the nature of treatment, and a lack of doctor-patient rapport in general as problems in the doctor-patient communication process that often results in noncompliance (Baumann, Tchicaya, Lorentz, & Le Bihan, 2016). Yet, there has been no documented improvement in communication, but instead studies continue to identify numerous additional doctor-patient communication problems whereby doctors often maintain a style of high control, involving interruptions, and neglect of patients' concerns (Waitzkin, 1984), among other unmentioned communication deficiencies. Study results on doctor-patient communication conducted by Khan, Hassali, and Al-Haddad (2011) added to the identified list of communication challenges, stating that “language used by the physician during the communication session, cultural gaps, physician attitude toward patients, and giving complicated information or instructions, are the commonly seen barriers during a patient-physician communication session” (p. 253).

From what studies have shown, suboptimal communication between doctor and Black patients do exist, and in fact, it was acknowledged that doctors display fewer positive, rapport-building nonverbal cues with black patients (Elliott et al., 2016). Doctor-patient communication challenges is particularly relevant with ethnic minority patients because of what often occurs during doctor-patient encounters, such as doctors showing less affective behavior, the occurrence of more misunderstandings, lower patients' satisfaction with care and communication, and increased patients' noncompliance (Rocque & Leanza, 2015). To put it simply, it can be said, “within the consultation room, the relationship between the doctor and patient remains unequal” (Mazzi et al., 2016, p. 59). Rocque and Leanza (2015) stressed the importance of maintaining awareness and sensitivity of the specific factors relating to ethnic minority patients that play a role in or influence communication experiences. These factors have been extensively mentioned throughout literature, and include, but not limited to, factors such as discrimination, and differing values and beliefs.

Doctor-patient communication has indisputable clinical importance in medical care as shown through the mounting number of research that continue to show the importance of establishing effective doctor-patient communication. According to Wong, Gudzune, and Bleich (2015) better patient-provider communication among patients with diabetes mellitus is associated with increased adherence to medication, diet and exercise recommendations, and foot care self- management. Baumann, Tchicaya, Lorentz, and Le Bihan (2016) report coincided with this finding, stating that good doctor-patient communication was related to nutrition such as increased consumption of fruits and vegetables, and reduced sugar and fat intake in diabetes. Achieving patient adherence, to recommendations and treatment plan, should be an ultimate goal for every doctor because of its overall resultant health outcome, but it all begins with effective communication.

Nonverbal Communication

Communication is not only spoken words, but it also involves nonverbal behaviors, such as eye contact, body positioning, and touch, that have the potential to influence how verbal messages are received and perceived (Elliott et al., 2016). In addition to verbal communication, Eun-Jung Shim et al. (2016) emphasized that particular attention should be paid to the non-verbal aspects of communication; and Namazi, Aramesh, and Larijani (2016) made mention of its importance in limited visiting time, linguistic, and discourse differences. Non-verbal communication aides in the diagnostic process, because it helps to qualify verbalized exchanges and guides doctor-patient interaction and other means of communication such as cordialities and other such observable courtesies (Stepanikova, et al., 2012). Non-verbal communication was also "linked to rapport, patient-physician trust, satisfaction, recall, compliance, symptom resolution, and long-term improvements in health" (Stepanikova, Zhang, Wieland, Eleazer, & Stewart, 2012, p. 576). Study results on nonverbal communication as a pain reliever have shown that supportive nonverbal communication behaviors have significant effects on the experience of pain as it leads to an "attenuated pain experience" (Ruben, Blanch-Hartigan, & Hall, 2016, p. 973). Based on the aforementioned, it can be concluded that such social interactions, which is said to influence the experience of pain and improve physical health, have the potential to improve the neuropathic pain that is often experienced in diabetic patients.

Nonverbal behaviors is a key component of effective communication because of its positive impact on doctor-patient relationship and patient satisfaction (Bayne, 2011) and "Blacks are particularly sensitive to non-verbal cues and may use them in making judgments about the quality of interpersonal treatment" (Martin et al., 2013, Discussion, para 7). Studies reveal that a doctor's nonverbal style of communication influences how patients rate a doctor, and in fact, social skills are more important than race in shaping patients' perception of physicians (Aruguete & Roberts, 2002). The doctor's style of communication may likely be the cause why studies have shown that Black patients contribute minimally in communication with their doctor (Gordon et al., 2006). Non-verbal communication is even more crucial in older patients because of increasing hearing difficulties.

Literature suggests, "nonverbal dimensions can be more salient than words in representing emotional expressions" (Gorawara-Bhat, Hafskjold, Gulbrandsen, & Eide, 2017, p.1987). Compared to verbal communication, nonverbal behaviors are processed faster and have a greater impact on the perceiver; so much so that Riess and Kraft-Todd (2014) identified it as a powerful predictor of the level of trust patients will place in their doctors, and how a doctor is judged in terms of empathy.

A patient's emotional experience all boils down to the doctor's ability to receive and demonstrate nonverbal communication behaviors (Riess & Kraft-Todd, 2014), and in fact, Peimani, Nasli-Esfahani, and Sadeghi (2018) identified emotional support as a factor that diabetic patients perceive as important in facilitating or hindering effective communication. Because nonverbal signals are often used to convey emotions, as a doctor, it is important to be able to understand nonverbal behavior communications, for example of confusion, distress, fears, but most importantly, of disagreement, which patients, out of respect for their doctor, are often reluctant to express verbally (Riess & Kraft-Todd, 2014). Doctors should also be familiar with the differing nonverbal preferences among different cultures; for example, Western cultures prefer maintaining eye contact, whereas Eastern cultures prefer a more flexible use of eye contact (Riess & Kraft-Todd, 2014). Nonverbal emotional behaviors are so powerful that Lorie et al. (2017) expound on its significance by stating that it actually take precedence over race when evaluating patient satisfaction, which means that, even with race concordance between doctor and patient, nonverbal behaviors such as showing emotion, making eye contact, and attentive listening is the best predictor of patient satisfaction.

Despite the importance of non-verbal communication in patients' outcomes, and its linked to rapport, patient- trust, satisfaction, recall, compliance, symptom resolution, long-term improvements in health, and malpractice litigation reduction, still physicians typically view non-verbal communication as a non-critical aspect of care (Stepanikova et al., 2012). This re-enforces the need for training in non-verbal communication skills to improve the delivery of care in an increasingly culturally diverse patient population.

Empathy. Empathy, the ability to share and understand the emotions of others, is particularly important in the context of medicine because of its numerous positive outcomes that have been established through research. Young et al. (2016) inferred patients receive communication behaviors better, when they perceive that their doctor is “encouraging, motivating, and compassionate about their daily circumstances and challenges” (p. 276).

Nonverbal communication, such as expressions of empathy, is an essential component of cross-cultural competency and high-quality care because it encourages a doctor-patient relationship based on trust (Lori et al., 2017). Although empathy is communicated both verbally and nonverbally, the power of nonverbal communication behavior of empathy should not be underestimated because it communicates emotional states subtly and automatically (Kraft-Todd et al., 2017). As Sinclair et al (2016) stated, empathy is an “emotionally engaged process” (p. 443) that promotes a personal connection with patients. Empathy, a core value and one of the main elements of doctor-patient communication, is important as a means of showing care, and contributes to feelings of safety, trust, support, development of new coping strategies, and overall patient satisfaction (Derksen et al., 2017). Past research has shown that non-verbal communication such as showing empathy and concern was positively associated with patients’ satisfaction, compliance and health outcome, particularly in patients whose physicians leaned forward and oriented their bodies towards them (Aruguete & Roberts, 2002).

The association of empathy with outcome is evident in research conducted on diabetic patients. Sinclair et al (2016) identified patients living with a chronic illness like diabetes as ideal for providing insight on empathy because of their extensive experience with the healthcare system. Empathy has been associated, among others, to “improved control and reduced admissions for complications of diabetes” (Lown, 2016, p. 333). Other study findings indicate a resultant decrease in HbA1c and LDL-cholesterol in diabetic patients (Derksen et al., 2017). It is a general consensus through evidence in research that nonverbal communication such as the conveyance of empathy not only improves patient satisfaction, but according to the reiteration of Riess and Kraft-Todd (2014), it has been shown to improve “hemoglobin A1C levels, systolic blood pressure, fewer days lost from work, and fewer functional limitations” (p. 1110).

Although nonverbal expressions of empathy vary across different cultures, with some being universally desired while others culturally specific, positive nonverbal expressions are generally valued by all (Lori et al., 2017). It is therefore crucial, according to Lori et al (2017), that doctors become acquainted with the specific nonverbal behaviors of the population that they serve, and should align their nonverbal behavior, like empathy, with their patients’ respective cultural norms. Empathy brings with it a deeper sense of concern for, and understanding of the need of others, and must be able to be conveyed to patients, through words and actions. It helps when healthcare providers can empathize with patients because as documented throughout literature, this fosters positive outcomes. In Addition to positive health outcomes, Kraft-Todd et al

(2017) study results provided evidence that nonverbal empathic behaviors increase patients' perceptions of doctors' empathy, warmth, and competence; and doctors should therefore use this understanding of how nonverbal behavior contributes to empathic communication and patients' perceptions, to improve their patients' emotional and physical health.

In spite of the fact that empathy and compassion facilitates healing, it is unfortunate that, at the same time, studies have and continue to identify a disturbing trend showing its decline in health care (Lown, 2016). Sinclair et al. (2016) concurred by reiterating the identification and indeed presence of a "troubling trend – the erosion of empathy" (p. 438) in clinical practice, in spite of its known benefits of improving patients' outcome and satisfaction. Bayne (2011) was of the same opinion that empathy is decreasing among residents and practitioners; and that's a major problem because this comes with ramifications such as stress and other negative feelings that can avoid patients from seeking medical care (Derksen et al., 2017). Besides empathy, other non-verbal communication aides in the delivery of healthcare, because it helps to qualify verbalized exchanges and guides doctor-patient interaction and other means of communication such as cordialities and other such observable courtesies (Stepanikova, Zhang, Wieland, Eleazer, & Stewart, 2012).

Listening. To define listening, Jagosh et al (2014) cited the International Listening Association's definition of listening as 'the process of receiving, constructing meaning from, and responding to spoken and/or non-verbal messages'. Among other things, a great doctor is expected to be attentive, and able to communicate and interact well with patients; however, it is reported that it is difficult to find a great doctor because some doctors do not listen to the patient (Sadati et al., 2016). Jagosh et al. (2011) identified listening as “the primary defining feature of a good doctor” (p. 370) that “must be mastered” (p. 374), however is lacking. Ioan et al (2017) reported on studies, which show the doctor “interrupts the patient’s speech after an average of 18 seconds” (p. 304).

Research has disclosed doctors’ frequent dominance during consultations, allowing very little input from the patients, besides the time allotted for responses to questions asked. Berkeley and Murphy (2018) discussed the importance of practicing Narrative Medicine, an emerging technique in medicine, that encourages doctors to listen attentively to patients’ stories about their lives and illnesses, in order to understand and get a true appreciation of their social and bodily conditions, which is vital for effective administering of proper care. Goddu, Raffel, and Peek (2015) identified narrative as an “effective empowerment strategy” (p. 1018) and expounded on its significance in “promoting health behavior change among racial/ethnic groups with a strong tradition of storytelling, and those with a history of medical mistrust” (p. 1018). Evidence suggested that this act of careful attentive listening to narratives on the part of doctors is effective, and greatly appreciated by patients, as it makes them feel comfortable (Berkeley & Murphy, 2018). This sense of comfort is naturally expected to encourage a good doctor-patient relationship.

A doctor’s ability to listen is a critical element in communication skills, which research has shown improves health outcomes. Listening is essential for gathering relevant information from patients and helping with diagnosis, it serves as a healing and therapeutic agent in itself, and it promotes and strengthens the doctor-patient relationship (Jagosh et al., 2011). In addition to facilitating joint decision making, and instilling confidence in adhering to treatment regimen, Jagosh et al. (2011) expressed that attentive listening also offers relief from the stress and anxiety that accompany illness.

Besides being a good listener, Mazzi et al. (2016) highlighted several other needed behaviors that should be mandatory in doctor-patient communication in order to achieve a good doctor-patient relationship. Some of these behaviors included granting enough time for consultation, taking the patient seriously, and treating the patient as a person and with respect on a whole.

Respect. Respect is an aspect of communication that is desired by all irrespective of one's status. It is important in all forms of communication in everyday life, and healthcare is no exception. In fact, Beach, Branyon, and Saha (2017) emphasized its importance particularly in healthcare "where its presence allows for some level of patient dependency without fear of mistreatment or abuse" (p. 2076).

Beach et al. (2017) reported on what respect means to those who are more likely to experience disrespect, minority groups. The identified desired features of respect by minorities include respect for autonomy in terms of wanting honest and clear explanations and involvement in treatment plan; respect for dignity by being treated like a person and as an equal; respect for integrity by refraining from stereotyping, and listening to one's story, with the awareness that everyone is unique and trusting the individual's self-knowledge; and finally, respect for vulnerability by recognizing that vulnerability is universal and everyone is vulnerable to something, and fragile as a human being.

Patients can identify respect and disrespect through verbal and nonverbal behaviors or expressions, which has the potential to greatly influence doctor-patient encounters. For this reason, Beach et al. (2016) suggested that respect must be shown and conveyed through appropriate communication behaviors in order to help create a more patient-centered relationship that represents the patients' values. However, to achieve that desired level of true patient-centered care, Beach et al. (2017) explained that it is critical to identify and understand what makes patients from different backgrounds and culture feel respected and disrespected.

Cultural Sensitivity

The multicultural complexities that make up the United States of America due to migration, demands competency in intercultural communication. The increase in patient diversity, that is quite obvious from the vast portion of patient population coming from a wide range of different ethnic background, have posed tremendous challenges in healthcare communication, and consequently, in the management of patients' health (Chang, Simon, & Dong, 2012). This warrants particular attention among diabetic Black patients because the Rose and Harris (2015) report concurred by stating "ethnically diverse diabetes patients face significant challenges in diabetes self-management ranging from cultural expectations to inequalities in health care provision" (p. 114).

Communication is thought to be naturally cultural because besides transmitting objective information, it conveys emotions, implicit content, and implicit meaning, which are derived from one's culture (Rocque & Leanza, 2015). Hence the need for intercultural awareness and sensitivity to avoid the potential for misunderstanding and low-quality communication, which stems from differences in perspectives, values, and belief about illness (Paternotte et al., 2015). Results of the research concluded that "unfamiliarity with ethnic notions may cause misinterpretations and misunderstandings and may influence interactions between older Black women and healthcare providers" (Sims, 2010, p. 495).

Lundgren (2011) explained that misunderstandings in communication emerge from differences in meaning and lack of proper understanding of language used; however, body language would at times give clues as to the need of the patient. None the less, as study indicates, interpretation of body language proves to be unreliable, as patients from differing cultural orientations may appear to need or not to require certain things, leaving care givers to wonder and end up rendering incorrect services (Lundgren, 2011).

For example, eye contact is expected in Western cultures as it is seen as essential to good communication and social interaction. Lack of eye contact indicates a lack of interest, lack of self-confidence, distraction or even a sign of Mental Disorders like Depression or Autism. In African, Asian and Latin American cultures, maintaining eye contact is interpreted as offensive and a challenge of authority. In Middle Eastern cultures eye contact between opposite sexes is seen as socially inappropriate. Health Care providers therefore need to depend on a bit more than guessing body language; experience in intercultural communication is the key. It is important to have a cultural awareness, and encounters with patients of different cultural background should be seen as opportunities for learning (Lundgren, 2011) because as The Joint Commission (2010) explained, when patients' cultural and communication needs go unmet, this put patients at risk for negative consequences.

During doctor-patient communication it is important to recognize and take into consideration that people from different cultural orientations conceptualize sickness and health differently; thus, affecting their perception of illness and how they approach treatment (Chang et al., 2012). In order to meet the required needs of the ever increasing diverse patient population, health providers are therefore encouraged to learn from patients, by active listening, in order to understand patients' beliefs and their preferred choice of treatment (Chang et al., 2012). Practicing cultural awareness skills, such as recognizing and knowing the differing cultural identities and belief, and utilizing patient centered communication, are means of overcoming barriers in intercultural communication (Paternotte et al., 2015).

Napier et al. (2014) expounded on the importance of intercultural communication in a multicultural society, and further identify the neglect of culture in healthcare as the single biggest barrier to the advancement in standard of health. For instance, Religion and Spirituality play a significant role in Black patients' culture, in terms of health and wellbeing, and ultimately interactions with their doctors; yet research suggest that health providers show little concern towards understanding how these beliefs and culture shape their health concerns and treatment preference (Black, 2012). Study results emphasize the role of spirituality in enhancing health promotion and behavioral change among African Americans with diabetes because of the role religious beliefs play in their diabetes care, in the area of self-management behaviors, coping strategies, and doctor- patient communication (Whitney et al., 2017). When healthcare professionals exercise cultural awareness and humility, a better understanding and appreciation of patients' health issues will be achieved, thereby resulting in improved patient satisfaction, medical adherence, and health outcomes. It is also important to mention, "doctor-patient communication and patients' perceptions of quality of care are influenced by the patient's cultural views"

(Paternotte et al., 2017, p. 170). It is therefore important, according to Lorie et al (2017) that doctors are able to provide culturally competent empathic care to avoid cross-cultural misunderstandings that increased diversity is likely to bring, which could result into medical errors, distrust, and decreased compliance and satisfaction.

This patient-centered approach with specific attention to the patient's biopsychosocial needs is particularly important in ethnic minority patients because of their vulnerability for misunderstanding (Paternotte et al., 2016). Lorie et al (2017) reported on a study with Caribbean medical students that "cautioned against the use of direct eye contact with some Caribbean elderly as this could be interpreted as a sign of disrespect" (p. 420). It is irrefutable that the absence of cultural competence and racial dynamics exist and poses a challenge to patient-provider interaction. Lorie et al (2017) research report in fact confirmed that medical professionals have demonstrated lack of preparation in providing cross-cultural competent care in the manner in which they provide care disproportionally to minorities, leading to disparities in treatment and health outcomes; they are noticeably less affective when interacting with ethnic minority patients. This explains the reason why patients are more likely to trust and feel more comfortable with physicians of the same ethnic group (Street, O'Malley, Cooper, & Haidet, 2008).

When a provider is from a different culture from the patient, this creates a language barrier (Lundgren, 2011). This is where intercultural communication skills come to play; something that all patients desire. It is therefore suggested that doctors adapt their communication style to each patient's preference because better intercultural communication enhances patient involvement, satisfaction and health outcomes

(Paternotte et al., 2017).

Race Concordance and Discordance

It is believed that race concordance plays an important role in Black patient's communication with their doctors. Studies have found that Black patients are more likely to rate a race concordant doctor more favorably than patients who had a race discordant doctor because they believe race concordant doctors understand their feelings and health problems (Saha, Komaromy, Koepsell, & Bindman, 1999). However, there are also research findings that indicate that race concordance is not always important in communication (Paternotte et al., 2017).

Race discordance, on the other hand, affects communication between patients and doctors and is therefore thought to contribute to disparities in health care. There is an immediate need to better understand how Black patients and doctors, particularly those of a different ethnic background from patient, communicate. However, it must also be recognized that even among the same ethnic group, differences in belief, customs, and values may exist base on individual's place of origin; consequently, impacting doctor-patient communication even with race concordance. This is in fact documented in an excerpt from the Population Reference Bureau website, which stated "substantial diversity also exists within racial and ethnic groups" (www.prb.org, Differences in Health & Life Expectancy, para. 3).

Bias Stereotyping

In order to communicate more effectively in a healthcare setting, inclusion needs to be actively practiced, and doctors should avoid making decisions based on quick biased assessments (Ha & Longnecker, 2010), as is often witnessed against minorities and demonstrated through nonverbal communication (Kraft-Todd et al., 2017). Everyone, regardless of their health care need, race, culture, or belief, has the right to be valued and treated with fairness, dignity and respect, because as soon as unconscious biases based on certain patient characteristics begin to surface, it has resultant undesirable effects such as preferential behaviors towards or against specific patients, and influence on treatment decisions and the doctor-patient relationship (Teal, Gill, Green, & Crandall, 2012).

The challenges that Black patients face in seeking health care is of major concern. According to Cooper et al (2012), traditionally, Blacks have experienced discrimination in the United States; bias and stereotyping is seen everywhere, even in providers within the healthcare system, whereby they hold varying attitudes toward members of racial minorities. Throughout all this, perpetrators fail to realize how profoundly this ill conduct could potentially affect the patient. Jalil, Zakar, Muhammad, and Fischer (2017) described the feelings that patients get from a doctor's inappropriate behavior "similar to a mental torture that distresses the diabetes patients" (Discussion, para. 6). So in addition to dealing with the challenges of already being a diabetic, patients may eventually wind up having psychological and emotional issues from the process of seeking medical care.

Adegbembo (2006) found that Blacks perceived more racism and discrimination in the healthcare system than any other ethnic group. Consequently, ethnic minorities, particularly Blacks tend to rate their doctor's interpersonal quality of care more negatively compare to other ethnic groups; generally sharing the most negative views on health care experiences because of their poor communication experience with doctors, particularly in race discordant doctor-patient relationships (Cooper et al., 2012).

Studies on clinicians' implicit attitudes about race demonstrate bias and stereotyping. The results of a study conducted by Cooper et al. (2012) showed:

> Among Black patients, general race bias was associated with more clinician verbal dominance, lower patient positive affect, and poorer ratings of interpersonal care; race and compliance stereotyping was associated with longer visits, slower speech, less patient centeredness, and poorer ratings of interpersonal care. (p. 979)

The results of the research conclude that clinician implicit race bias and compliance stereotyping are associated with poor patient-provider communication and poor ratings of care, particularly among Black patients (Wong, Gudzune, & Bleich, 2015). Stereotyping, such as Blacks being perceived as noncompliant, causes a lower level of patient-centered conversation and lower patient ratings of trust and confidence in the clinician.

Unfortunately, some of these, often unconscious, biases develop from social and learning environments. For example, some research encourages providers to discriminate between Black and non-Black patients when treating certain conditions such as hypertension (Flack et al., 2010). When prejudices and assumptions about ethnic minority patients comes into play, whereby there are generalized thoughts about patients of one ethnicity, this causes an additional challenge to communication, which results in patients feeling discriminated and a sense of being treated unequally (Paternotte et al., 2015). Black patients would rather be seen as a person and not a member of a racial group with all the stereotype and bias that comes with it (Black, 2012). While these biases may be unintended, they however have significant consequences on patients' health, as it contributes to health disparity, as demonstrated in research.

Perceived stereotyping and discriminatory experiences is said to affect health outcome (Pascoe & Richman, 2009) because it is associated with patients being non-compliant to recommended treatment, medical tests and follow-up visits (Van Houtven et al., 2005), which consequently can lead to poor patient outcome. This may be a contributing factor to the reason why older African American women 40 and over, experience more disease, disability, and premature death from conditions such as diabetes than White women in the same age group (Sims, 2010).

Research reports on the first-hand perspectives of older Black women within healthcare encounters that impact the trajectories of health-seeking behavior; and examine their perceptions, expectations, and beliefs about the role of cultural difference within predominantly White (US) healthcare settings; and explore how sharing personal experiences as a fund of knowledge influences ethnic notions. It was noted by participants from ethnographic data collected over a 24-month period (2003-2005) from 50 older Black women in Tucson, AZ, USA that they had perceived or experienced bias through non-verbal cues, which included a lack of eye contact, a lack or hesitation of physical touch, and actual speech such as the tone of voice used. Lorie et al (2017) research findings also correlated with the aforementioned study result from its discovery statement that bias can be manifested through unintended negative nonverbal expressions, verbal dominance, and lower patient positive affective voice tone.

Lown (2016) added voice to the topic of bias, stereotyping and empathy, by reiterating what research as already discovered, that devaluing or dehumanizing members of a particular group, for instance, minority group members, due to “stereotypes or bias, may compromise personal interactions, clinical decision making and a patient's health" (p. 335). Other factors that may also affect interactions include distrust.

Patient-Centered Care

In the delivery of healthcare, a collaborative communication approach should be used because, after all, the main independent predictors of patient satisfaction have been their perceptions of communication and a positive doctor approach (Ha & Longnecker, 2010). For this reason, it is advised that communication should therefore be tailored to the evolving needs and preferences of patients because no one is the same; individual's needs and preferences vary (Eun-Jung Shim et al., 2016). Paternotte et al. (2017) stated it best by emphasizing patients' desire for being "treated as a unique person and not as a disease" (p. 172), which in turn contributes to patient satisfaction.

Collaboration is identified as one of "the most salient means of addressing self-care communication with a chronic disease such as diabetes" (Ritholz et al., 2014, p. 308). Greenfield, Kaplan, Ware, Yano, and Frank (1988) reported on a study on patient participation in medical care decisions, which confirmed that such intervention actually improved blood sugar control in diabetic patients.

Everyone is different with varying needs and preferences, and in the way they react and adapt to diabetes. Therefore, doctors in turn should be able to adapt and be flexible with communication, in order to meet patients' differing needs because, as Mazzi et al. (2015) posited, "there is no such thing as one size fits all" (p. 1224). Several studies in the literature confirm that tailoring to patients' needs is a key aspect of patient-centered care, which is essential for performing a satisfactory doctor-patient communication encounter, and is also associated with greater patient trust which in turn is associated with adherence and continuity of care (Cooper et al., 2012). Therefore, it can be concluded that patient-centered communication enhances trust and with the combination of collaborative communication, whereby patients share in the decision-making, this can significantly increase patient treatment adherence and ultimately patient outcomes (Ratanawongsa et al., 2013). Conversely, when there is a lack of trust, this negatively affects interactions.

Distrust in Healthcare

Distrust in the healthcare system, according to White et al. (2016), is “an underrecognized factor known to influence health-related quality of life, self-care behaviors, and treatment adherence for vulnerable populations, including those with diabetes” (p. 127). Effective doctor-patient communication should be a doctor’s duty in the deliverance of care, with an aim at establishing a relationship based on trust because of the association between distrust and poor communication. According to Ranjan, Kumari, and Chakrawarty (2015) a trustworthy doctor-patient relationship is a prerequisite for therapeutic success, especially in a chronic condition such as diabetes. However, one of the contributing factors which have been shown to influence Black patients’ perception and experiences is their distrust. In fact, Martin, Roter, Beach, Carson, and Cooper (2013) reported on study findings, stating that Physician communication behaviors may have a varying effect on patient trust, depending on patient race. Studies show increasing evidence that lower levels of trust in health care providers is related to less patient-centered communication behavior and lower patient satisfaction, particularly in Blacks (Martin et al., 2013). For this reason, White et al. (2016) advised that doctors should take heed of the impacts of mistrust among patients, especially those who represent groups, such as Blacks, that have a history of experiencing discrimination, marginalization, and stigma.

Prior discrimination is strongly associated with trust. It is a documented fact that mistrust towards the healthcare system is prevalent among Blacks. Townes (2009) explained that their reluctancy to trust the healthcare system is due to historical events and experiences, and present-day experiences with racism and suppression, where Blacks have been treated unfairly. However, as Martin et al. (2013) suggested, positive physician affect may moderate trust and compliance.

One of the past events which is believed to have contributed to this distrust is the Tuskegee Study of 1932-1973 where black males were recruited for observation but were neither informed of or given treatment for active syphilis (Cook et al., 2005). Cook et al. (2005) recognized that “patients with low levels of trust are less satisfied with their care” (p. 1078). Hammond (2010) reiterated that Black patients distrust in the healthcare system and providers lead to dissatisfaction. As a result, Black patients may tend to express more negative views and expectations of their doctor (Thompson, Bazile, & Akbar, 2004).

The problem of distrust in the healthcare system within the African American community is associated with communication problems and health disparities. Although healthcare services have been on the rise in America, statistics indicate that such care is not administered in same proportions among the races; there is a disparity in the health of blacks, in the areas of healthcare utilization and outcome (Cook, Kosoko-Lasaki, & O'Brien, 2005, p. 1078). As a recommended solution to the problem, Cook et al. (2005) stated “in order to decrease health disparities, it is necessary for blacks and other minorities to trust the healthcare system and to participate in health care research" (The Problem, p. 1078).

Summary

Research has established that effective doctor-patient communication is one of the most important elements of patient experience, and is essential for diabetic patients "both to promote a positive patient experience of care and facilitate good self-management" (Paddison et al., 2015, p. 473). White et al. (2014) attributed the disproportionate challenges that minority diabetic patients face, such as poorer health outcomes and increased burden of disease, to ineffective doctor-patient communication, which consequently result to suboptimal care. Reports of non-satisfactory service quality by diabetic patients that are seen in studies worldwide is attributed to, among others, the effect of health care providers' performance and behaviors for example in the area of communication, which in turn, affect the delivery of healthcare and customers' perception and outcomes (Tabrizi, 2009); hence the importance of understanding the different aspects of doctor-patient communication.

In summary, it can be concluded that the key to providing a positive communication experience, which in turn encourages trust and a sense of partnership, is to customize the approach to each individual's preference, while taking into account one's culture, and using appropriate verbal and nonverbal communication behaviors simultaneously. Paternotte (2017) summarized it best by stating the fact that non-verbal communication, the social dimension and cultural sensitivity of communication all jointly play a role in intercultural communication and doctor-patient communication on a whole.

The articles on non-verbal communication were of particular interest because non-verbal communication has many benefits in healthcare. Lundgren (2011) reiterated its benefits by saying it gives clues to patients need. It also aids in the diagnostic process and is particularly crucial in older patients who often have difficulty hearing (Stepanikova et al., 2012). However, to obtain maximum result in doctor-patient communication, both verbal and nonverbal behaviors should coincide to avoid implications, but in many situations, this is not always the case; for instance, when doctors show difficulty in relating to patients' emotional needs (Gorawara-Bhat, Hafskjold, Gulbrandsen, & Eide, 2017).

Additionally, The Joint Commission (2010) identified effective communication, cultural competence, and patient centered care among the important components of safe, quality care. It was also reaffirmed that modification of communication style which includes development of interpersonal communication skills, showing empathy, the use of non-verbal communication, and familiarizing with ethnic beliefs, contribute to the reduction in health disparities. As it relates to diabetic patients, effective doctor-patient communication is associated with receiving recommended diabetes care, better glycemic control and fewer diabetes complications which should be the ultimate goal of every healthcare provider, in an attempt to alleviate the health disparities that exist particularly among minorities. However, it is documented that approximately 50% of diabetic patients fail to achieve adequate glycemic control mainly due to poor medical adherence, which typically results from poor doctor-patient communication and negative patient perceptions (Polonsky & Henry, 2016).

Irrespective of the noted benefits of practicing good communication skills in the delivery of healthcare, there remains urgent need for its improvement with regards to doctor-patient communication, particularly within the minority patient population. It is well documented throughout literature that there is an immediate need to examine and improve the communication problems that are encountered between Black patients and health care providers because problems such as distrust in the healthcare system within the black community, lack of cultural sensitivity, and bias and stereotyping, contribute to negative consequences and their resultant health disparities. Rocque and Leanza (2015) mentioned some of the harmful consequences that may result from unsatisfactory or negative communication experiences such as treating patients as inferior and talking down to them, to include, relational issues and distrust; lower quality of care; overuse of resources by seeking additional opinions from other doctors; dissatisfaction which may hinder the desire to seek continued care by delaying or skipping follow-up appointments to avoid the negative experiences; and non-adherence whereby patients are unmotivated to comply to treatment plan. Riess & Kraft-Todd (2014) further inferred that the lack of effective communication skills “contributes to dehumanization” (p. 1110).

In an attempt to alleviate these harmful effects of negative experiences, Rocque and Leanz (2015) encouraged doctors to strive, through communication, to treat patients with dignity and respect, and show sensitivity and empathy. Other studies emphasize the need for improvement in doctor-patient interaction and communication by developing cultural sensitivity because lack of cultural understanding and sensitivity by providers contributes to problems of communication, establishment of trust and satisfaction. More specifically, it was deduced from Aruguete and Roberts’ (2002) research, that there is an immediate need for further research to describe the effective non-verbal behavior for physicians in diverse cultural setting after observing that participants evaluation of physician were influenced by non-verbal style of communication and was positively associated with an increase in patient satisfaction. Among other communication challenges, this research also shed light on the non-verbal communication problems between healthcare providers and Black patients. Afterall, the first step to alleviating or improving a problem is identifying and understanding the problem.

Research Questions

The following research questions guided this study:

1. What are Black Caribbean diabetic women patients' experiences of their doctors' communication behavior?
2. How do Black Caribbean diabetic women patients think about their experiences with doctor-patient communication?
3. What situations have influenced Black Caribbean diabetic women patients experiences of communication with their doctors?

Chapter 3: Methodology

Aim of the Study

The purpose of this proposed study was to examine the verbal and non-verbal communication experiences of Black diabetic patients with their doctors at a Health Care Center in Palm Beach County, as they managed their condition. The study explored the phenomenon of doctor-patient communication, to get a better understanding of the essential aspects of Doctor-Patient communication, of Black diabetic patients.

Qualitative Research Approach

The qualitative approach that was used for this proposed dissertation study was phenomenology. The phenomenological design was used in this study because of its appropriateness in answering the research questions and describing the participants lived experiences with doctor-patient communication. As Creswell (2012) explains, "a phenomenological study describes the common meaning for several individuals of their lived experiences of a concept or a phenomenon" (p. 76). Although there have been different philosophical arguments for its use, these are the shared philosophical assumptions: the study of the lived experiences of persons; the view that these experiences are conscious ones; the development of descriptions of the essences of these experiences, not explanations or analyses (Creswell, 2012).

In this study, data were collected from diabetic Black patients on their experiences with doctor-patient communication, from which a composite description of the essence of their experiences was developed. Since the study was based on the lived experiences of the participants, with an emphasis on the phenomenon of doctor-patient communication, the interpretive (hermeneutic) phenomenology design was most appropriate. Hermeneutics is the theory of interpretation whereby participants attempt to make sense of their experiences from the accounts that they provide; and the researcher attempts to interpret participants' accounts in order to understand their experiences. Smith, Flowers, and Larkin (2009) states it best by describing this research engagement as a double hermeneutic because the researcher tried to make sense of the participant trying to make sense of what is happening to them.

The focus of a hermeneutic study is on what humans experience rather than what they consciously know. In relation to the study of human experience, interpretive (hermeneutic) phenomenology does not only describe core concepts and essences, but also looks for meanings embedded in common life practices that are not always apparent to the participants but can be gathered from the narratives produced by them (Lopez & Willis, 2004). The data collection involved interviewing individuals who had experience with doctor-patient communication as they managed their condition (Creswell, 2012).

Participants

The sampling procedure that was used for this study was purposeful sampling because this technique selects cases that are information-rich with respect to the purpose of the study. By so doing, the participants possessed the qualifications that the researcher needed to conduct the study, and hence they were able to inform an understanding of the research problem and central phenomenon in the study (Creswell, 2012). Basically, the sample was fairly homogenous, for whom the research question was meaningful; and participants were selected on the basis that they could grant access to a particular perspective on doctor-patient communication. In an attempt to achieve a homogenous sample, the same gender was selected to participate. The researcher chose women instead of men because it is a documented fact that women have more frequent doctor visits than men.

Since the phenomenon of interest was doctor-patient communication the participants consisted of 12 diagnosed Black diabetic patients, all of whom were Caribbean women, with age ranging from 32 to 78. Although the researcher reached out to a diverse group of Black diabetic women patients, all the participants were from the Caribbean. They were migrants who came from various Caribbean Islands, and had been residing in the United States for numerous years. They had been receiving diabetes management services from their doctor at this health care center for at least a year and were willing to provide the information; and were able to communicate fluently in English. Participants were located at a single Health Care Center site because these participants would have had experience with doctor-patient communication and therefore, would be able to share their experiences. Access to participants was obtained through the site administrators (gatekeepers), after getting permission to carry out the study at the site. Participants were required to attend an in-depth semi-structured interview session for 45-75 minutes.

Data Collection Tools

Face-to-face, one on one interviews were conducted with the participants to investigate experiences and perceptions of doctor-patient communication behaviors. The in-depth semi-structured interview technique was used to collect data, as this allowed the participant to share and provide a rich account of their personal and lived experiences that were important to them. An interview questionnaire was used but the participants led the direction of the interview, while the researcher guided the discussion in a way that focused on the lived experience of the phenomena of interest. The instrument/questionnaire, which included semi-structured questions, is included in Appendix A. The interviews were audiotaped and professionally transcribed verbatim. Notes were also taken during the interview.

The interview instrument/questionnaire was developed by the researcher, using an expert and lecturer in Research and Graduate Studies in Public Health to validate it. To validate the instrument/questionnaire that was created, literature was cited that influenced the development of the research questions. Expert review was conducted to determine alignment with purpose statement, study research questions, and questionnaire. After this was done, the questionnaire was adjusted accordingly. Then a pilot was conducted with one similar participant who was not in the study. Then suggestions and observations from the pilot interview to improve the questionnaire were made and this last revision was the final questionnaire.

Procedures

Once Institutional Review Board (IRB) approval was sought and received, a recruitment flyer (Appendix B) with the list of required criteria for participant selection, was provided to the research site, to be displayed in the reception/waiting room. Site approval letter is included in Appendix C. The researcher, who has no affiliation with the research site, was present on site to give out recruitment flyers to all Black women patients coming in. With the assistance of health providers at the research site, when Black diabetic patients were seen, eligible individuals were further informed of the research study, and those who were interested in participating were referred to the researcher, who was on site for recruitment purposes to provide more information about the research including making them understand what an interview was and what to expect in terms of time commitment.

During that time, consent to participate was obtained, and the researcher went through the consent form, which was given to each participant to review, sign and return in a stamped addressed envelope, within 3 days, before the interview could be conducted. Participants were given information on the style of interview, and the option of having the interview conducted at the research site in a quiet private room (conference room) or at a preferred, comfortably familiar location of their choice, which was safe for both researcher and participant, reasonably quiet, and free from interruptions.

The researcher's initial plan was to have the interviews arranged to be conducted over a period of 60 days or shorter depending on how soon they could be scheduled and completed. However, it took longer than anticipated because of the slowness in getting volunteers during the recruitment process. The researcher allowed each participant to schedule the interview at a time and place that was conducive for them. While some participants had their interviews prescheduled during the initial meeting, the researcher had to contact the others to schedule their interview. Some participants chose to have the interview in a conference room at the research site, whereas, others chose to have it at their place of residence. In both settings, the interviews were conducted in privacy. Participants opted to hand deliver the signed consent forms on the day of the interview.

On the day of interview, the researcher began by briefly summarizing again the main principles of the study and interview, and the informed consent form (Appendix D) was reviewed and signature obtained. Participants were given an opportunity to ask questions before the interview officially began. The researcher used an interview schedule (Appendix A) to help with the content and direction of the interview. However, the interview was aimed to facilitate an interaction which allowed the participants to tell their own stories in their own words, so for the most part, the participants were talking and the researcher listening.

The interview was semi-structured, using open-ended questions to give the participants the opportunity to express their opinions and give detailed answers. The questions were focused on understanding their experiences with doctor-patient communication. During the interview, probes were used to follow up on areas of interest from participants' responses. The interview (questions and answers) were recorded on an audio recorder, and downloaded to a password protected laptop. Each recorded interview was subsequently transcribed verbatim using a professional transcriber. During the interview, written notes were also taken, which were labeled with assigned numbers for anonymity, and date and time of interview. The duration of the interviews was between 45-75 minutes, with flexibility when it was necessary. The interview was conducted with anonymity, respect and courtesy, thanking each participant for the interview at the end. Each participant was associated with an assigned number and each of their response data was labeled with their respective number.

Data Analysis

The transcribed audiotaped data and notes were analyzed and results reported. Participants used oral responses to answer the open-ended questions, which were administered by the researcher. Data was from the participants' open-ended responses to the questions, and was in the form of textual and non-textual data comprising of interview transcripts, notes, and audio recordings of participants' responses.

Interpretative phenomenological analysis, whereby focus is placed on participants' attempt to make sense of their experiences, was used to interpret the meaning of the content of the participant's account. The Data from participants' interview responses were used to develop a narration of their lived experiences of doctor-patient communication as they managed their condition.

Data analysis, which was guided by Smith, Flowers, and Larkin (2009), involved several processes and strategies for organizing and developing that analysis. It began with the close examination and reading and re-reading of the first written transcript. The researcher listened to the audio recording of each participant twice; once at the end of each interview recording and then while first reading the transcript. By so doing, the researcher was able to imagine the voice of the participant during subsequent reading of the transcript, which in turn assisted with a more complete analysis (Smith, Flowers, & Larkin, 2009).

As the transcript was being read, observations and anything of interest within the transcript was recorded in the margin. The notes that were made included descriptive comments from the participant's account; linguistic comments based on the participant's use of words; and conceptual comments from the researcher's acquired knowledge from literature readings. The manual use of different highlight colors and underling assisted with identifying the different types of comments. A three-column table was created to display the emergent themes, original data, and comments, in this particular order, for each participant's transcript. In a nutshell, at this phase, the researcher produced a comprehensive and detailed set of notes and comments on the data.

The next stage of analysis was developing emergent themes from this larger data set that now included notes. Emergent themes, in the form of a concise phrase, were deduced from the previously noted comments and the original transcript, while simultaneously ensuring that the themes addressed the research questions. The researcher then looked for connections across emergent themes by first dividing the emergent themes under the overarching research question and then grouping them into different superordinate themes based on subordinate themes and the guidance of theoretical knowledge. This created a visual pattern whereby underneath the research questions followed the superordinate themes and then the subordinate themes.. By so doing, a structure that points to all the most interesting and important aspects of the participant's account was produced. The next participant's transcript was approached with fresh eyes, bracketing the ideas and themes emerging from the previous analysis, and allowing new themes to emerge with each transcript. The researcher continued with this method for each subsequent transcript.

The Researcher then looked for patterns across the interview transcripts by seeking to identify any connections across participants' responses, and recurrent superordinate themes that were pertinent to the research questions. The researcher also identified which themes were most potent, which also led to a reconfiguring and relabeling of themes. In the final stage of analysis, the researcher drew on existing theory to further explore the data; and IPA findings were reported as a coherent analytical account using common patterns across participants, and data extracts such as relevant participant quotes that closely addressed the research questions, to support the final themes.

Ethical Considerations

The data collection events such as interviews, and data analysis were managed with sensitivity and care. Ethical approval was obtained from Institutional Review Board (IRB), and permission was attained from administrators at the research site (gatekeepers) and participants. Information about the study, and consent forms requiring signature was given to all participants.

Each participant approached was given the opportunity to refuse to participate in the research. By so doing, the data collected involved only participants who were genuinely willing to take part and contribute freely. Informed consent was gained for participation in data collection, making and use of audio recording, and likely outcomes of data analysis, particularly inclusion of verbatim extracts in published reports. Participants were assured that their anonymity and confidentiality would be maintained during data analysis and reporting, by each participant being assigned a number. Besides the professional transcriber, the researcher was the only one to see raw, unedited data transcripts; any data for wider use was edited for anonymity. Participants were informed of their freedom to withdraw from the study at anytime without any resulting consequences, and they would not be required to disclose an explanation to the researcher for withdrawing. Additionally, the independent status of the researcher was emphasized so that participants could express their experiences without fear of losing rapport with the research site.

The data was stored using a filing system in a locked filing cabinet in the researcher’s home, and a backup computer file copy was made and kept on a password secured computer. All data will be kept for 36 months from the end of the study and destroyed after that time by shredding paper files, and deleting computer file and recorded materials.

Trustworthiness

In the study, trustworthiness was fulfilled by utilizing the credibility and dependability criteria introduced by Lincoln and Guba (1985). To establish credibility, a technique for establishing validity of an account, the researcher used member checking by asking participants to review her interview data for accuracy and feedback. Also, during analysis, the researcher listened to the audio recordings to avoid the potential for the researcher to superimpose own opinions or interpretative bias onto the data. To achieve dependability, the researcher ensured that the research process was logical, traceable, and clearly documented (Tobin & Begley, 2004) using inquiry audit to evaluate the accuracy and validity of the study. A qualitative expert person reviewed and examined the research process and the data analysis in order to ensure that the findings were consistent and could be repeated.

Potential Research Bias

The risk of bias can come from the questions, participants, and researcher. In an attempt to minimize potential impact on the study, the researcher considered all potential sources of bias and took all possible actions to reduce deviation from the truth. The order in which some questions are posed could affect participants' responses to the next question. Also, leading questions could prompt a certain response. To avoid such bias answers, the researcher framed the questions and structured the interview meticulously, and had the questions reviewed by an expert panel for an unbiased opinion.

Selection bias was avoided by using purposeful sampling to recruit participants who met the study aims. Some anticipated biases from participants included acquiescence bias, which often occurs when the participant becomes tired during the interview, whereby participants tend to agree with and be positive about everything the researcher presents just to finish the interview. To avoid this, the researcher replaced questions that imply there is a right answer with those that focus on the participant's true point of view. The researcher tried to avoid habituation bias, whereby participants start providing similar or same responses to questions that are worded in similar ways, by keeping the interview conversational and varying question wording to minimize habituation. Oftentimes participants could demonstrate social desirability bias by answering questions inaccurately just to be acceptable and liked. The researcher attempted to minimize this bias by reassuring participants that it was okay to answer in a way that was not socially desirable, and used indirect questioning for socially sensitive questions when necessary.

The researcher is aware that her experiences as a medical student while observing physicians during clinical rotations and interacting with patients herself; her ideas and personal philosophies; and the fact that the researcher is of the same ethnicity and therefore was quite familiar with that culture, could pose a challenge in maintaining objectivity and avoiding biasness. Thus, attempt was made to stay objective and try to minimize bias throughout the entire research process. The researcher also exercised cultural relativism and was mindful of own cultural assumptions.

Confirmation bias is a common form of bias in research, whereby the researcher uses participants' responses to confirm their belief or hypothesis, thereby interpreting the data to support their hypothesis while omitting data that does not favor their hypothesis.

To minimize confirmation bias, the researcher continually reevaluated impressions of participants and challenged preexisting assumptions and hypotheses.

Limitations

The researcher is aware that self-reported data is limited by the fact that it rarely can be independently verified. Although what participants say during the interview have to be taken at face value, the researcher was mindful that self-reported data could contain several potential sources of bias. The researcher is aware that everyone has biases, whether consciously or subconsciously, and therefore took all necessary measures to avoid maintaining that bias.

Since this study depended on having access to patients, there was potential for access to be denied or limited in keeping with Health Insurance Portability and Accountability Act of 1996 (HIPPA) standards. However, the researcher did not anticipate any obstruction with following through on the study due to HIPPA standards because the researcher would not have access to patients' medical records. Besides knowing that the participants were diabetic due to the fact that they were willing to participate in the study, the researcher did not have any access to participants' personal health information. Any information disclosed during the interview was from the participants' own free will, and even so, because the study was conducted with utmost anonymity and confidentiality, participants were not identifiable.

The size of the sample was limited to participants who were willing to participate in the study. Although the intended sample size was 15, even with an extended recruitment period, that was not achieved because of patients' unwillingness to participate mainly due to lack of time. For this reason, in person interview may not have been the best interview method to attract participants, and maybe the use of an alternate method of interview, such as a virtual interview, would have been more effective and efficient. Also, for the purpose of maintaining homogeneity, the sample was limited to only women participants who agreed to participate in the study. As a result, the participants lived experiences may not be a true representation of Black diabetic patients on a whole as men's experiences were not accounted for.

Chapter 4: Results

Participants represented communication experiences with their present Health Care providers, including Primary Care Providers and Specialists that they had seen in the past. At the time of the interview participants had been receiving care mainly from their primary care provider, however, the interview questions also explored participants communication experiences with past providers as they managed their care.

To put the management of diabetes into perspective, it is a condition that requires constant medical care on a regular basis, and because of Black Caribbean diabetic women patients' relatability to the condition and its management, this warranted them the ability to give a true understanding of the communication experiences with doctors as they managed their condition. Although all participants had their unique experiences as would have expected, interestingly, there were many similarities among their experiences. Overall, there were several factors that influenced participants' doctor-patient communication experiences and consequently their general perception of doctors, and resultant impact on their behavior and health outcomes.

Participants' Background Information

The results represent the interview responses of the 12 participants out of the 15 potential participants who were actually asked to participate; and highlights their lived experiences of doctor-patient communication as they managed their condition. The other 3 potential participants refused or were unable to participate mainly due to time constraints. Recruitment was a challenge because in many instances patients were in a hurry to leave, either because they had other matters to attend to or they were hungry from having to fast overnight in preparation for their doctor's visit. Therefore, they were often unwilling to spare the time to get information about the research.

The participants were all Black women, age ranged 32 to 78 at the time of the interview, who had been diabetic for the duration of one year to several years, as mentioned by many, because of how long it had been since they were diagnosed. Although the researcher's aim was to recruit Black women patients, it so happened that all the actual participants were migrants from the Caribbean, which included Islands such as Bahamas, Haiti, Jamaica, and the Virgin Islands. Each participant was assigned an identification number for the purpose of maintaining anonymity. Their individual background summaries follow below.

Participant 1. She was the youngest participant; she was 32 years old at the time of the interview, and it had been approximately one year since she was diagnosed with diabetes. She exhibited a newly diagnosed patient, eager to be educated about her condition. She reiterated that fact when she described how her doctor sees her, stating, "I think she sees me as, and she's told me that before, as an individual who has been diagnosed, and wants to be educated and she take notes of that, so whenever she communicates with me she educates me".

Participant 2. She has been a diagnosed diabetic for numerous years, and once feared that she would not live for long because of what she had heard from people, that diabetes can kill. As someone who has had diabetes for a long time, seeing specialists through referrals by her primary care doctor was part of her management. She demonstrated the need to feel comfortable with her doctor, and cared for. She has had previous doctors in the past but due to her dissatisfaction decided to change. She reaffirmed "I think it's, it's good to feel comfortable with your doctor because, like I said, I had some other doctors before I didn't feel comfortable with". At the time of the interview, she had been seeing her present primary care doctor for about 12 years.

Participant 3. She was the eldest participant and was 78 years at the time of the interview. She described herself as having "a very strong mind, and nobody, nothing you would do or say would make me change about myself… I'm very confident… I have a very high self-esteem". She expressed her appreciation for having some form of shared control over her choice of treatment without being condemned or belittled by her doctor for taking something other than what was prescribed. She expressed her intolerance of doctors who see her as a way of making money instead of seeing her as the person she is. According to her, when this happens, "I just give up and get another doctor".

Participant 4. She has had diabetes for several years. In addition to diabetes, she has a history of high blood pressure and asthma. She identified herself as Haitian and also disclosed that her doctor was also Haitian. She related her comfort with her present doctor, compared to past doctors, to being originally from the same place, which makes communication more understandable. She stated "I'm Haitian he's Haitian, he communicates the way I can understand".

Participant 5. She has been a nurse working for the Health Department. She described her diabetes as being "well controlled, under control" and therefore reported "I don't have to see anybody else". She has been seeing her present primary care doctor for approximately 16 years after moving from Philadelphia, and described their relationship as being "very close", making relations to "like my friend, my sister" and consequently her comfort in talking to her about everything, and her satisfaction with their general communication on a whole. She asserted, "I am Haitian, and she's Haitian… she communicates at my level, the way that I can understand”. She expressed her appreciation of respect for one’s time, opinion, and presence. In her own words, when “I don’t think I have a good quality of care… I switch”. She described herself as “a picky patient… I know exactly what I need [and] if a person is not okay, I’m not going to stay”.

Participant 6. She has been seeing her present primary care doctor for about 20+ years, and described their relationship as “an excellent relationship” and “very close”. She expressed dissatisfaction with the way she has been managing her diabetes, avowing, “still sometimes I fail… because I am doing what I should not do, eating what I should not eat, not exercising enough”. As a result, she expressed continued concerns about her diabetes and how she has been doing. She conveyed her desire to do better with her diabetes management, and “make her [doctor] happy” but justified that her lifestyle does not permit her to. She explained “I got two jobs, I have to be running all over, running to my job, when I come back, go to the other job… I haven’t got enough time for myself to do everything that I’m supposed to do”.

Participant 7. She has had diabetes for such a long time that she proclaimed “I got experience with my sickness”. She recalled being “like this since 2005” and therefore has had to see “a lot of doctors”, and having to change many as well. She explained, “If I don’t like the doctor, I’m not gonna go, I go to the doctor I like… I like when I have a doctor to concern about my sickness, because that’s why I go to the doctor”.

Participant 8. Was a diabetic on dialysis at the time of the interview, and quite knowledgeable about her illness, and her diabetes treatment in terms of how it works and how her body responds to her treatment regimen. As stated, “I know myself and I’ve been diabetic for a long time”. She has “been to several doctors”, however confessed that she does not like to go to the doctor, and only goes because she has to go. She has had some “bad experiences” including a near death experience due to a doctor’s medical error whereby in an attempt to reduce her blood sugar, she was given double insulin shots which drove her into hypoglycemia, despite her informing the doctor that one would suffice and based on her experience would require just a little more time to take effect. There were also other unpleasant experiences that contributed to her sentiments.

Participant 9. A very upbeat elementary school teacher confessed, “I was in denial that I was diabetic” but now “I have resigned to the fact that I’m diabetic”. She was diagnosed with diabetes in 2010 after migrating from Bahamas, and has been seeing her primary care doctor since then. She reported having blood sugar spikes in the mornings and consequently having to monitor it closely. She explained:

> Because of my work… I do, I teach elementary school, and, lunch. So... I might... the amount of food I consume, and the blood, you know, might spike. And then I go to work, and so sometimes when I get home I am hungry, the right type of food might not be there. But then I still eat. So when I wake in the morning, the blood sugar is- it's spiked.

Besides her primary care doctor, she has also seen other doctors for other conditions like laryngitis.

Participant 10. She has a family history of diabetes. At the time of the interview, she had recently returned from the Virgin Islands for the burial of her diabetic brother who died suddenly. She described being nervous, along with an elevated blood pressure every time she goes to the doctor. This has been the norm for her and actually believes that “maybe it’s just a normal thing”. Some of her anxiety involves wondering “oh my

God what is he going to say to me, especially when I get on the scale”.

Participant 11. She is a breast cancer survivor, with a family history of diabetes. She reported that her mother succumbed to diabetes. At the time of the interview, she had been diagnosed with diabetes for approximately 3 to 4 years, and was put on metformin treatment at the time of diagnosis. She however explained that every time she took the metformin, it made her feel sick, so she decided not to take it, and instead chose the diet route for diabetes management. According to the participant, her blood sugar has been controlled using this method. At the time of the interview, she had been seeing her primary care doctor for 27 years, and declared, “there is nothing I can hide from her”. She also reported having a history of painful episodes and was diagnosed with “rheumatism” for which she is seeing a rheumatologist. Other diagnoses that have been given to her by specialists include “TMJ disorder, connectivity disorder, autoimmune disorder, neuralgia, sciatica nerve and diabetic nerve”.

Participant 12. She is a breast cancer survivor and nurse, who had been practicing nursing for 30 years, at the time of the interview. She has had diabetes for several years and noticed that ever since she was diagnosed, she has had an increased love for food and eating, which has been one of her challenges. She explained, “I love food, I love to eat. And then, uh, the diabetes probably… when I was young I was skinny, I never like to eat. But now maybe the diabetes make you have an appetite, that you cannot stop”. She appeared to be a jovial, humorous, and easy going individual who described herself by stating “I like to play, and I always like to smile, even though if I fall on the floor, I’m laughing; if you fall I’m going to smile, but don’t take it personal because it’s me (laughs)”. She reported satisfactory blood sugar results with her present primary care doctor; however, that was not the case with her previous doctor. For her diabetes management, she requested not to be on insulin but rather pills only, supplemented with life style modification.

Presentation of Findings

This phenomenological qualitative study was designed to examine the verbal and non-verbal communication experiences of Black Caribbean diabetic women patients with their doctors at a Health Care Center in Palm Beach County, as they managed their condition. The phenomenological design was used in this study because of its appropriateness in answering the research questions and describing the participants lived experiences with doctor-patient communication. Purposeful sampling was used to recruit participants as it facilitated cases that would likely be information-rich with respect to the purpose of the study. The study was guided by the following research questions:

1. What are Black Caribbean diabetic women patients' experiences of their doctor's communication behavior?

2. How do Black Caribbean diabetic women patients think about their experiences with doctor-patient communication?

3. What situations have influenced Black Caribbean diabetic women patients experiences of communication with their doctors?

To begin the analysis process, verbatim transcripts were read and re-read while listening to the audio recording. Areas of interest from the data were identified, and notes and comments were made in the margin, from which emergent themes were deduced. The researcher then identified connections across the emergent themes to see how everything relates, in order to produce an analysis of the most pertinent and dominant aspects of the participants' accounts. Analysis of the data on the lived doctor-patient communication experiences of Black Caribbean diabetic women patients, revealed 6 recurrent themes significant to both the research study and the research questions:

1. High value care promotes satisfaction
2. Patient-centered care stimulates empowerment and self-efficacy
3. Concordance helps communication
4 Communication as a tool to build doctor-patient relationship
5. Communication as a tool to understand unmet needs and expectations
6. Communication as a tool to understand patients' reactions.

The findings are presented using themes, from the participants' overall interviews, as they relate to each participant and the research questions. The themes discussed in these findings are supported by at least a third of the participants, and using supporting quotes as evidence.

High Value Care Promotes Satisfaction

The definition of value is likely to differ depending on which perspective it is coming from, as what would be of value or expected to be of value to one person might not be to another, and is therefore relative. While value may focus on the economy and profitability for some, for others it may focus on moral and ethical features based on standards, importance, and one's principles, for example their belief in what's right or wrong. (Gentry & Badrinath, 2017).

In exploring Black Caribbean diabetic women patients' doctor-patient communication experiences, there were several aspects of communication that was noticeably valued. Besides doctors demonstrating good verbal and non-verbal communication skills such as tone and listening respectively, other aspects of doctor-patient communication that Black Caribbean diabetic women patients value encompass accessibility to doctor - in specific having access to doctor's mobile phone, adequate doctor-patient time, educating respective patients on their condition, shared decision making, and empathetic care.

When Black Caribbean diabetic women patients have open access to their doctor via cell phone, this added privilege is often seen as a qualification of established relationship with their doctor. As Participant 3 puts it "We have a good relationship. Who doctor you hear giving out his cell phone number to his patients? That's the type of doctor he is". She further explained:

> When I see my blood sugar in the morning get to 140, I call him to let him know that I'm gonna start to take two pills again. When I call him, and he call me back he say, 'You know where I am now- I'm on vacation. I am in Boston.' And I explain it to him, he say, 'Okay, I agree with you… I'm gonna call the pharmacy so they can give you enough, so you can start.' So that, this is the kind of relationship I have with him.

Participant 2 shared similar sentiments:

> I get along very well with him, as I say. I even call his cellphone sometime if I needed it. I call his cellphone because I know, after hours, he's a busy doctor. But I know if I call his cellphone, he's gonna answer, so if I have a question, or sometimes if we discuss something when I'm here, and we didn't finish, he say, 'Call me by nine o'clock tonight, and I'll tell you what to do'.

Participant 1 stated “I call her and she will answer me within 24 hours”. Likewise, Participant 5 also mentioned “I can call her any time… if I don't have any medicine, to call her, to say, ‘Can "you send this to the pharmacy?” This welcomed utilization of access by the doctor is seen as a demonstration of concern from the doctor, as expressed by Participant 7 who explained “My doctor uh he always say, whatever you feel… If you don't call me, you'd better text me to let me know… he's very concern”.

As much as patients value respect for their time, which is often overlooked at doctors’ appointments where wait time is often long, patients consider adequate time spent with their doctors to be of significant importance. It also has a positive influence in the overall doctor-patient communication. According to Participant 5:

> I feel okay, because I think the doctor give you the time, your time, and respect your opinion, or your presence… she doesn't put any pressure on me… she's opened to me… she always ask this question, ‘Do you have any more question?’ She has a lot of respect for your feeling. And I can tell her everything about myself, my health- the way I eat. I feel like she is very responsive. She like to listen to me. She listen when I'm talking- ... she listen to me. And she takes her time too… I know that I'm not going to see a monster, a person that is not going to improve, who is there for the money.

There was a shared dissatisfied sentiment among participants with regards to the amount of time some doctors spend with patients during a doctor-patient encounter.

Some of the sentiments expressed included Participant 5 who spoke about a past doctor, stating, “She doesn't want to listen to you. She just going, choo, choo, choo, choo, choo, do whatever they have to do, and bye bye... They don't have time to talk to you”.

Participant 9 thoughts were they “just in there for how much medication they can prescribe, how much they are going to make out of it, they don't spend time with you to alleviate you of your fears, and what can happen”. Participant 10 recalled “The doctor that I use to see… he has no time. It's from one patient to another. Like, he will not sit down and take the time to talk me through and ask you questions, like what my doctor does now”. As Participant 2 put it, “Some doctors… they do not take time to explain to you the situation or to tell you what to do”. She made particular reference to a past doctor, and lamented:

> She didn't spend that much time, not even five minutes with me… she didn't take the time for me, you know? She didn't take no time with me. It's like she had too many patients. She didn't make no time for me. So I hope she's not like that with everybody… I still don't know if I, if I'm going back to her… because she, she didn't take the time for me, you know.

In Participant 5 words “I think that they don't have enough time to listen to what I want to tell them. Uh, to answer my questions- ... and to give me a good care.” When patients do not receive adequate time from their doctors as seen in the aforementioned scenarios, they feel that their care is being compromised, when in fact what they desire, expect and value is empathetic concern from their doctors.

Empathetic concern has the potential to significantly influence doctor-patient communication. Participants illustrated how this could be attained through their shared experiences. Participant 10 detailed, “He shows a lot of concern, as far I could tell… like, his demeanor, the way he talk to you, the way he approaches you. Um, he shows concern towards your sickness... I feel like he’s a caring person”. Participant 11 also shared her experience on the subject, stating:

> He sees me- as a person who got a problem, and they want to help… Like for my eyes, he make sure that I go to the specialist. And when somebody is coming like here to do something in the eye, he calls me at home, ‘You have to be there, you know? Because they have to take some picture to see if you have diabetes in your eye’… So he cares… to me he don't want nothing bad happen, or things going out of control. That's the way he sees me.

When Black diabetic patients feel that their doctors genuinely care about their health and wellbeing, and their expectations and values are met in terms of doctor-patient communication, it is often associated with patient contentment.

Patient Centered Care Stimulates Empowerment and Self-Efficacy

Black Caribbean diabetic women patients appreciate being seen as an individual with specific unique needs, as disclosed by Participant 1 and Participant 9 who proclaimed “I don't feel as if I'm, y’know, simply, just a patient coming in” and “I don't feel like I'm just a statistic, when I go to him”, respectively. Likewise, when decision for treatment is customized to patients’ preference and values, they tend to be more compliant and determined to do well, driven by their desire to not disappoint their doctor.

In Participants recollection of past experiences, they expressed their appreciation in having a say in their treatment choice. Participant 11 shared:

> He prescribed me Metformin and I took it. I didn't feel good at all. Every time I take that thing, it make me so sick. I tell him, ‘I'm not taking anything, but I'm gonna follow a diet’. He said, ‘since you don't think the medicine make you feel

> good and it make you worse, but you have to abide by all the rules… If you think you cannot follow the diet, you know, you have to let me know, because if your blood sugar go up, it's no good'. And I follow the diet. I follow everything he tells me… he didn't force me.

The shared responsibility for management of one's own health is a much-desired aspect of doctor-patient communication by all patients including Participant 12 who similarly stated:

> When I came here, I was, uh, very low, 5.1. She said, 'Oh my gosh, it's too low [name], I'm going to stop you on this medicine.' I said, 'No, [Dr. name] please leave me on that medicine.' And that's what I said, 'Please, I like to eat, leave me on that medicine.' And she said, but you need to increase your feed, I was on a strict diet… she said, 'I'm gonna leave you on it.' She said, 'Eat more, and if you don't eat, don't take it.' So I'm doing well since three years and a half, or four years with [Dr. name].

Participants' reports proved that there's a positive relationship between patient-centered care and adherence, and whenever Black Caribbean diabetic women patients play a part in the treatment choice of their health management, it gives a sense of empowerment.

In addition to shared responsibility and decision making in the management of one's own health, patient-centered care involves consideration for each patient's circumstances as Participant 9 identified:

> I remember although I have health insurance, and I said, 'I can't afford this medication. It's too expensive. Is there any other medication that I can get that is not as expensive as this one?' And, yes, he listens to you as a patient. Not only on

> the medical aspect but also- you're financially concerned. Because it makes no sense, you're going to prescribe medication to somebody, and they cannot afford it. You know, what is going to happen? It's going to be left in the pharmacy. And yeah, so, he's willing to work with you, on that aspect of it, too.

When such compromise is made between doctor and patient, the aspect of trust comes into play. Trust is something that is built on, and is essential in all relationships including doctor and patient, as this facilitates effective communication. Consequently, patients do not want to break that trust with their doctors, as conveyed by Participant 12, who declared:

> He trust in me- I ask him permission, don't put me on the insulin. Let me try to do exercise and change my diet. And then, uh, when I come in two, or three months you can repeat it again, see how I feel, and then he listen to me. We both, uh, have agreement that this is what you're going to do, and I had to work on it too because I want to be good.

As seen in the aforementioned referenced cases, when there is collaboration through shared decision making, and respect for Black Caribbean diabetic women patients' preferred choice of care such as treatment choice, for example the preference for life style modification over prescribed medication, patients become self-motivated and empowered to be compliant in managing their condition to achieve the desired health outcome.

When reassurance and encouragement, is added to the empowerment gained from shared decision making, together, they have the potential to positively impact patients, significantly, as they manage their condition. These elements not only motivate Black Caribbean diabetic women patients to take the necessary actions needed to manage their diabetes and overall health, but also give them confidence in their ability to successfully accomplish that. When doctors communicate with their patients in an encouraging and complimentary way, this serves as a form of motivation and inspiration which patients often need to build their confidence, and improve their willingness to take action towards working on improving their condition. This was demonstrated with Patient 12 who described how her doctor's communication contributes to her self-efficacy. She stated:

> She always said I'm smart. And- 'Why didn't you go for doctor?'… So she always see me as a smart person… and this feedback- also this positive- uh, bring up your self-esteem… I feel great after I see [Dr. name], because she put me, she raise my, uh, increase my self-esteem… and I think I can, that's why I try to do my best with my diabetes, because the way she treat me, I think I can do good, I can do better, control my diet, my exercise… she makes me feel good. She doesn't put me down. Never put me down.

When patients are reassured any doubts are dismissed, and instead, they become inspired.

Patients do not, however, always respond positively to doctors' call to action. Nonetheless, when the appeal is made in a skillful way, positive response and results ensue, as expressed by patients including Participant 7 who explained:

> She talks to me in every way that I could do better… when she talks to me, I always tell her I'm giving her the promise that I should do... I'm going to do whatever she ask me to… [She] makes me feel that I should listen to her and do better with my life.

It can be concluded that patient-centered care accompanied with encouragement and reassurance give Black Caribbean diabetic women patients belief in themselves, that they can succeed in managing their diabetes effectively and ultimately achieve blood sugar control.

Concordance Helps Communication

Concordance can be summarized as the shared identity between doctor and patient based on certain demographic characteristics. Among participants' responses, 5 out of 12 participants felt that concordance contributed to communication effectiveness. Black Caribbean diabetic women patients tend to gravitate towards doctors who they share similar demographics with. Participants who were from Haiti, shared similar thoughts on the benefits of having a doctor who was also from Haiti. Participant 4 stated "I'm Haitian he's Haitian. He communicates the way I can understand". Likewise, Participant 5 shared "I am Haitian, and she's Haitian. I think that I'm very ... She communicates at my level, the way that I can understand. And she always has something nice to tell me". Despite being fluent in English, it is beneficial for the Haitian to be able to communicate in their native language, and is often a contributing factor to their choice of doctor, as expressed by participant 8 who acknowledged "she speak my language too… This is good for me… for me that was the reason I go to her".

In addition to racial concordance, gender concordance was also an influential factor in Black Caribbean diabetic women patients' communication experiences with their doctors. Besides being a migrant from the same Caribbean Island and speaking the same native language, having a same gender doctor also contributed to the favorability of doctor-patient communication. In clarifying why communication with her doctor was different in a favorable way, Participant 5 explained "she is different because she is ... well, and then she's a female too" which implies that Black Caribbean diabetic women patients favor doctor-patient communication with same gender. Participant 1 went even further, giving insight into the possible reason why this is the case, through her statement:

> I think because she is a female physician, there's a different degree of understanding. So, she understands me on certain levels because she understands what's going on with me, so it's- it's a little different from the others because they were male.

Interestingly, when both doctor and patient were members of the subgroup of Black immigrants from the Caribbean, that was identified as a factor which encouraged favorable communication because of the unique cultural similarities that members believe exist among individuals of that Black subgroup. In sharing her lived experience with doctor-patient communication Participant 9 highlighted the qualities of Caribbean migrants which make communication different and effective. She explained:

> Sometimes we talked things that have nothing to do with medicine. (Laughs.) I don't know if it is because we are- we are Caribbean people. We see things differently. We are more people oriented. We have that family connection. So you see people as individuals and not people as numbers or people as your earnings… When you're able to talk outside of what you are here for, you become more open, the dialogues become more fluid, and that trust is there because you're listening. And listening, and talking back, means you can understand a person.

Communication as a Tool to Build Doctor-Patient Relationship

One of the most common themes revealed from the interviews was that relationship building communication improved doctor-patient relationships. The association between doctor-patient relationship and communication was summarized best by participant 1 who noted, “the relationship a doctor has with the patient depends on how the doctor communicates with the patient”. By being a nice person towards the patient, in ways such as being friendly, showing care, as towards a family member, and listening to and taking interest in the patient, are all means of building a bridge to effective communication and subsequently, relationship building. Participant 3 highlighted this when she described her doctor-patient conversation as “It’s positive- the way he treat me, the way he talk to me, and the way he listen to me… he's very friendly to us- me and my husband.”.

Participant 7 added to this by stating:

> Like a friend, like a family… he's very concern like a family… And ask for your family when you go, even though, like he know my husband, if I go by myself, he always ask for my husband… [he] always have a long conversation before he start to check you.

When communication begins with an icebreaker such as storytelling, it gives a deeper understanding and appreciation of the patient’s life and experiences, and sets the stage for a more receptive and cordial exchange in communication, as expressed by Participant 8 who shed light on initial relationship building conversations during doctor visits, as follows:

> I've been to several doctors. But some of them was kind of not too friendly. But some of them was friendly, I can tell- she's a really nice lady the one I see right now… She's a very nice and open doctor. When she come to the room, she always say "Mrs So-and-so, how you doing? How do you feel? when she come to the room, she always have a little story to tell me. Me also I always have a little story

> to tell her… This is the day we can talk about whatever the subject, we can discuss about the subject, you know?

In describing her doctor and their communication, Participant 10 also gave added insight into what Black Caribbean diabetic women patients identify as aspects of a relationship building conversation, by stating:

> He's a very pleasant person… He's very pleasant, very kind… as soon he walk up to you, he'll greet you and ask you how are you? And how is the sugar? And are you taking care of yourself? Are you doing what you're supposed to do? And he will always ask please don't smoke and don't drink alcohol.

Besides this expression of concern for the patients, and interest in their wellbeing, greeting was an identified way of being pleasant, and a means of building relationship. In fact, being greeted by the doctor was something that was made mention of by the majority of participants which indicates the importance of something as simple as good morning or good afternoon, and how are you doing, in relationship building. By so doing, it acknowledges the patient being greeted, gives a sense of importance and connection, and is seen as a form of respect.

Friendly conversations along with the use of icebreakers such as jokes, not only build on relationship, but also facilitate comfort and openness in conversation, by capturing patients’ interest and getting them to participate in the conversation, as seen in Participant 12:

> My relationship with the doctor I have now for my diabetes is a really, uh, we have a good rapport… I don't even say doctor and patient, I can even say like family or friends, more likely friend. We do have a good friendship, she always

> listen to my joke, and I listen to her joke. Before we start the real thing, we do always joke at the beginning.

With this sense of friendship, comes the additional facet of trust and the manifestation of its subsequent benefits. Friendship is of great importance to patients like participant 2 who spoke about her doctor-patient relationship stating “He call me, um, ‘my friend’- ‘If you don't do this, my friend’. He calls me like a friend. I mean, we're not like a doctor, we're like a buddy, because that's the way I feel about him”. When doctors go even a little further and not only show care and interest in the patient but also their family, this does not go unnoticed by the patient. In addition to Participant 5 who highlighted “We always start by asking, how you doing? How is your day? How is your kid(s)? And talking about the family issues”, Participant 11 shared similar recognition, stating:

> It's like two friends talking. Talking about everything… we have a very good relation… she's a person I can talk about anything… we talk about families… She would ask me about my family and I will ask her about her children and stuff.

The ability to talk about something as personal and treasured by all, such as family, build even a stronger connection and favorability to the communication and doctor-patient relationship.

When patients felt that they were treated as a friend or family member, they saw the doctor as a friend as well, someone they have a cherished relationship with, can relate to, and trust. Since trust is such a desired aspect of any relationship, when the participants felt that they were trusted, this brought about a reciprocation of trust between the doctor and patients; whereby the patients were inspired to live up to the expectations of the doctor to avoid disappointing them, in an effort to continue to nurture and maintain that desired trust and relationship, which was also evident in Participant 12, who further added:

> We have a trusting- he trust in me and I trust in him too- he listen to me, and that's why you not gonna, uh, disappoint him not to do what, uh, you tell him you're going to do. I want the trusting relationship- is really good between the two of us.

Communication as a Tool to Understand Unmet Needs and Expectations

Black Caribbean diabetic women patients usually pay very close attention to their doctors' verbal and non-verbal style of communication, especially when communication does not meet their expectation. Afterall, it is human nature to emphasize the negatives because for some reason bad events or memories are remembered more. And for this reason, every participant recalled displeasing events from their doctor's communication behavior. The elements of verbal and non-verbal communication that participants took particular note of include tone and listening respectively. In some instances, as in the case of Participant 2, undesired tones resulted in negative encounters whereby the patients' needs and expectations were left unmet. In sharing her encounter with a specialist whom she was referred to, she stated:

> The last time he sent me to a specialist, for my diabetes. I left. I didn't even know if I should have another appointment, if I should come back… She's from India. She was so mean, and da-da-da-da-da-da, and then she sound mean.

In fact, unpleasant tones were identified in numerous doctor-patient communication encounters.

One of the most challenging and frustrating aspects of diabetes management is achieving and maintaining satisfactory blood sugar level and weight, through diet modification, because it requires a lot of self-discipline and sacrifice on the part of patients. Consequently, Black Caribbean diabetic women patients expect their doctors to display sensitivity, for example, through their voice tone, not only in this aspect but towards their every need. This is not always the case though, as indicated by Participant 7 who sadly described an encounter with a doctor:

> She’s mean. She always say, no, no, no, no, no, you're not supposed to eat that. You're not supposed to do that. Because you're supposed to lose weight. If you don't eat, you don't eat. I say, no doctor, because when I take my medicine, you always complain about that… You're supposed to eat. And she say, no, it doesn't matter if you don't eat. Just eat a little salad, a little thin thing. I say, no it's not going to be enough, because you know, when you take the pill and you take the shot and my blood sugar is coming down and with that one it is no good.

Black Caribbean diabetic women patients expect a sensitive voice tone from doctors, as was lacking in the aforementioned case, because it’s an expression of sympathy which influences patients’ willingness to adhere to life style modification, such as diet. The lack thereof makes patients more reluctant to adherence, due to its resultant negative emotional effect, and consequently affects patients’ outcome and satisfaction.

Participant 12, gave possible insight as to how a doctor’s tone might be an indication of the existence of implicit bias in communication. She proclaimed that her Doctor communicates with her differently compared to other patients, mainly due of her education background, along with other reasons. She explained:

> I think with me, because the way I am very jovial, or pleasant, and I have a medical background, I think, uh, their communication with me is maybe better. But with other clients who are non-compliant, they may be angry, and then they may have another tone… I saw that with the other doctor- with, a client with high blood pressure. The way he- not yelling but talking very hard, you know talk hard with adult… I saw they can have a different tone with, uh, other client, mainly because of my background like I told you, and then the way I am. The way I am too. Uh, you cannot be mad at me (laughs). Even if you mad I'm gonna just smile at you (laughs).

This implies that the existence of disparity in communication, for example the doctor's tone towards Black Caribbean diabetic women patients may be dependent to their education level and background.

The general consensus, however, among Black Caribbean diabetic women patients was that doctors do not exercise good listening skills. According to Participant 1 "some doctors will not listen to you". A pleasant tone and good listening skills facilitate good communication; however, when a doctor's tone is not pleasing, and s/he is unwilling to listen to the patient, this sets a barrier to communication, whereby the patient may not be comfortable asking questions. This occurred with Participant 2 when she attempted to ask her Doctor a question but as a result of the tone of her response, the participant refused to inquire any further. She explained:

> When I tried to explain- something I remember, I need to ask her before I forgot, she said, "Okay, listen to me first, then I'll answer your question later". And, before I know it, she was done. I didn't even have a chance to ask her more

> questions… she didn't even ask me about ‘what is it you tried to tell me?’ She didn't even try to ask me.

When the interviewer asked the participant whether she tried to remind the doctor of the question, the participant responded “No, no. I wasn't gonna do that because she was not a very friendly type of person”. Black Caribbean diabetic women patients often have many questions about their condition which they expect to get answer for from their doctors; and this was a good demonstration of how doctors dominating the conversation during a meeting, and allowing limited input from patients, result in unanswered questions and hence dissatisfaction and poor health outcome.

In making reference to some doctor-patient communications that did not meet expectation, while concurrently voicing what was actually expected from each respective conversation, Participant 2 further disclosed another incident, stating:

> I was trying to, uh, ask her some question that I always had in mind. She refer me to, uh, um, not dietician… Um, what you call the people who tell you how to eat- how you call those people? The ones who will explain to you how to take your medication, how to eat? Not a dietician. Um ... Um ... Oh, when I remember the name, I'll tell you. But she refer me to somebody else to answer my questions. She didn't want to answer my questions. She's a specialist. She's supposed to answer my questions. I was hoping she did.

Participant 5 shared similar sentiments about doctors reluctance to answering questions. Based on her experience, in her opinion “you don't have time to ask questions. Or, they don't answer the way that- Uh, they don't answer, the way doctors and patients supposed to be, you don't have the answers that you're supposed to have”.

Participant 8 summarizes the concept of being able to ask questions of doctors best. Like she explained, “The doctor is there to ask question, if you have problem. If you cannot ask your doctor a question, I mean, who are you going to ask a question? About your sickness, or about something you concern about”. In addition to entertaining questions from the patients, Black Caribbean diabetic women patients would also like their doctors to engage them in conversations pertaining to their health and lab results by asking questions such as “what did you eat” as Participant 12 expressed. Likewise, this resonates with Participant 2 who recalled “before him, I use to go to some other doctor, and they didn't even call me about the test result, and they never really asked me a question”.

Active listening, by doctors, redirects the focus to patients, which is every patient’s ultimate desire as it’s a form of respect. Participant 12 shared her experience on this subject matter, and in fact rated a particular doctor’s communication behavior less in comparison to her present doctor, as a result. She explained:

> The other one was average. The reason I said average, you know when you go to a doctor, and then they always talk about their family… he doesn't focus on me… that's not what I want to hear, I want to hear me, how I feel because my insurance is paying you. So I want you to focus on me, but him he always focus on his family. And then my health was degenerating with him because I didn't like him. But I didn't stop seeing him, you know… my husband also said all his client will always end up going to nursing home… he doesn't give you really the medicine that required for your disease. And that's exactly what happened to me before I switched to [Dr. name]… When I was there my A1C was 9.4,

> blood sugar was 439.

These conversations demonstrate that when doctor-patient communication behavior expectations go unmet, negative consequences result.

Communication as a Tool to Understand Patients' Reactions

Black Caribbean diabetic women patients often react or take action, be it positively or negatively, in response to the feelings experienced or generated from their doctor-patient communication, as was demonstrated in all 12 participants. They drew conclusions about their doctors, such as competence, based on the general nature of the conversation or interaction that they share. Patients' satisfaction with their doctor's communication behavior, and doctor-patient relationship was associated with their perceived level of the doctor's competence as was seen through many of the statements or comments made by the participants, including Participant's 12, who declared:

> I have an excellent relationship with my doctor; she's very good… She talks very well. And listens too… she listens to you, to what you have to say, and, uh, she doesn't interrupt, she listens to you, give a good eye contact and then give feedback… I love her… she's very good, I feel great about her.

It can therefore be concluded that Black Caribbean diabetic women patients' feelings or perceptions about their doctor, correlates with their general satisfaction with the overall doctor-patient communication experience, which Participant 8 reiterated in her comment:

> She's a really nice lady the one I see right now. Well she like to talk, she spend time with you, you know? She explains whatever she's going to do. She's a very nice and open doctor… I like her from the beginning. She's a young person too. I like a young person, even if I'm old but I like young people [laughs] you know?

For Participant 6, the duration of their established doctor-patient relationship was used to justify and validate her feelings towards her doctor. She explained:

> Because she's my long-time doctor, I have more confidence in her than any other doctor. I'm used to her. So, whenever I'm with her, I feel more comfortable than being with any other doctor… To me I feel more free to discuss everything with my primary doctor because I have her for a very long time.

The aforementioned were some examples of ways satisfaction with doctor-patient communication and relationship had a positive impact on patients' reactions, but this is not always the case; there are many instances where patients are often dissatisfied with their doctor-patient communication experience and react negatively as a consequence.

So likewise, when doctor-patient communication does not meet Black Caribbean diabetic women patients' standards, they do not shy from expressing their disapproval and voice their opinions and criticisms. Participant 9 shared her views on certain doctors' communication behavior, by stating:

> To me, it's cultural… in certain places, they just see people as not individual, but see people as just herding, like cattles. And, that the more they can get people in and out of their office, the more money they can make. That's my opinion, I might be wrong. Uh, the more money they can make, so they don't spend quality time with their patients… I have gone to, um, doctors who are American doctors, and that is what I have discovered with them… they have never seen you, they don't know your history… But in two minutes I'm out of your office, and you have been diagnosed what it is you have.

The notion that doctors are profit driven was a common opinion among Black Caribbean diabetic women patients. It is believed that Doctors are only concerned about making money and not necessarily the patient. This is mainly because patients feel that some doctors do not do enough for them in terms of patient care, and not enough time is spent communicating with the patient. Participant 7 used a past experience to reiterate, “Some doctor when you come in- he just need the money (laughs). Even though he not gonna put the stethoscope on you, to check your heart, your lung, nothing. Just give you the prescription. No talk. Nothing.”

The amalgamation of all the feelings that Black Caribbean diabetic women patients experience from aspects of their doctor’s style of communication affects their emotional wellbeing and ultimately patients’ behavior response and health outcome. They typically experience the emotion of fear and anxiety ahead of a doctor’s meeting mainly because they are concerned about what their A1C levels are going to be, and their desire to not disappoint their doctors in fear of how the doctor may react. They are often nervous about their doctor’s anticipated reaction to unfavorable vitals and test results. Participant 12 recalled having these sentiments:

> I feel very, very anxious, I can say very anxious before, I see my doctor… When you come here they have to do vital sign, and if you see just a little thing wrong with the vital sign, like the (laughs) blood pressure is high, so you start questioning yourself… the blood work always make me feel very frustrated…
>
> And I don't want to make her mad… I always want to make my doctors happy.

So therefore, just the thought or likelihood of not meeting their doctor’s expectation raises anxiety. Participant 10 shared similar sentiments:

> Anytime I have to go to the doctor I always get nervous. Whenever I get to the office I get nervous and my blood pressure is always raising sky high… maybe it's just, uh, normal thing… just being in the doctor's office that just make you anxious… I'll wonder, oh my God what is he going to say to me, especially when I get on the scale. When you get to the office and he's reading your chart, he'll be like oh Ms. (name), you gained one pound. Why are you gaining weight when you're supposed to be losing? He'll tell you stuff like that.

The anticipation of such comments that call out patients, questioning them about their weight gain and challenging them for an explanation causes anxiety and discomfort in Black Caribbean diabetic women patients. Such comments insinuate dissatisfaction in their efforts, which is often not received very well because of their desire to please their doctor.

On a more serious note, doctors can drive fear and traumatize patients, by the very nature of their communication. Participant 11 shared an experience she had with a past doctor, which proves that. She recapped the entire incident:

> The moment he come and touch me and he saw that little thing, he said, "You know something, I'm going to talk to you, you're not going to like me anymore, I have to tell you whenever... who- whoever come here and have a little lump or whatever, I cut their breast… I said, "What do you mean you cut the breast?" And he said, "People are not supposed to have lump in their boobs." If you have a lumpectomy it gonna become a cancer, okay? So if you agree for what I say, we're gonna go to the thing and then out- ... cut the thing. If it comes for me to cut both of them, I will cut both of them." And he went outside where the patient

> was sitting then, and he said, "You see all these people? They don't have- some of them have one, some of them don't." He said, "I know what other doctors gonna tell you, to have a lumpectomy. If you have a lumpectomy, you're gonna see what gonna happen, okay? You're gonna get sicker and you're gonna have cancer and you're gonna die." I was crying. I almost get a seizure.

Everybody responds to fear in his or her own way, however it is generally not received in a good way and that was evident in Participant 11 case. Patients would rather doctors be mindful and act in a humane manner when addressing such sensitive health issues.

While many experience fears when meeting with their doctors, Participant 9 was an exception because of the level of trust in her doctor's guidance. She expressed "I have no fear, because it's somebody who is open, and I can talk to and I trust… I try to use him as my Bible... (Laughs.). And follow what he says, so I can stay on track". This is an example of how satisfied doctor-patient communication stimulates positive response.

Black Caribbean diabetic women patients are intolerant of suboptimal communication from their doctors. Their eventual reaction to dissatisfied doctor-patient communication is to change the doctor to one whom they can relate to, and may change as many times as necessary to find that doctor who satisfies their needs. While sharing their doctor-patient communication experiences, many expressed disgust with namely past doctors, and was the predominant reason for the transition to their present doctor. They generally conveyed satisfaction with their present doctor, but in situations where they felt that their expectations or needs were not being met, they expressed a strong feeling of dislike and disapproval of the doctor, and were actually contemplating switching to another doctor. In Participant 7 justification for changing doctors, she stated:

> I have the sickness, from a long time ago. And I'm seeing a lot of doctor, I change the doctor. If I feel I don't like the doctor, I'm not gonna go, I go to the doctor I like. I had one doctor before and my insurance didn't change, and I always say I'm going to change him, and I change him. That's how I got this one... This is the third one I have and I am happy with the third one.

Not only do they change doctors, but while they are still under the treatment of a doctor whom they are dissatisfied with, they are often noncompliant. Participant 12 admitted, "I wasn't compliant… I eat whatever I want to eat". Others simple chose to just miss their doctor's appointments. Participant 12 reasoning for this was,

> He wasn't doing well with me, even though he was my doctor from 2003 to uh, 2012, no, not 2012, 2000, uh, 16- I left him 2016, when I came here… I never went to appointment, that's another thing. If he give appointment in three months I don't go, I go six months or nine months. Because I don't think he was doing anything for me. That's why, uh, if he give me three months, I says he want me to come for the money. So I'm not gonna go… but here I follow every three or four months, I'm here every three or four months. But with him, because when you go it's more likely about his family, so, I barely go in a year.

On the contrary, when patients are satisfied with their doctor-patient communication, they are more compliant, and consequently report better health outcome, which was evident in the case of Participant 12 who proclaimed:

> I am in charge of my diabetes, but she also help me to control my diabetes… she's

> there to help me get better in life. And, uh, that's why I think with [Dr. name] I'm doing very well with my diabetes... She give me good reinforcement…good good good way to manage myself too in life, not only diabetes, in life. We always have good communication.

Her shared doctor-patient communication experience effectively gave insight into how doctor-patient communication impacts Black Caribbean diabetic women patients' emotional, physical and overall health outcome.

Summary

Chapter 4 presented the research findings from the lived experiences of 12 Black Caribbean diabetic women patients, as it relates to the research questions. The chapter provided justification for choosing phenomenology as the qualitative approach for this study design, a brief summary of the data collection and analysis process, and the background of each participant. Each of the participant's respective transcript from their responses to the face-to-face semi-structured interview was scrutinized to provide insight into how participants make sense of their doctor-patient communication experiences. The overall emergent themes were used to address the research questions.

The 6 recurrent themes identified were: high value care promotes satisfaction, patient-centered care stimulates empowerment and self-efficacy, concordance helps communication, communication as a tool to build doctor-patient relationship, communication as a tool to understand unmet needs and expectations, and communication as a tool to understand patients' reactions. The emergent themes discussed were common among participants' accounts, and were supported with evidence. These emergent themes gave insight into the meaning of Black Caribbean diabetic women patients' lived experience, while also making evident their values, expectations, dissatisfaction, and reactions to the doctor-patient communication phenomena. The subsequent chapter will discuss interpretation and implications of the findings, along with limitations of the study and future research suggestions.

Chapter 5: Discussion

Summary of Findings

Among the many disparities that Blacks face, disparity in health care is one of the areas that has been of utmost concern because of the dire consequences that this population tends to face as a result. For this reason, the existence of disparity in health care, for certain demographics more so than others, has been a topic of prolonged concern and discussion. Blacks have been known to be the documented racial group most impacted, in terms of prevalence of diseases such as diabetes, among others. Diabetes is a chronic medical condition that has been plaguing the minority population in a disproportionate manner. Although it is a medical condition that afflicts every race, it is however noted for its impact and severity in minority groups, in particular Blacks. They are known to have a higher burden of the disease, worse diabetes control, and consequently suffer more complications secondary to diabetes.

There have been continuous talks over the years on the need to close this gap in the quality of health and healthcare. However, to even attempt to close this gap, the basis of the problem must be first understood, in order to come up with effective means of achieving that goal. This research served the purpose of examining the doctor-patient communication experiences of Black Caribbean diabetic women patients as they managed their condition, which gave some insight into likely contributing factors to their higher burden of the disease, based on their shared lived experiences. Three research questions guided this study:

1. What are Black Caribbean diabetic women patients’ experiences of their doctor’s communication behavior?

2. How do Black Caribbean diabetic women patients think about their experiences with doctor-patient communication?

3. What situations have influenced Black Caribbean diabetic women patients experiences of communication with their doctors?

The six common themes identified from the 12 participants' collective accounts were (a) high value care promotes satisfaction, (b) patient-centered care stimulates empowerment and self-efficacy, (c) concordance helps communication, (d) communication as a tool to build doctor-patient relationship, (e) communication as a tool to understand unmet needs and expectations, and (f) communication as a tool to understand patients' reactions.

The results of this research showed that even when there is access to health care, there still exist ineffective diabetes management which all stems from suboptimal or breakdown in both verbal and nonverbal doctor-patient communication. Lack of effective doctor-patient communication significantly influenced Black Caribbean diabetic women patients' behavior towards managing their condition. Black Caribbean diabetic women patients have values and expectations of their doctor-patient communication experiences that if not met, results in dissatisfaction and eventually, negative reactions or behavior towards managing their condition. These resultant negative behaviors ultimately affect their health outcome which is often demonstrated in uncontrolled blood sugar and possible secondary health complications.

These findings support the research questions and are in alignment with Sadati, Lankarani, and Hemmati, (2016) assertion that challenges exist in doctor-patient communication, whereby patients experience disappointing, unexpected, and unacceptable interactions; and Elliott et al. (2016) declaration that suboptimal doctor-patient communication impacts trust, compliance, health outcomes, and mortality. And in fact, the results of the present study proved that effective doctor-patient communication, which has been documented by prior studies to be lacking in healthcare, is a much desired and necessary factor for Black Caribbean diabetic women patients’ satisfaction, compliance, and outcome.

Interpretation and Context of Findings

This study focused on Black Caribbean diabetic women patients’ lived experiences as they managed their condition with respect to doctor-patient communication. Besides each participant’s unique experience, there were several similar experiences that were shared among participants. Black Caribbean diabetic women patients described their doctor-patient communication experiences with mixed sentiments, some good, some not so good, and some distasteful to the point where they chose to no longer see that doctor.

The stories that were told revealed that Black Caribbean diabetic women patients have values and expectations where doctor-patient communication is concerned, which when left unmet as was often the case, resulted in dissatisfaction and negative reactions or behaviors. Black Caribbean diabetic women patients value accessibility to doctor, in particular, access to doctor’s mobile phone, adequate doctor-patient time, shared decision making, and empathetic care. They expect a pleasant, sensitive, sympathetic voice tone, and good active listening skills from their doctors; and their reactions and behaviors were dependent on, or was a reflection of, their satisfaction or dissatisfaction to whether these expectations were met during their doctor-patient communication experiences. Patient-centered care, concordance, and relationship building conversations were also influential factors in Black Caribbean diabetic women patients' communication experiences with their doctors.

Valued care. The findings of the study showed that good doctor-patient communication skills or behaviors, although often lacking, were highly valued and desired by Black Caribbean diabetic women patients, and played a significant role in their satisfaction, compliance and health outcome. This concurs with Paddison et al (2015) studies which identified doctor-patient communication as one of the most important elements of patient experience in both promoting satisfactory patient experience of care and facilitating good self-management. In assessing the aspects of doctor-patient communication that were valued by Black Caribbean diabetic women patients, it revealed behaviors such as accessibility to doctor specifically by having access to the doctor's cell phone, good listening, adequate doctor-patient consultation time, friendly tone, empathetic care, shared decision making, and answering or addressing questions and concerns.

Time was a topic of great mention in the stories relayed, and participants were unified in terms of needing more doctor-patient time. In spite of the fact that Black Caribbean diabetic women patients generally appreciate respect for their time, adequate doctor-patient time during consultation was an integral element of valued patient care. This result parallels Mehra (2016) study which espoused that increased doctor-patient encounter time makes up for patients' dissatisfaction with extended wait time.

Patient centered care and self-efficacy. Participants were unified in terms of their desire and the satisfaction achieved from collaborating with their doctors on individualized treatment choice through shared decision making, as this not only motivated and empowered them to take responsibility for management of their own health to achieve their desired health outcome, but also, such compromise established a sense of trust between doctors and patients. Prior studies have established the existence of distrust in the healthcare system and providers; however, this study, like Martin et al (2013) establish that patient-centered communication behavior is associated with the enhancement of trust in health care providers.

Participants expressed their appreciation of being seen as an individual, and not as a statistic or means of making money, but instead, as someone with specific needs and circumstances. Likewise, Paternotte et al (2017) study reiterated patients' desire to be treated as an individual and not as a disease; and Eun-Jung Shim et al (2016) assertion that patients' needs and preferences vary. There is not uniform, one size fits all method of dealing with Black Caribbean diabetic women patients.

This research findings highlighted the need for Doctors to personalize each patient's treatment plan to align with their individual preference, value, and circumstance, as this resulted in higher compliance, and a determination to do well, driven by patients' desire to avoid disappointing their doctors and destroying highly valued established trust. This coincides with Cooper et al (2012) findings which identified tailoring to patients' needs as a key aspect of patient-centered care which is essential for performing a satisfactory doctor-patient communication encounter, enhance patient trust, and subsequently adherence and continuity of care, particularly when patients feel equally involved. The aforementioned findings can be further explained by Beach et al (2017) which found that minorities desire respect in terms of wanting honesty and clarity in explanations and involvement in their treatment plan, to be treated equally as a person, listening to and trusting their self-knowledge, and recognizing their vulnerability and fragility as an individual.

The study also unveiled the need for doctors to encourage self-efficacy in patients, as this motivates Black Caribbean diabetic women patients to take charge of the management of their health. When patient-centered care was accompanied with empowerment through encouragement and reassurance, participants believed in themselves and their capability in effectively managing their diabetes and ultimately achieving blood sugar control. This is in line with Greenfield et al (1988) study which found that collaboration improves blood sugar control in diabetic patients. Josh et al (2011) reasoning for why this may be the case concurs with this study's findings by reiterating that facilitating joint decision-making helps instill confidence in adhering to treatment plan.

Concordance. Although Paternotte et al (2017) suggested that race concordance is not always important in communication, the present study concluded that race and gender concordance, in fact, have a strong effect on Black Caribbean diabetic women patients' doctor-patient communication experiences. Race concordance contributed to doctor-patient communication effectiveness, and participants conveyed a gravitation towards doctors who were of similar demographic. This echoes the claim by Street et al (2008) that patients are more likely to trust and feel more comfortable with doctors of the same ethnic group. The results of the study revealed not only does race concordance play a role, but coming from the same country of origin was even of more importance. This could be explained by the fact that even within the same Black race, there exist differences within subgroups, for example Caribbean Islanders, such as culture, native language, upbringing, and belief, based on individuals place of origin. This concurs with the Population Reference Bureau website (www.prb.org) which states that significant diversity also exists within racial and ethnic groups.

The role of gender concordance in doctor-patient communication might have an influence on Black Caribbean diabetic women patients' perception of their doctors. Participants expressed favorability for same gender (female) doctors as they felt that these doctors understood them better, were more relatable, and therefore were easier and more comfortable talking to. However, not all participants were satisfied with their same gender doctors; there were cases where participants expressed more satisfaction in their male doctors compared to female doctors that they had seen. This may be explained by the study of Leung and Cheng (2016) which found that other factors and differences such as cultural norms, values and practices, rather than just gender differences, may account for patients' perceptions of their doctors' communication skills or behaviors; and Lorie et al (2017) findings that non-verbal emotional behaviors prevail over race when evaluating satisfaction.

Doctor-patient relationship. From participants' responses, such as participant 1 statement that "the relationship a doctor has with the patient depends on how the doctor communicates with the patient", it can be inferred that doctor-patient communication has a direct effect on doctor-patient relationship, which is also supported by Bayne (2011) assertion that communication behaviors impacts doctor-patient relationship and patients' satisfaction. Friendly conversations, listening, empathetic care and concern, and taking interest in not only the patient but also their family on a whole, were integral attributes of doctor-patient relationship as articulated by the participants. The current findings indicated that a good doctor-patient relationship is a desired and highly valued need for Black Caribbean women diabetic patients, which in turn helps with openness in conversation or ‘fluid dialogue’ as Participant 9 described it; trust; satisfaction; and compliance. Participants admission to openness during doctor-patient communication was as a result of good doctor-patient relationship which Chipidza, Wallwork, & Stern (2015) also espouse, through the statement that patients sometimes divulge secrets, worries, and fears to doctors that they may not have necessarily shared with anyone else, while drawing reference to the importance of doctor-patient relationship.

Participants’ stories showed that seeing the doctor as a friend and vice versa was influential in building good doctor-patient relationship. A good doctor-patient encounter begins with a friendly greeting, as deduced from participants consistent comments. Emphasis on the satisfaction from being greeted by the doctor and asking how the patient was doing prevailed as an identified means of building relationship, based on participants disclosures. The results of this study also found that the use of icebreaker such as jokes, and in particular, listening to and taking interest in patients and their stories were highly favored, as this served to initiate a cordial and satisfactory doctor-patient communication.

Such doctor-patient behaviors contribute to doctor-patient relationship building, and set the stage for a more receptive and cordial exchange in communication. This coincides with Berkeley and Murphy (2018) declaration that evidence suggest that this act of careful attentive listening to stories or patients’ accounts on the part of doctors is effective, and greatly appreciated by patients, as it makes them feel comfortable; and it is therefore encouraged that doctors listen attentively to patients’ stories about their lives and illnesses, in order to understand and get a true appreciation of their social condition and state of health, which is vital for effective administering of proper care. Goddu, Raffel, and Peek (2015) gives further justification why this should be a standard practice when providing health care particularly to minorities, as it's an effective strategy, and promotes health behavior change among racial/ethnic groups with a strong tradition of storytelling, and a history of medical mistrust, such as in Black Caribbean diabetic women patients.

The strong sense of care for not only the patient but also their immediate family was identified as a doctor-patient relationship building tool for patients. From the study findings, showing interest and concern for family members was identified as a valued cultural aspect of Black Caribbean diabetic women patients as expressed by a number of the participants; and doctors must be aware of this when communicating with these patients. When doctors inquired about family members, patients saw the doctors as a friend and sometimes even as family, which not only facilitated a good doctor-patient relationship and a more satisfactory encounter for the patients, but most importantly, the manifestation of trust between doctor and patient came into play. Participants' perceptions of doctor-patient relationship building that evolved from the results of this study, align with Chipidza, Wallwork, and Stern (2015) which identified vulnerability and trust as elements of the doctor-patient relationship.

Unmet needs and expectations. There are certain things that Black Caribbean diabetic women patients expect of their doctor-patient communication which must be made mention of because that is the only way remedial strategies can be identified to bring about change. The results from participants' responses established taking time to greet, good listening skills, adequate consultation time, response to questions and concerns, shared decision-making, sensitivity for example in voice tone, empathy, among others, as pertinent communication needs that are expected of doctors.

The current study recognized the display of empathy and sympathy as integral elements of doctor-patient communication that influenced Black Caribbean diabetic women patients' willingness to adhere to doctor's follow-up visits or appointments, treatment plan, and life style modification such as diet, due to the negative emotional effect of its lack thereof; and this consequently had an effect on patients' outcome and satisfaction. The results also parallel Derksen et al (2017) study that identified empathy as a core value and one of the main elements of doctor-patient communication which shows care, and also contributes to feelings of trust, support, development of new coping strategies, and overall patient satisfaction.

The study discovered that when the patients' needs and expectations, such as listening, sensitive voice tone, and empathy were left unmet, this resulted in patients being left with unanswered questions, dissatisfaction, and poor health outcome. Patients either refused to ask their questions because of the unpleasant state of the conversation or doctors did not take the time to respond or address the patients' questions or concerns. These results support Lipp et al (2016) that calls for doctor-patient communication skills to be centered on empathy and the demonstration of care because of its potential to yield benefits in terms of satisfaction, compliance, and outcome. The study also agrees with assertions reported by Chipidza, Wallwork, & Stern (2015) that poor outcome evolves from impaired doctor-relationship issues which often stems from unmet patients' needs;

and The Joint Commission (2010) statement that when patients' cultural and communication needs go unmet, this put patients at risk for negative consequences.

Referring to the study of Jalil et al (2017) that described a doctor's inappropriate behavior as a mental torture that distresses diabetic patients, this current study concurs. Besides the challenges of being a diabetic, Black Caribbean diabetic women patients reported psychological and emotional issues evolving from doctor-patient communication while seeking medical care; however, when empathy was involved, improved blood glucose level was reported. Lown (2016), and Riess and Kraft-Todd (2014) studies also deduced that empathy is associated with improved diabetic control and A1C levels respectively.

Based on participants responses, it's worth noting that one's culture is an influential factor in participants' doctor-patient communication perception, which corresponds to Rocque and Leanza (2015) claim that communication is naturally cultural because meaning is often derived from one's culture. Likewise, Paternotte et al (2017) also found that doctor-patient communication and patients' perceptions are influenced by the patient's cultural views. Participant 9 actually verbalized her views on certain doctors' communication behavior by stating that in her opinion it is cultural; she has been to American doctors and noticed that they do not see people as individuals but instead they "see people as just herding, like cattles" and "they do not spend quality time with their patients". This agrees with Rose and Harris (2015) declaration that different ethnic diabetes patients face major challenges in diabetes self-management from cultural expectations to inequalities in health care.

The results of this study therefore prove Lorie et al (2017) claim that doctors lack preparation in providing cross-cultural competent care to minorities which leads to disparities in treatment and health outcomes. Participants in the study consistently reported unpleasant voice tones from doctors, lack of good listening skills, dominating conversations and allowing limited patient input resulting in unanswered questions, and lack of empathy during doctor-patient communications, which resulted in negative and dissatisfied interactions. For this reason, this study like Lori et al (2017), encourages cultural awareness to avoid cross-cultural misunderstanding which often stems from cultural differences, and the use of culturally competent empathetic care in an attempt to improve Black Caribbean diabetic women patients' satisfaction, adherence, and health outcome.

Patients' reactions. It is the disclosing of Black Caribbean diabetic women patients' negative experiences which speaks to their health management decisions, and consequent effects on their general health. Participants' responses in this study revealed that patients often react or take action dependent on, or in response to, their doctor-patient communication experiences. Although prior studies allege that minorities are noncompliant, the present study dispels the notion that Black patients are just generally non-compliant without dissecting the underlying reasons why this appears to be the case. It was discovered that patients' perceptions and health outcome often correlate with whether or not doctor-patient communication is satisfactory. When patients were dissatisfied with their doctor-patient communication experience, there was a general consensus among patients' opinions that doctors were profit driven, and were only concerned about making money and not the patient.

Participants rated their doctors' competence based on the general doctor-patient communication skills or behaviors displayed, which reiterates Young et al (2016) view point that communication is perceived as acceptable when doctors demonstrate compassion and encouragement which in turn motivates action. This finding may also be explained by Ha & Longnecker (2010) proclamation that the main independent predictors of patient satisfaction have been their perception of communication and a positive doctor approach. When a doctor's communication behavior and doctor-patient relationship were to the patient's expectation and satisfaction, the doctor was often perceived as being competent; and a doctor who listened was often qualified or described as being a 'great doctor'. This finding in fact correlates with Jagosh et al (2011) that identified the ability to listen as the primary determining feature of a good doctor; and Kraft-Todd et al (2017) assertion that doctors' communication behaviors such as empathetic behavior, increases patients' perception of doctors' empathy and competence. Participants' overall accounts conveyed a positive correlation between doctor-patient relationship and competence; for example, with statements such as "I have an excellent relationship with my doctor, she's very good" which was expressed by participant 12.

From the numerous narratives of negative experiences that were relayed, the decision to change doctors as a response to unsatisfied doctor-patient communication, prevailed; which is in line with Chipidza, Wallwork, and Stern (2015) statement that a doctor's style of communication with their patient dictates how often, and if at all, the patient will return to that doctor. The findings of this study showed that participants' decision to frequently change doctors was based on their desire to find the appropriate doctor who was able to meet or satisfy their desired needs and expectations, and whom they could relate to.

Other ways that participants reacted to unsatisfied doctor-patient communication, that was discovered from their responses, included anxiety, non-compliance, and avoiding follow-up doctors' appointments, which jointly resulted in reported negative health outcome. The aforementioned findings match Derksen et al (2017) disclosure that poor communication from doctors comes with ramifications such as stress and other negative feelings that can avoid patients from seeking medical care; and Rocque and Leanza (2015) statement that unsatisfactory or negative communication experience lead to relational problems, dissatisfaction which may hinder the desire to seek continued care by delaying or skipping follow-up appointments to avoid the negative experiences, and non-adherence whereby patients are unmotivated to comply to treatment plan. These results are in line with, and can also be confirmed by, Polonsky and Henry (2016) study that have shown approximately 50% of diabetic patients fail to achieve adequate glycemic control mainly due to non-adherence, resulting from poor doctor-patient communication and negative patient perceptions.

Implications of Findings

Black Caribbean diabetic women patients' stories on doctor-patient communication experiences are important in aiding a better understanding of the social injustice and short comes in healthcare that exist, and the much-needed development of health improvement initiatives; thus, it can be used to effect change. It serves as a means of informing healthcare providers, Government policy makers, public health officials, and researchers, to get a sense of what Black Caribbean women diabetic patients are experiencing, their perception of these experiences, and the effects of these experiences. Diabetes is an established major predictor of poor health outcome which adds to the health disparity that Blacks are already faced with. If health care providers and policy makers do not understand what is going on in these Populations then the present health disparities in health care will persist. Only when efforts are made to understand the experiences and thought processes of Black Caribbean diabetic women patients in a way that aligns with their needs and expectations that positive health results will be attained.

Limitations of the Study

This study has several limitations. The results of this study are a representation of only Black Caribbean women diabetic patients' experiences and not necessarily all Black diabetic patients' experiences with doctor-patient communication. This study did not account for Black women who were not of Caribbean origin since all participants coincidentally were of Caribbean origin. Furthermore, the results are based on the experiences of a small number of participants, which encompassed only Black Caribbean diabetic women patients and not doctors; and the sample was limited to only one Primary Care Health Center. Black diabetic women from different black origin subgroups would have offered more generalizability and comparability. Also, for the purpose of maintaining homogeneity, male participants were excluded. A sample of only Black Caribbean diabetic women patients is not a true representation of the Black diabetic population. The use of purposive sampling also posed possible researcher biases.

Suggested Future Research

Additional research should be carried out on the male gender for insight into Black diabetic male patients' perception of their doctor-patient communication experiences. Future research should include Blacks from different nationalities. The study's revelation of existing differences within black origin subgroups warrants future studies within the different Black origin subgroups for comparison. Although there has been extensive research on Blacks on a whole, they are a diverse group with notable differences, and there are not many studies among these Black subgroups. Additionally, future study could recruit participants from different primary healthcare centers for comparison, instead of a single site.

Participants negative perceptions of Doctor's communication can be changed with some effort on the part of doctors. However, in order for that to be achieved, an understanding of patients' psychological framework must be acquired through more research. Therefore, further study is needed to determine what other factors might influence patients' perception of their doctors from their doctor-patient communication experiences beyond what was already mentioned. There is also need for further research focused on doctor's lived experiences in terms of doctor-patient communication to get insight into the different ways doctors and patient make meaning of their doctor-patient communication experiences. Not ignoring the benefits of in person interview, the way of life is changing and continues to evolve. Hence these future studies should utilize virtual interviews to eliminate or alleviate the challenges that in-person interviews pose, such as the willingness of volunteers to participate due to time constraints and the inconvenience of commuting to the research site, which often hinders the efficiency and efficacy of such research. Blacks have a higher chance of having diabetes and the presence of this pre-existing condition makes them even more susceptible to disparity in health outcome. With the ever-increasing disproportionality in health consequences that Blacks face, such as what’s being witnessed with chronic diseases such as diabetes and presently with COVID-19, and furthermore, the disparity in Black women representation, this warrant continued and further studies in Black women and the general Black population on a whole.

References

Adegbembo, A. O., Tomar, S. L., & Logan, H. L. (2006). Perception of racism explains the difference between Blacks' and Whites' level of healthcare trust. *Ethnicity & Disease*, *16*(4), 792-798.

Aruguete, M. S., & Roberts, C. A. (2002). Participants' ratings of male physicians who vary in race and communication style. *Psychological Reports, 91*(3), 793-806. doi:http://dx.doi.org/10.2466/PR0.91.7.793-806

Baumann, M., Tchicaya, A., Lorentz, N., & Bihan, E. L. (2016). Impact of patients' communication with the medical practitioners, on their adherence declared to preventive behaviours, five years after a coronary angiography, in luxembourg.*PLoS One, 11*(6), 1-10. Retrieved from http://doi.org/10.1371/journal.pone.0157321

Bayne, H. B. (2011). Training medical students in empathic communication. *Journal for Specialists in Group Work, 36*(4), 316-329.

Beach, M. C., Branyon, E., & Saha, S. (2017). Diverse patient perspectives on respect in healthcare: A qualitative study. *Patient Education and Counseling, 100*, 2076-2080.

Beach, M. C., Saha, S. Branyon, E., Ehanire, I. Mathews, Z., & Cooper, L. A. (2016). Communicating respect for patients as persons: A qualitative study, International *Journal of Person Centered Medicine, 6*(1), 32-41.

Beckles, G. L., & Chou, C. (2013). Diabetes – United States, 2006 and 2010. Morbidity and Mortality Weekly Report (MMWR). Division of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC. *62*(03), 99-104.

Berkeley, F., & Murphy, J. W. (2018). Reconsidering the role of language in medicine. *Philosophy, Ethics and Humanities in Medicine, 13*(5), 1-7. https://doi.org/10.1186/s13010-018-0058-z

Black, H. K. (2012). The Influence of african american elders' belief systems on health interactions. Journal of Religion & Spirituality in Social Work: Social Thought, 31(3), 226-243.

Blair, I. V., Steiner, J. F., Fairclough, D. L., Hanratty, R., Price, D. W., Hirsh, H. K., … Havranek, E. P. (2013). Clinicians' Implicit Ethnic/Racial Bias and Perceptions of Care Among Black and Latino Patients. *Annals of Family Medicine*, *11*(1), 43–52. http://doi.org/10.1370/afm.1442

Burgess, D., van Ryn, M., Dovidio, J., & Saha, S. (2007). Reducing Racial Bias Among Health Care Providers: Lessons from Social-Cognitive Psychology. *Journal of General Internal Medicine*, *22*(6), 882–887. http://doi.org/10.1007/s11606-007-0160-1

Center for Disease Control and Prevention (CDC). Black or African American Populations. Retrieved on January 23, 2014, from http://www.cdc.gov/minorityhealth/populations/REMP/black.html

Center for Disease Control and Prevention. (2017). Health Disparities. Retrieved from https://www.cdc.gov/aging/disparities/index.htm

Chang, E., Simon, M., & Dong, X. (2012). Integrating cultural humility into health care professional education and training. *Advances in Health Sciences Education,* *17*(2), 269-278.

Chipidza, F. E., Wallwork, R. S., & Stern, T. A. (2015). Impact of the doctor-patient relationship. *The Primary Care Companion for CNS Disorders*, *17(5)*. DOI: 10.4088/PCC.15f01840

Communication. (n.d.). In Merriam-Webster's online dictionary. Retrieved from https://www.merriam-webster.com/dictionary/communication

Cook, C. T., Kosoko-Lasaki, O., & O'Brien, R. (2005). Satisfaction with and perceived cultural competency of healthcare providers: The minority experience. *Journal of the National Medical Association, 97*(8), 1078-1087.

Cooper, L. A., Roter, D. L., Carson, K. A., Beach, M., Sabin, J. A., Greenwald, A. G., & Inui, T. S. (2012). The Associations of Clinicians' Implicit Attitudes About Race With Medical Visit Communication and Patient Ratings of Interpersonal Care. *American Journal Of Public Health*, *102*(5), 979-987. doi:10.2105/AJPH.2011.300558

Creswell, J. W. (2013). *Qualitative inquiry & research design: Choosing among the five approaches*. Thousand Oaks, CA: Sage Publications, Inc.

Culture. Cambridge Dictionary. Retrieved on September 10, 2018, from https://dictionary.cambridge.org/us/dictionary/english/culture

Deledda, G., Moretti, F., Rimondini, M., & Zimmermann, C. (2013). How patients want their doctor to communicate. A literature review on primary care patients' perspective. *Patient Education and Counseling, 90*(3), 297-306.

Derksen, F., Hartman, T. C., van Dijk, A., Plouvier, A., Bensing, J., & Lagro-Janssen, A. (2017). Consequences of the presence and absence of empathy during consultations in primary care: A focus group study with patients. *Patient Education and Counseling, 100*, 987-993.

Diabetes. Medline Plus. Retrieved on October 18, 2017, from https://medlineplus.gov/diabetes.html

Elliott, A. M., Alexander, S. C., Mescher, C. A., Mohan, D., & Barnato, A. E. (2016). Differences in physicians' verbal and nonverbal communication with black and white patients at the end of life. *Journal of Pain and Symptom Management, 51*(1), 1-8.

Empathy. Cambridge Dictionary. Retrieved on September 3, 2018, from https://dictionary.cambridge.org/us/dictionary/english/empathy

Eun-Jung Shim, Park, J. E., Yi, M., Jung, D., Kwang-Min, L., & Bong-Jin Hahm. (2016). Tailoring communications to the evolving needs of patients throughout the cancer care trajectory: A qualitative exploration with breast cancer patients. *BMC Women's Health, 16*(65), 1-8. doi:10.1186/s12905-016-0347-x

Flack, J. M., Sica, D. A., Bakris, G., Brown, A. L., Ferdinand, K. C., Grimm Jr, R. H., Hall, W. D., Jones, W. E., Kountz, D. S., Lea, J. P., Nasser, S., Nesbitt, S. D., Saunders, E., Scisney-Matlock, M., & Jamerson, K. A. (2010). Management of High Blood Pressure in Blacks: An Update of the International Society on Hypertension in Blacks Consensus Statement. *Hypertension 56*(5), 780-800. doi: 10.1161/HYPERTENSIONAHA.110.152892

Gentry, S., & Badrinath, P. (2017). Defining Health in the Era of Value-based Care: Lessons from England of Relevance to Other Health Systems. *Cureus, 9*(3), e1079. doi:10.7759/cureus.1079

Goddu, A. P., Raffel, K. E., & Peek, M. E. (2015). A story of change: The influence of narrative on african-americans with diabetes. *Patient Education and Counseling, 98*(8), 1017-1024.

Gorawara,-Bhat, R., Hafskjold, L., Gulbrandsen, P., & Eide, H. (2017). Exploring physicians' verbal and nonverbal responses to cues/concerns: Learning from incongruent communication. *Patient Education and Counseling, 100*(11), 1979-1989.

Gordon, H. S., Street, R. L., Jr., Sharf, B. F., & Souchek, J. (2006). Racial differences in doctors' information-giving and patients' participation. *Cancer*, *107*(6), 1313–1320.

Greenfield, S., Kaplan, S. H., Ware Jr., J. E., Yano, E. M., & Frank, H. J. (1988). Patients' participation in medical care: Effects on blood sugar control and quality of life in diabetes. *Journal of General Internal Medicine, 3*(5), 448-457.

Ha, J. F., & Longnecker, N. (2010). Doctor-Patient communication: A review. *The Ochsner Journal*, *10*(1), 38–43.

Hammond, W. P. (2010). Psychosocial correlates of medical mistrust among African American men. *American Journal of Community Psychology*, *45*, 87-106.

Healthcare Disparity. U.S. National Library of Medicine. Retrieved October 18, 2017, from https://www.nlm.nih.gov/hsrinfo/disparities.html

Ioan, B. G., Ciuhodaru, T., Velnic, A. A., Craucuic, D., Hanganu, B., & Manoilescu, I. S. (2017). The role of doctor-patient communication in preventing malpractice complaints. *International Journal of Communication Research, 7*(4), 303-307.

Jagosh, J., Boudreau, J. D., Steinert, Y., Macdonald, M. E., & Ingram L. (2011). The importance of physician listening from the patients' perspective: Enhancing diagnosis, healing, and the doctor-patient relationship. *Patient Education and Counseling, 85*(3), 369-374.

Jalil, A., Zakar, R., Muhammad, Z. Z., & Fischer, F. (2017). Patient satisfaction with doctor-patient interactions: A mixed methods study among diabetes mellitus patients in pakistan. *BMC Health Services Research, 17*(155), 1-13. http://doi.org/10.1186/s12913-017-2094-6

Kaplan, S. H., Greenfield, S., & Ware, Jr., J. E. (1989). Assessing the effects of physician-patient interactions on the outcomes of chronic disease. *Medical Care, 27*(3), S110-S127.

Kee, J. W. Y., Khoo, H. S., Lim, I., & Koh, M. Y. H. (2018). Communication skills in patient-doctor interactions: Learning from patient complaints. *Health Professions Education, 4*(2), 97-106.

Khan, T. M., Hassali, M. A., & Al-Haddad, M. S. N. (2011). Patient-Physician communication barrier: A pilot study evaluating patient experiences. *Journal of Young Pharmacists*, *3*(3), 250-255. doi: 10.4103/0975-1483.83778

Kraft-Todd, G. T., Reinero, D. A., Kelley, J. M., Heberlein, A. S., Baer, L., Riess, H. (2017). Empathic nonverbal behavior increases ratings of both warmth and competence in a medical context. *PLoS One, 12*(5), e0177758.

Leung, V., & Cheng, K. (2016). Female and male patients' perception of primary care doctors' communication skills in Hong Kong. *Patient Experience Journal, 3(1),* 7-14.

Lincoln, Y., & Guba, E. G. (1985). Naturalistic inquiry. Newbury Park, CA: Sage.

Lipp, M., Riolo, C., & Riolo, M., & Farkas, J. (2016). Showing you care: An empathetic approach to doctor-patient communication. *Seminars in Orthodontics, 22(2)*. Doi:10.1053/j.sodo.2016.04.002.

Lopez, K. A., & Willis, D. G. (2004). Descriptive Versus Interpretive Phenomenology: Their Contributions to Nursing Knowledge. *Qualitative Health Research*, *14*(5), 726–735. doi:10.1177/1049732304263638

Lorie, A., Reinero, D. A., Phillips, M., Zhang, L., & Riess, H. (2017). Culture and nonverbal expressions of empathy in clinical settings: A systematic review. *Patient Education and Counseling, 100*(3), 411-424.

Lown, B. A. (2016). A social neuroscience-informed model for teaching and practising compassion in health care. *Medical Education, 50*(3), 332-342.

Lundgren, S. (2011). Learning opportunities for nurses working within home care. *Journal of Workplace Learning, 23*(1), 6-19. doi:http://dx.doi.org/10.1108/13665621111097227

Martin, K. D., Roter, D. L., Beach, M. C., Carson, K. A., & Cooper, L. A. (2013). Physician Communication Behaviors and Trust among Black and White Patients with Hypertension. *Medical Care*, *51*(2), 151–157.

Mazzi, M. A., Rimondini, M., Boerma, W. G., Zimmermann, C., & Bensing, J. M. (2016). How patients would like to improve medical consultations: Insights from a multicentre European study. *Patient Education and Counseling, 99*(1), 51-60.

Mehra, P. (2016). Outpatient clinic waiting time, provider communication styles and satisfaction with healthcare in India. *International Journal of Health Care Quality Assurance*, 29(7), 759-777. DOI 10.1108/IJHCQA-02-2016-0017

Mercer, S. W., Higgins, M., Bikker, A. M., Fitzpatrick, B., McConnachie, A., Lloyd S. M., et al. (2016). General practitioners' empathy and health outcomes: A prospective observational study of consultations in areas of high and low deprivation. *Annals of Family Medicine, 14*(2), 117-124.

Namazi, H., Aramesh, K., & Larijani, B. (2016). The doctor-patient relationship: Toward a conceptual re-examination. *Journal of Medical Ethics and History of Medicine, 9*(10), 1-6.

Napier, A. D., Ancarno, C., Butler, B., et al. (2014). Culture and health. *The Lancet, 384*(9954), 1607-1639.

National Healthcare Disparity Report (NHDR). (2012). U.S. Department of Health and Human Services. *Agency for Healthcare Research and Quality*. Retrieved on January 23, 2014, from https://archive.ahrq.gov/research/findings/nhqrdr/nhdr12/2012nhdr.pdf

Non-verbal Communication. BusinessDictionary.com. Retrieved October 18, 2017 from http://www.businessdictionary.com/definition/non-verbal-communication.html

Paddison, C. A. M., Saunders, C. L., Abel, G. A., Payne, R. A., Adler, A. I., Graffy, J. P., & Roland, M. O. (2015). How do people with diabetes describe their experiences in primary care? evidence from 85,760 patients with self-reported diabetes from the english general practice patient survey. *Diabetes Care, 38*(3), 469-475.

Pascoe, E., & Smart Richman, L. (2009). Perceived discrimination and health: A meta-analytic review. *Psychological Bulletin*, *135*(4)*,* 531-554.

Paternotte, E., Scheele, F., Seeleman, C. M., Bank, L., Scherpbier, A. J. J. A., & van Dulmen, S. (2016). Intercultural doctor-patient communication in daily outpatient care: relevant communication skills. *Perspectives on Medical Education*, *5*(5), 268–275. http://doi.org/10.1007/s40037-016-0288-y

Paternotte, E., van Dulmen, S., Bank, L., Seeleman, C., Scherpbier, A., & Scheele, F. (2017). Intercultural communication through the eyes of patients: Experiences and preferences. *International Journal of Medical Education, 8*, 170-175. doi:http://doi.org/10.5116/ijme.591b.19f9

Peimani, M., Nasli-Esfahani, E., & Sadeghi, R. (2018). Patients' perceptions of patient-provider communication and diabetes care: A systematic review of quantitative and qualitative studies. *Chronic Illness, 0*(0), 1-20.

Polonsky, W. H., & Henry, R. R. (2016). Poor medication adherence in type 2 diabetes: recognizing the scope of the problem and its key contributors. *Patient Preference and Adherence*, *10*(1), 1299-1307.

Population Reference Bureau (PRB). (2008). Race, Ethnicity, and Where You Live Matters: Recent Findings on Health & Mortality of U.S. Elderly. Retrieved on September 13, 2018, from https://www.prb.org/racialdisparities/

Problems. (n.d.). In Merriam-Webster’s online dictionary. Retrieved from https://www.merriam-webster.com/dictionary/problems

Ranjan, P., Kumari, A., & Chakrawarty, A. (2015). How can doctors improve their communication skills? *Journal of Clinical and Diagnostic Research, 9*(3), JE01-JE04.

Ratanawongsa, N., Karter, A. J., Parker, M. M., Lyles, C. R., Heisler, M., Moffet, H. H., & et al. (2013). Communication and medication refill adherence: The diabetes study of Northern California. *JAMA Internal Medicine, 173*(3), 210-218.

Rawls, J. (1971). *A theory of justice*. Cambridge, MA: The Bedknap Press of Harvard University.

Riess, H., & Kraft-Todd, G. (2014). EMPATHY: A tool to enhance nonverbal communication between clinicians and their patients. *Academic Medicine, 89*(8), 1108-1112.

Ritholz, M. D., Beverly, E. A., Brooks, K. M., Abrahamson, M. J., & Weinger, K. (2014). Barriers and facilitators to self-care communication during medical appointments in the United States for adults with type 2 diabetes. *Chronic Illness, 10*(4), 303-313.

Rocque, R., & Leanza, Y. (2015). A systematic review of patients' experiences in communicating with primary care physicians: Intercultural encounters and a balance between vulnerability and integrity. *PLoS One, 10*(10), 1-31. doi:10.1371/journal.pone.0139577

Rose, V. K., & Harris, M. F. (2015). Experiences of self-management support from GPs among Australian ethnically diverse diabetes patients: A qualitative study. *Psychology, Health & Medicine, 20*(1), 114-120.

Ruben, M. A., Blanch-Hartigan, D., & Hall, J. A. (2016). Nonverbal communication as a pain reliever: The impact of physician supportive nonverbal behavior on experimentally induced pain. *Health Communication, 32*(8), 970-976.

Sadati, A. K., Iman, M. T., Lankarani, K. B., & Ebrahimzadeh, N. (2016). From good to great physician: A critical ethnography based on patients' views. *Journal of Medical Ethics and History of Medicine, 9*(18).

Sadati, A. K., Lankarani, K. B., Hemmati, S. (2016). Patients' description of unexpected interactions: A critical ethnography of the quality of doctor-patient interactions in One Educational Hospital in Shiraz, Iran. Shiraz E-*Medical Journal, 17*(7-8), e59931.

Saha, S., Komaromy, M., Koepsell, T. D., & Bindman, A. B. (1999). Patient-physician racial concordance and the perceived quality and use of health care. *Archives of Internal Medicine, 159*(9), 997-1004.

Sims, C. (2010). Ethnic notions and healthy paranoias: understanding of the context of experience and interpretations of healthcare encounters among older Black women. *Ethnicity & Health*, *15*(5), 495-514. doi:10.1080/13557858.2010.491541

Sinclair, S., Beamer, K., Hack, T. F., McClement, S., Bouchal, S. R., Chochinov, H. M., et al. (2016). Sympathy, empathy, and compassion: A grounded theory study of palliative care patients' understandings, experiences, and preferences. *Palliative Medicine, 31*(5), 437-447.

Smith, J. A., Flowers, P., & Larkin, M. (2009). Interpretative phenomenological analysis: Theory, method, and research.

Stepanikova, I., Zhang, Q., Wieland, D., Eleazer, G. P., & Stewart, T. (2012). Non-verbal communication between primary care physicians and older patients: How does race matter? *Journal of General Internal Medicine, 27*(5), 576-81. doi:http://dx.doi.org/10.1007/s11606-011-1934-z

Street, R. L., Jr, O'Malley, K. J., Cooper, L. A., & Haidet, P. (2008). Understanding concordance in patient-physician relationships: Personal and ethnic dimensions of shared identity. *Annals of Family Medicine, 6*(3), 198-205.

Tabrizi, J. S. (2009). Quality of delivered care for people with type 2 diabetes: A new patient-centred model. *Journal Of Research In Health Sciences, 9*(2), 1-9.

Teal, C. R., Gill, A. C., Green, A. R., & Crandall, S. (2012). Helping medical learners recognise and manage unconscious bias toward certain patient groups. *Medical Education, 46*(1), 80–8.

The Joint Commission. (2010). The Joint Commission: *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*. Oakbrook Terrace, IL. Retrieved from http://www.jointcommission.org/Advancing_Effective_Communication/

Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. Journal of Advanced Nursing, 48, 388–396. doi:10.1111/j.1365-2648.2004.03207.x

Townes, D. L., Cunningham, N. J., & Chavez-Korell, S. (2009). Re-examining the relationships between racial identity, cultural mistrust, help-seeking attitudes, and preference for a Black counselor. *Journal of Counseling Psychology*, *56*(2), 330-336.

U.S. Census Bureau. (2011). The black population: 2010. Retrieved from https://www.census.gov/prod/cen2010/briefs/c2010br-06.pdf

Van Houtven, C. H., Voils, C. I., Oddone, E. Z., Weinfurt, K. P., Friedman, J. Y., Schulman, K. A., & Bosworth, H. B. (2005). Perceived discrimination and reported delay of pharmacy prescriptions and medical tests. *Journal of General Internal Medicine*, *20*(7), 578-583.

Verbal Communication. BusinessDictionary.com. Retrieved October 18, 2017, from http://www.businessdictionary.com/definition/verbal-communication.html

Waitzkin, H. (1984). Doctor-patient communication: clinical implications of social scientific research. *JAMA, 252*(17), 2441–2446. doi:10.1001/jama.1984.03350170043017

White, R. O., Chakkalakal, R. J., Presley, C. A., Bian, A., Schildcrout, J. S., Wallston, K. A., . . . Rothman, R. (2016). Perceptions of provider communication among vulnerable patients with diabetes: Influences of medical mistrust and health literacy. *Journal of Health Communication, 21*, 127-134.

White, R. O., Eden, S., Wallston, K. A., Kripalani, S., Barto, S., Shintani, A., & Rothman, R. L. (2015). Health communication, self-care, and treatment satisfaction among low-income diabetes patients in a public health setting. *Patient Education and Counseling, 98*(2), 144–149.

Whitney, E., Kindred, E., Pratt, A., O'Neal, Y., Harrison, R. C. P., & Peek, M. E. (2017). Culturally tailoring a patient empowerment and diabetes education curriculum for the african american church. *The Diabetes Educator, 43*(5), 441-448.

Williams, D. R., Wyatt R. (2015). Racial bias in health care and health: challenges and opportunities. *JAMA, 314*(6), 555-556. doi:10.1001/jama.2015.9260.

Wong, M., Gudzune, K. A., & Bleich, S. N. (2015). Provider communication quality: influence of patients' weight and race. *Patient Education and Counseling*, *98*(4), 492–498.

Young, S. A., Azam, L. S., Meurer, J. R., Hill, R. S., & Cui, C. (2016). The influence of patient and provider communication on diabetes care delivery. *The Journal of Ambulatory Care Management, 39*(3), 272-278.

Appendix A

Questionnaire/Interview Schedule

Questionnaire/Schedule

Assigned #: ____________________ Interview Date: _________________ Time: _____________

1. Can you describe what a typical conversation with your doctor is like? *Possible prompts*: who initiates? What happens? How do you feel about it? What do you mean by ___? Do you feel comfortable asking questions?

2. Can you tell me about your relationship with your doctor?

3. How do you feel ahead of a doctor-patient meeting? *Possible prompts*: why so?

4. Can you describe how your doctor communicates with you? *Possible prompts*: verbally? Non verbally?

5. Can you tell me what you think of your doctor's communication style? *Possible prompt*: why do you think so?

6. How do you think your doctor sees you?

7. Have your doctor's communication style changed the way you think or feel about yourself? *Possible prompts*: in what ways? Can you tell me a bit more about that?

8. How do you think your doctor-patient communication style affects your doctor-patient relationship? *Possible prompts*: in what ways?

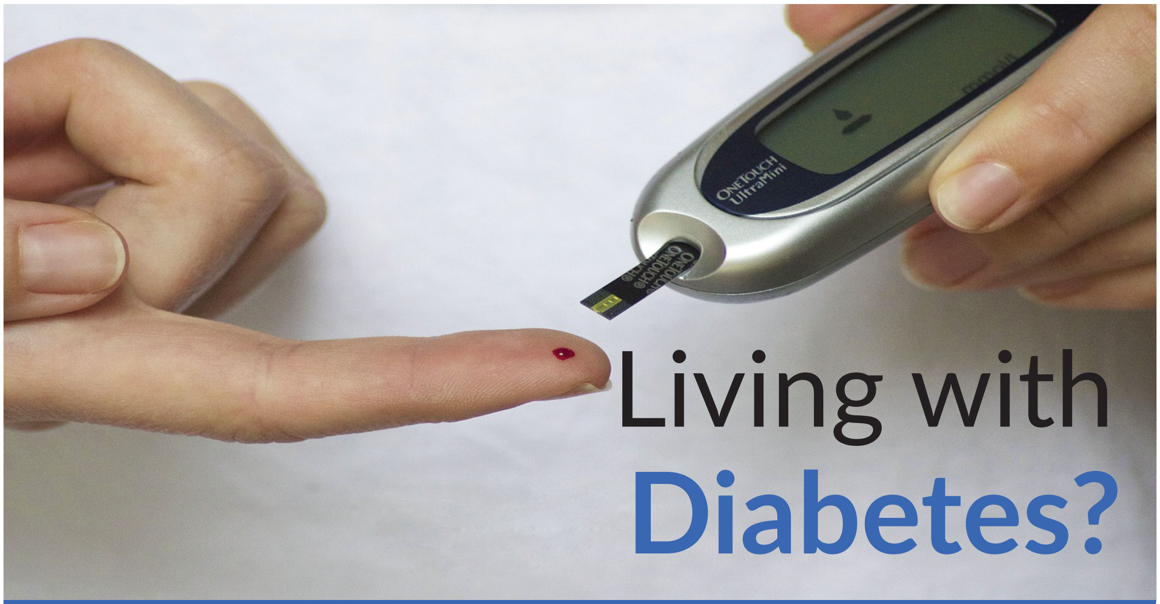
9. How would you compare your doctor's communication style to other doctors you have seen? *Possible prompts*: what do you mean by ___? Can you tell me a bit more about that?

10. Do you think your doctor communicates differently with other patients, and why (be it positively or negatively)?

Appendix B

Recruitment Flyer

Recruitment Flyer



Enroll in a Research Study

Recruiting volunteers who have been diagnosed with diabetes for a research study examining doctor-patient communication experiences.

To qualify, participants must:

- Be 25 - 80 years of age
- Be a black woman
- Have been diagnosed with Diabetes
- Be fluent in English

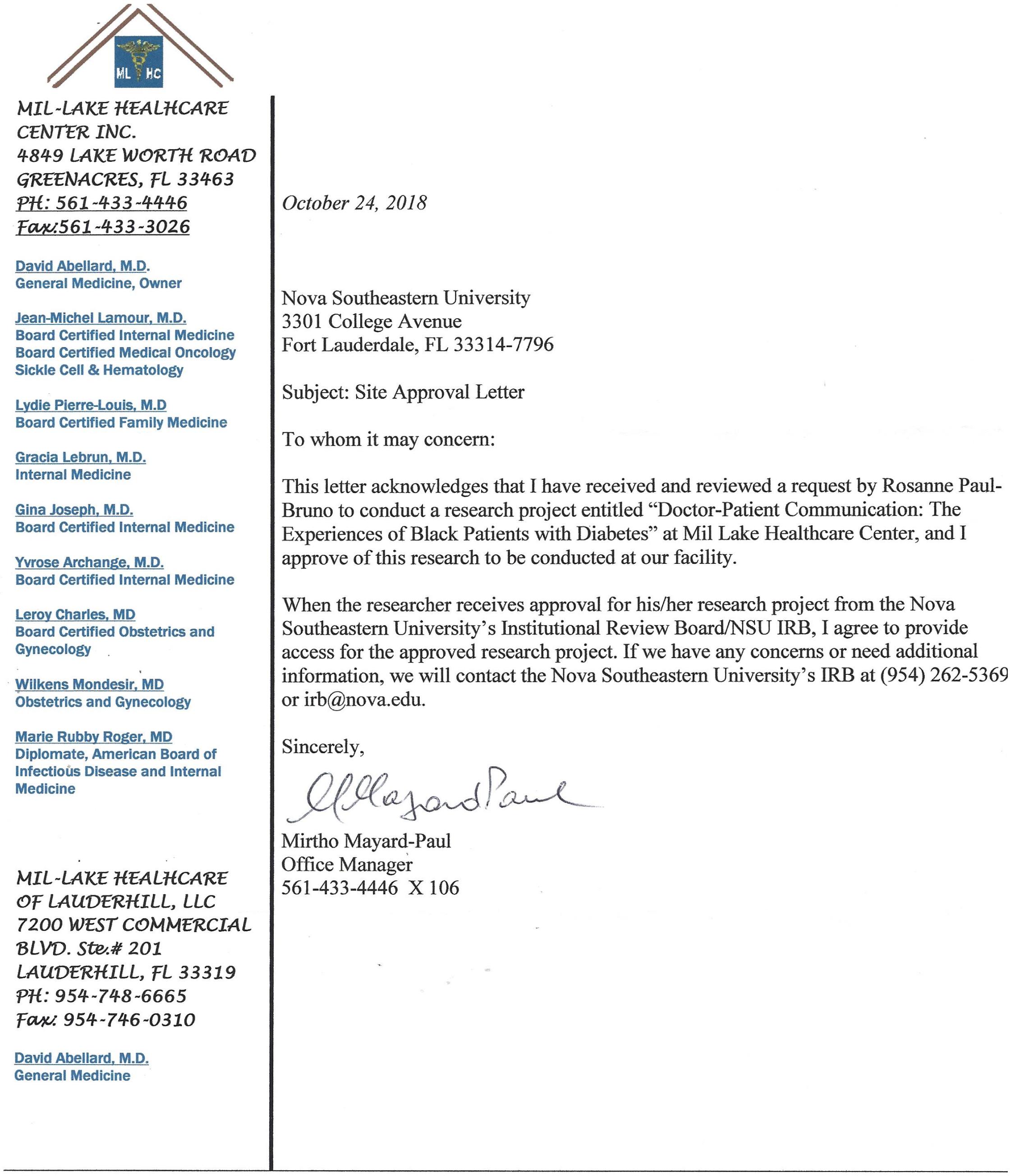
Talk to your doctor to learn how you can participate or for more information call:
[redacted]
Rosanne Paul-Bruno
Nova Southeastern University
Rp740@mynsu.nova.edu

Location:
Mil-lake Healthcare Center
4849 Lake Worth Road
Greenacres, FL 33463

Appendix C

Site Approval Letter

Site Approval Letter



MIL-LAKE HEALHCARE
CENTER INC.
4849 LAKE WORTH ROAD
GREENACRES, FL 33463
PH: 561-433-4446
Fax:561-433-3026

David Abellard, M.D.
General Medicine, Owner

Jean-Michel Lamour, M.D.
Board Certified Internal Medicine
Board Certified Medical Oncology
Sickle Cell & Hematology

Lydie Pierre-Louis, M.D
Board Certified Family Medicine

Gracia Lebrun, M.D.
Internal Medicine

Gina Joseph, M.D.
Board Certified Internal Medicine

Yvrose Archange, M.D.
Board Certified Internal Medicine

Leroy Charles, MD
Board Certified Obstetrics and Gynecology

Wilkens Mondesir, MD
Obstetrics and Gynecology

Marie Rubby Roger, MD
Diplomate, American Board of Infectious Disease and Internal Medicine

MIL-LAKE HEALHCARE
OF LAUDERHILL, LLC
7200 WEST COMMERCIAL
BLVD. Ste.# 201
LAUDERHILL, FL 33319
PH: 954-748-6665
Fax: 954-746-0310

David Abellard, M.D.
General Medicine

October 24, 2018

Nova Southeastern University
3301 College Avenue
Fort Lauderdale, FL 33314-7796

Subject: Site Approval Letter

To whom it may concern:

This letter acknowledges that I have received and reviewed a request by Rosanne Paul-Bruno to conduct a research project entitled "Doctor-Patient Communication: The Experiences of Black Patients with Diabetes" at Mil Lake Healthcare Center, and I approve of this research to be conducted at our facility.

When the researcher receives approval for his/her research project from the Nova Southeastern University's Institutional Review Board/NSU IRB, I agree to provide access for the approved research project. If we have any concerns or need additional information, we will contact the Nova Southeastern University's IRB at (954) 262-5369 or irb@nova.edu.

Sincerely,

MMayard Paul

Mirtho Mayard-Paul
Office Manager
561-433-4446 X 106

Appendix D

Informed Consent Form

General Informed Consent Form
NSU Consent to be in a Research Study Entitled
Doctor-Patient Communication: The experiences of Black Patients with Diabetes

Who is doing this research study?

College: Abraham S. Fischler College of Education; Healthcare Education

Principal Investigator: Rosanne Paul-Bruno, B.S., M.S.

Faculty Advisor/Dissertation Chair: Gail Johnson, EdD.

Co-Investigator(s): N/A

Site Information: MilLake Health Care Center, 4849 Lake Worth Road, Greenacres, FL 33463

Funding: Unfunded

What is this study about?

This is a research study, designed to test and create new ideas that other people can use. The purpose of this research study is to examine the verbal and non-verbal communication experiences of Black diabetic patients with their doctors, as they manage their condition; and how these communication behaviors have an effect on Patient. The study will explore the phenomena of doctor-patient communication, leading to a better understanding of the essential aspects of Doctor-Patient communication, which affect Black diabetic patients. This study will benefit all levels of healthcare providers (doctors, nurses, pharmacists, medical assistants, and those involved with the management of social services), by raising awareness of doctor-patient communication problems, particularly in the black population, in an effort to improve their standard of care. The study will also help policy makers in the development of interventions to alleviate disparities in the quality of healthcare provided to minorities.

Why are you asking me to be in this research study?

You are being asked to be in this research study because you are a diabetic, and as a patient living with such a chronic illness, you would have had some experience with the healthcare system and would therefore be able to speak on your lived experiences regarding doctor-patient communication.

This study will include about 10-15 people.

What will I be doing if I agree to be in this research study?

While you are taking part in this research study, you will be required to attend one interview session for 45-75 minutes.

Research Study Procedures - as a participant, this is what you will be doing:
You will have one interview session in a quiet private room at the research site or at a preferred location of choice. The average length of time to complete the interview/questionnaire is 45-75 minutes. The research site assisted with the screening procedures to determine participants' eligibility to participate in research study, since they know who their diabetic patients are. The research site assisted with the recruitment of participants, by referring potential participants to the researcher for further information, based on the eligibility criteria listed on the recruitment flyer. The eligibility criteria included being a black diabetic, who have had previous doctor visits for diabetes management. The participant must be a woman, age 25-80, and speaks English fluently.

Are there possible risks and discomforts to me?

This research study involves minimal risk to you. To the best of our knowledge, the things you will be doing have no more risk of harm than you would have in everyday life.

What happens if I do not want to be in this research study?

You have the right to leave this research study at any time or refuse to be in it. If you decide to leave or you do not want to be in the study anymore, you will not get any penalty or lose any services you have a right to get. If you choose to stop being in the study before it is over, any information about you that was collected **before** the date you leave the study will be kept in the research records for 36 months from the end of the study and may be used as a part of the research.

What if there is new information learned during the study that may affect my decision to remain in the study?

If significant new information relating to the study becomes available, which may relate to whether you want to remain in this study, this information will be given to you by the investigators. You may be asked to sign a new Informed Consent Form, if the information is given to you after you have joined the study.

Are there any benefits for taking part in this research study?

There are no direct benefits from being in this research study. We hope the information learned from this study will lead to a better understanding of the essential aspects of doctor-patient communication, which affect Black diabetic patients.

Will I be paid or be given compensation for being in the study?

You will not be given any payments or compensation for being in this research study.

Will it cost me anything?

There are no costs to you for being in this research study.

Ask the researchers if you have any questions about what it will cost you to take part in this research study (for example bills, fees, or other costs related to the research).

How will you keep my information private?

Information we learn about you in this research study will be handled in a confidential manner, within the limits of the law and will be limited to people who have a need to review this information. To protect your anonymity, you and your response data will be associated with an assigned number. This data will be available to the researcher, the Institutional Review Board and other representatives of this institution, and any regulatory and granting agencies (if applicable). If we publish the results of the study in a scientific journal or book, we will not identify you. All confidential data will be kept securely using a filing system in a locked filing cabinet in the researcher's home, and a backup computer file copy will be made and kept on a password secured computer. All data will be kept for 36 months from the end of the study and destroyed after that time by shredding paper files and deleting computer file.

Will there be any Audio or Video Recording?

This research study involves audio recording. This recording will be available to the researcher, the Institutional Review Board and other representatives of this institution, and any of the people who gave the researcher money to do the study (if applicable). The recording will be kept, stored, and destroyed as stated in the section above. Because what is in the recording could be used to find out that it is you, it is not possible to be sure that the recording will always be kept confidential. The researcher will try to keep anyone not working on the research from listening to the recording.

Whom can I contact if I have questions, concerns, comments, or complaints?

If you have questions now, feel free to ask us. If you have more questions about the research, your research rights, or have a research-related injury, please contact:

Primary contact:
Rosanne Paul-Bruno B.S., M.S. can be reached at xxx-xxx-xxxx

If primary is not available, contact:
Gail Johnson EdD can be reached at xxx-xxx-xxxx

Research Participants Rights

For questions/concerns regarding your research rights, please contact:

Institutional Review Board
Nova Southeastern University
(954) 262-5369 / Toll Free: 1-866-499-0790
IRB@nova.edu

You may also visit the NSU IRB website at www.nova.edu/irb/information-for-research-participants for further information regarding your rights as a research participant.

All space below was intentionally left blank.

Research Consent & Authorization Signature Section

Voluntary Participation - You are not required to participate in this study. In the event you do participate, you may leave this research study at any time. If you leave this research study before it is completed, there will be no penalty to you, and you will not lose any benefits to which you are entitled.

If you agree to participate in this research study, sign this section. You will be given a signed copy of this form to keep. You do not waive any of your legal rights by signing this form.

SIGN THIS FORM ONLY IF THE STATEMENTS LISTED BELOW ARE TRUE:

- You have read the above information.
- Your questions have been answered to your satisfaction about the research.

Adult Signature Section

I have voluntarily decided to take part in this research study.

Printed Name of Participant	Signature of Participant	Date
Printed Name of Person	Signature of Person Obtaining Consent &	Date