5-2006

Physician Communication Behaviors That Elicit Patient Trust.

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Physician Communication Behaviors that Elicit Patient Trust

A thesis
presented to
the faculty of the Department of Communication
East Tennessee State University

In partial fulfillment of
the requirement for the degree
Master of Arts in Professional Communication

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May 2006

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Keywords: trust, patient perceptions, IMGs, physician communication behaviors,

comfort/caring, agency, competence, compassion, honesty

ABSTRACT

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The general relationship between the physician and the patient is one where communication is used to establish and maintain what will likely become a long-term partnership. Health communication research indicates that physicians who have apt communication skills in the patient-physician relationship develop a platform of trust behaviors. The physician communication behaviors perceived to elicit trust reported by patients are; comfort/caring, agency, competence, compassion, and honesty. The objective of the research project was to assess patient perceptions of previously determined physician communication behaviors that predict patient trust through individual surveys (N=162) between foreign-born international medical graduates and American-born non-IMG resident physicians. Patients reported finding a difference in the exhibited communication behaviors between non-IMG and IMG resident physicians, with the exception of comfort/caring. A modified Trust Model guided the research and supported certain prior findings, claiming that effective communication cannot exist in the absence of a solid, trusting physician-patient relationship.

ACKNOWLEDGMENTS

The author would like to acknowledge the Interview Study Group at the East Tennessee State University Department of Family Medicine for their on-going support and advice in making this research project possible: Special thanks to Dr. Forrest Lang, Dr. Kelly Dorgan, Dr. Michael Floyd, and Dr. Evelyn Kemp.

Thanks go out to:

Dr. Charles Roberts and his wisdom, patience, guidance, and tutelage through the dreaded art of interpreting statistics.

Marc, for adding daily laughter, a little bit of sanity, and a lot of love to my life.

Last, but never least of all, my daughter Marissa for her love, support, and encouragement on the journey to achieve my goals. When I started taking the obstacles this project presented as signs of potential defeat, I saw who I was through her eyes and found out, once again, that just about anything is possible. Thank you.

DEDICATION

This thesis is dedicated to Amber Kinser, PhD., and Kelly Dorgan, PhD., for their unwavering faith in me as an academic and for giving me the knowledge, confidence, and encouragement to succeed.

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CHAPTER 1

INTRODUCTION

"As contagion of sickness makes sickness, contagion of trust can make trust"
-Marianne Moore

The Purpose and Concept of Trust

The concept of "trust" may seem obscure to many researchers because it is a variable that cannot be investigated easily through quantitative or qualitative measures. Butler and Cantrell (1984) and Jenning (1971) found that trust is a behavioral expectation that consists of "consistency, reliability and predictability of the trusted person to perform as expected" (as cited by De Furia, 1996, p.19). Some researchers say that "trust is not an acquired trait; it is an expectation," resulting from communication behaviors exhibiting caring and concern (Bruhn, 2005, para. 1). However, although it is true that trust is an "expectation" that gives an individual a feeling of confidence a particular event will indeed occur, without the acquired trait of trust, (i.e., a learned behavior) expectations would go unrecognized. Dibben, Morris, and Lean (2000) argue that although trust is an internal event and not directly observable, it remains one of the most central factors for an individual developing a relationship. Health communication research indicates that apt communication skills in the patient-physician relationship develop a platform of trust behaviors that help to reduce patient uncertainty and increase overall relationship satisfaction. The general relationship between the physician and the patient is one where verbal and nonverbal communication is used to establish and maintain what will likely become a long-term partnership. In order to build and maintain trust there are certain agreements that must be negotiated by physicians to reaffirm relationship quality. To an

extent the negotiation consists of exhibiting physician behavioral factors that are strongly correlated with trust: comfort and caring; technical competency; encouraging patients to ask questions; and explaining thoroughly what they are doing (Hall, Camancho, Dugan, & Balkrishnan, 2002; Thom & The Stanford Trust Study Physicians, 2001). If physicians are to gain patient trust, it is necessary for them to be effective communicators and be able to, "adapt to be responsive and to manage self-awareness during the process of talking and listening" (Schirmer et al., 2005, p.184).

The trust element may be defined as a vital construct in all relationships, (Anderson & Dedrick, 1990; Bonds, Foley, Dugan, Hall, & Extrom, 2004; Hall, 2001). These collective researchers suggest that trust is: 1) the willingness of an individual to be vulnerable (with respect to medical care); 2) related to the expectation that the physician will protect and take care of his or her patient's health. De Furia (1996) argues that "high trust" will lead to greater emotional stability that facilitates acceptance and openness of expression and "low trust" will result in less accurate communication. Trust is based on personal perceptions and expectations that others will act in their best interest. As well, interpersonal trust leaves an individual vulnerable to another's behavior towards her/him, and if the behavior does not meet expectations, the individual may feel that her/his trust has been violated (De Furia).

Expected physician communication behaviors that elicit patients' trust will stand to foster a relationship that not only facilitates communication by increasing patient trust but will result in a more open (trusting) relationship (Thom, 1997) and patient satisfaction. Doescher, Saver, Frank, and Fiscella (2000) discovered that the relationship between satisfaction and trust is corollary with ethnicity; reiterating that minorities have

significantly less trust and satisfaction in physicians than do their Caucasian counterparts. However, this study investigates physicians' communication behaviors of both foreign-born international medical graduate (IMG) and non-IMG American born resident physicians to gain a clearer picture of this little studied aspect relating to health care; specifically patient perceptions related to trust levels in the resident physician IMGs (e.g., from non- U.S. nationalities) versus the American born and educated physician are examined. To explain further, a foreign-born IMG has received her/his medical degree in a country other than the United States. However, IMGs may also be American natives who have received their medical degree outside of the U.S. in a foreign country. In this study IMGs studied were foreign-born, specifically two IMGs from Pakistan and one from India along with nine non-IMG resident physicians.

The challenge of building cross-cultural trust between the patient and the IMG physician requires more than understanding communication styles or language usage. Unlike graduates from medical schools across the U.S., the IMG from another nation entering an American medical residency program frequently lacks the knowledge of the communication expectations that American medical graduates consider common knowledge, thereby making trust-building with the American patient more difficult. Foreign-born IMGs enter the U.S. being technically proficient in their communications, but in order to build trust there are specific communication behaviors that must be demonstrated because building trust is not simply an intellectual exercise, it is, in fact, an interactive ballroom dance.

Physician Culture/Ethnicity Relationship with Trust

When patients and physicians of differing ethnicities and cultures interact in the office setting initially, a relationship of trust may be more difficult to establish due to the presence of significant cultural differences and language barriers. Therefore, cultural competence on the part of the physician is essential. An attempt to find a common ground is needed for communication between the physician and patient for there to be working partnership of understanding.

There are numerous definitions of what components are needed to establish cultural competence, but for current purposes, the following two definitions will be used:

> 1) "Any group of people who share experiences, language, and values that permit them to communicate knowledge not shared by those outside the culture. Culturally competent physicians are able to provide patient-centered care by adjusting their attitudes and behaviors to account for the impact of emotional, cultural, social and psychological issues on the main biomedical ailment" (American Medical Association (1999) as cited by HRSA Bureau of Health Professions, 2005).
>
> 2) "Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs" (Betancourt et al., (2002) as cited in the Compendium of Cultural Competence Initiatives in Health Care, 2003, pg. 6).

Language Barriers

> The transition for the IMG coming into the United States culture can be laden with not only language barriers but also by unexpected challenges in the doctor/patient relationship that are markedly different from those to which they are accustomed (McMahon, 2004). Language barriers can be a source of anxiety for the IMG in interactions with patients and, "a lack of communication can be anxiety producing during cultural adaptation" (Dorgan, Bambino, & Floyd, 2006, p. 6). Therefore, quality health care requires attention to differences in culture of the patient and provider and the epitome of human communication behaviors that "communicate thoughts, actions, customs and cultural beliefs" and the values of a specific race, ethnicity or a "collective social group" (The national Center for Cultural Competence as cited by Brach & Fraser, 2002, p. 2).

Dialectical and Cultural Differences

When a patient is seeing a physician native to another country, there are more than linguistic and dialectic difficulties, there are cultural differences as well (McMahon, 2004). Some of the most significant obstacles involve misunderstandings and contrary views resulting from multicultural differences. Tsing-Toomey (1992) states that communication differences between cultures are apparent; whereas Americans communicate with one another in a low context manner (e.g. direct, open, and explicit) Eastern cultures communicate in high context (e.g. indirect, unspoken, and implicit). These cultural differences of low and high context communication may lead to misunderstandings when the two cultures are not sensitive to differing styles of

communication. What is seen as perfectly normal communication in the West may be perceived as rude and unacceptable in the East, placing undue stress on a new physician-patient relationship and compromising the possibility of building trust.

The challenge of dialectical differences and language barriers for the IMG can be frustrating to both the patient and provider. Western patients may clearly and openly express any frustration or problems in communicating with the provider who is from another ethnicity and culture; but any complaints may be seen by the IMG as being intolerant or racist, therefore, adding an additional layer of stress to the foreign-born physician already struggling with perceived "suspicion" (McMahon, 2004). When suspicion is present in any context, matters of trust come into question.

Researchers have made steps toward discovering what it is in a relationship that will elicit patient trust in the physician (e.g. exhibiting comfort/caring, compassion, competence, honesty, and loyalty.). A number of studies have examined the relationship of trust between physicians and patient demographics (i.e. patient race and socioeconomic status) but have not specifically focused on the relationship of trust between the American patient and those physicians who immigrate to the U.S. from vastly different cultures and ethnicities (IMGs). However, the prior research is an invaluable foundation because it is pertinent to this study. Currently, there is approximately one in every five physicians practicing medicine in the U.S. who have received their medical degree outside of the United States (Miller, Laugesen, Lee, & Mick, 1998). Of the 20% of IMG physicians and residents in the United States, 20% - 25% of those physicians are of Indian descent. The next seven most prevalent nationalities are from the Philippines, Cuba, Pakistan, Iran, Korea, Egypt, and China.

Forty percent of IMGs are in primary care programs nationwide and two thirds of IMG residents serve in hospitals that provide the majority of patient care to the poor and underserved members of communities (Khorana, 2005; McMahon, 2004). Interestingly, IMGs provide patient care to populations that primarily consist of patients from low socioeconomic and educational levels, whose communication needs for clarity and trust are even greater than the general population.

It is expected that the above percentages will continue to increase due to the shortages of American-born physicians willing to serve in rural communities (McMahon, 2004); additionally, because more and more foreign-born IMGs are staying in the U.S. post-residency and practicing in many rural communities across America, the impact on patients becomes apparent in the cross-cultural context. Therefore, it is necessary to investigate if physicians' culture/ethnicity has an effect on patients' perceptions of trust in physicians with whom they have ethnic, cultural, linguistic, and geographical differences. Those internationally born physicians who remain in the U.S. may overcome cultural differences as the patient-physician relationship is established; however, those initial differences can create misunderstandings between individuals even before they have had a chance to establish any credibility with each other (Asherman, Bing, & Laroche, 1999). Cultural differences, both subtle and overt, may in fact be greatly minimized when a degree of trust is established between the individuals from the beginning.

Importance of Trust

Trust is an essential component in increasing patient self-efficacy and compliance with treatment and improving overall patient health in all patient/physician interactions regardless of cultural ethnicity. In addition, patients report that physicians who focus on

meeting their immediate medical needs promote a sense of interpersonal trust and satisfaction (Doescher et al., 2000). If patients are to seek care and adhere to prescribed medical treatment, trust is necessary as it gives the patient-physician relationship "meaning, importance and substance, in the same way that love and commitment give meaning and define the quality of spousal relationships" (Hall, Comancho, et al., 2002, p. 188).

Effective communication cannot exist in the absence of a solid, trusting physician-patient relationship. Whether a physician is a foreign-born IMG or not, verbal and nonverbal communication behavior can either build rapport, thereby preserving and strengthening the physician-patient relationship, or impede the establishment of a healthy patient-physician relationship. Arguably, all physicians who work toward meeting patient needs and approach the practice of medicine in a more empathetic, humanistic manner (e.g., by exhibit trust-eliciting communication behaviors) will develop a more open, honest dialogue with the patient. In the presence of honest, open, two-way communication, a patient's compliance to a prescribed treatment will theoretically improve. Patient satisfaction in the physician will also increase along with patient trust once an open dialogue is established. Then, a patient may feel freer to participate in the partnership building process and become an active participant in her/his health care decisions. Contemporary physicians need to bear in mind that a sense of trust in the physician by the patient is no longer inherent and is something that must be earned in this age of "patient as consumer" (Berlinger, 2004).

With the patient in the position of both patient and consumer, physicians may seek to overcome this barrier to trust by acknowledging their patient's access to outside

information that comes from a variety of medical and non-medical sources. Although it is impossible for a physician with a busy schedule to keep abreast of every fount of outside information available, a general awareness remains necessary if a physician is intent on meeting patient needs. The awareness and acceptance by the physician about every patient's access to health related information through web sites; educational programs on television; magazine and news stories; advertisements; and other abundant information about various disease and illness may be a useful tool as the physician works toward establishing rapport with the patient. This will not only gain patient trust but will also assist in crafting social bonds with the patient by showing that the patient's opinion and/or concerns are valid, resulting in a positive interaction. "Trust is more than a predictor of positive results in the medical encounter" (Hall, 2001, p.188); it is also an indicator of patients' willingness to be placed in a vulnerable position with the expectation that physicians will act in the patients' best interest (Anderson & Dedrick, 1999; Bonds et al., 2004; Hall, 2001).

The Vulnerability of Trust

One of the fundamental social bonds that individuals in a vulnerable position are willing to extend themselves to is akin to the interpersonal trust based on a patient's belief in a doctor's agency to them, (i.e., that a physician will act in their best interest). In light of this vulnerability, interpersonal trust needs to be built through "small initial cooperative gestures," (i.e., through continuity in relationships) in order to promote cooperation (Kydd, 2000, p. 398). Developing interpersonal trust in a new relationship is a difficult task because trust is a "fragile" element that can be easily compromised or broken (Berlinger, 2004; McKnight & Chervany, 1996). The patient-physician bond that

is being formulated can be shattered if the physician is not responsive to the needs of the patient in the early phases of the relationship building process (Berlinger, 2004). There will be challenges and difficulties in cementing trust into the patient-physician relationship if an individual feels that he or she is unable to establish a working partnership with the physician (Hall, 2001; Hall, Camancho, et al., 2002). However, the physician who listens and is responsive to his/her patient needs will, with the passage of time, establish continuity in the patient-physician relationship. Once the aspect of trust becomes cemented into the relationship, it will be much more difficult to destroy.

Active Listening, Partnership, and Trust

Listening closely to patients is also a crucial part of gaining patient trust and relationship building. When physicians attempt to build a relationship and gain patient trust, they realize that they have no control over the situation or the circumstances, (i.e., accident, injury, or grave illness) that has prompted the patient into coming to the office or clinic. However, they do have the ability to engage in communication that will make the interaction one that will elicit trust. It is not likely that a person who has a negative disposition (i.e., general attitude) on initial visits can be changed, but it may be argued that the physician exhibiting consistent trusting communication behaviors over time will increase the likelihood that the relationship will become a strong, long-term partnership. It is the long-term dispositional, knowledge based trust that will predict relationship success and improve patients' physiological health. Although difficult, physicians may modify a patient's learned behavior, if they are able to recognize those patients with low levels of trust in the early stages of the patient-physician relationship and alter their communication patterns with patients. For example, by actively listening to the patient

narrative (i.e., focusing attention on what the patient is saying, summarizing by repeating back what the patient says) physicians will be better able to understand what the patient is saying (Lang, Floyd, & Beine, 2000). It can then be argued that physicians participating in active listening in the patient-physician interview will be able to establish rapport and gain patients' trust. This does not mean that the physician must completely agree with the patient, but that by listening to the patient's story (i.e., narrative about his/her problem) she/he gains the ability to incorporate a different perspective in how the patient sees the condition, disease, and treatments (Franks et al., 2000).

Engaged Behavior and Trust

In addition to using active listening, engaged behavior (i.e., involving the patient in the interaction and decision making process) will demonstrate that an equal power base between physician and patient is being established. Engaged behavior aids in the partnership building process of the patient and physician who are now working together as a team for optimal results (Mohr, 1997, p. 273). As has been established, trust to some extent is dependant upon patient attitudes, prior experiences with other physicians, and/or perceptions of physicians (Dibben et al., 2000; Hall, Camancho, et al., 2002). Patient attitudes, experiences, and perceptions of trust are influenced in part through the ever increasing access to information technology. Health related websites and other media channels have made patients more aware and educated about health information that they have been exposed to in print and electronic sources, (e.g., advertisements, educational programs on television, magazine articles, and news stories.) As the physician responds to patient needs, the relationship develops and strong bonds of general trust are built between patient and physician that are able to withstand threats to the internal stability of

the relationship from outside sources (Hall, Zheng, Dugan, Camancho, Kidd, & Mishra, 2002). Surbone and Lowenstein (2003) argue that the core of the partnership between the patient and physician is trust, and the difference in roles is a necessary part of the relationship (p. 184). However, if a patient feels as if she/he is viewed as a disease or body part instead of a real person with a real story, the patient will be reduced to an object, and not a human being. When physicians' communications appear detached, inaccessible, or insensitive to patients' needs, it may discourage patients to become active participants in their own physical and emotional health (Franks, 2000; Surbone & Lowenstein), ultimately affecting the delicate balance of patient trust in the physician. Therefore, the physician communication behaviors of comfort/caring plays a continuous role in the patient-physician relationship that may aid in maintaining the patient's physiological health. As well, the behavior of compassion exhibited by the physician reflects the physician's willingness to share the patient's anguish and to attempt to understand what the sickness means to that person (Rakel**,** 2000).

Mohr (1997), Street, Krupat, Bell, Kravitz, and Haidet (2003), and Thom, Kravitz, Bell, Krupat, and Azari (2002) argue that physician behaviors that communicates caring, comfort, and technical competency are necessary in a relationship based on trust. The physician using verbal and nonverbal communication to prompt the patient to disclose further information will encourage the patient to interact. As physicians exhibit the humanistic behaviors of caring and comfort through verbal and nonverbal communication, they are able to better assist patients in acquiring the trust in the physician needed to increase efficacy and become active participants in their own health care decisions. By acknowledging and addressing patient concerns and questions about

traditional and alternative health information acquired outside the physician's office, the physician will compliment the relationship between the patient and physician further by reducing uncertainty and encouraging patient disclosure. Further, as physicians validate patient concerns and interest in her/his own health, it will benefit the patient's physical health in what may become a long-term relationship between the patient and the physician.

Summary

The concept of trust is a vital part of the patient/physician relationship that is dependant on apt communication skills on the part of the physician. Patients are in a vulnerable position and have the expectation that they can trust their physicians to protect and take care of their health to the best of their ability. Physician ethnicity and cultural competence has a bearing when building trust and foreign-born IMGs have to have more than knowledge of language usage and communication styles: The IMG physician will need a working knowledge of the communication skills necessary for building a relationship of trust with patients. Culturally competent physicians, whether foreign-born IMGs or American-born non-IMGs, will be better able to provide patient centered care when employing certain communication behaviors that exhibit comfort/caring, agency, competence, compassion, and honesty. With there being one out of every five practicing physicians in rural communities of the U.S. who are foreign-born IMGs, it is then necessary to examine the impact, if any, on patient perceptions of care.

CHAPTER 2

LITERATURE REVIEW

Redefining Trust in Relationships

Trust may be viewed as a characteristic of interpersonal transactions between individuals or as an institutional phenomenon based on societal beliefs and value systems. Psychologists have traditionally viewed trust as an individual characteristic and argued, for example, that trust is an expectation about the behavior of others in transactions and focuses on the contextual factors that enhance or inhibit the development and maintenance of trust (Lewicki & Bunker, 1995). That is, a patient should have some degree of confidence as she/he enters a physician's office that the physician will work towards the best health outcome for her/him. Trust in the patient-physician relationship is crucial as patients trust that physicians are competent and motivated to protect their interest in the healthcare setting (Leisen & Hyman, 2004). In addition, Leisen and Hyman argue that, "trust in the physician is requisite to successful medical care" (p. 991). Dibben et al. (2000) claim that there are three levels of interpersonal trust that are constantly being redefined in relationships; situational, learnt, and dispositional trust, as will be discussed below.

A Model of Trust

Dibben et al. (2000) identified three areas on which interpersonal trust can be built: Dispositional trust (i.e., the personality trait of an individual to be trusting to another or not); Learnt trust (i.e., an individual's generally tendency to trust or mistrust another); and Situational trust (i.e., dependant upon situational cues). Figure 1 describes three levels of trust and seeks to plot how trust is developed, thereby making it possible

to identify what physician communication behaviors need modification in order to gain patient trust (Dibben et al., 2000).

Dispositional trust The personality trait or disposition of an individual to be trusting or not; not modifiable
Learnt trust A individual's general inclination to trust another specific individual; modifiable
Situational trust Dependent on the situational cues that modify the expression of general propensity; modifiable.

Figure 1: Three Types of Trust

Adapted from: Dibben, M.R., Morris, S.E., & Lean, M.E.J., (2000). Situational trust and co-operative partnerships between physicians and their patients: A theoretical explanation transferable from business practice. [Electronic Version]. QJM, 93, 55-61.

The Dibben et al. stages of trust stop at situational trust not allowing for a permanent behavioral and attitudinal change; therefore, Figure 2 introduces the concept of Type A and Type B dispositional trust resulting in a fourth level of trust. A modified trust model (Figure 2.1) takes the three stages of trust one step further by proposing a second phase of dispositional trust as described by McKnight and Chervnay (1996) in their research on trust. The modified trust model illustrates how trust is developed and cemented into the patient/physician relationship, thereby making it possible to identify which physician communication behaviors need modification in order to gain patients trust.

Psychological trait to trust or distrust *(Type A Dispositional trust)* →
Physician communication behaviors → (Caring/compassion, agency, competence, compassion and honesty)
→ Patient situational cues to trust physician *(Situational trust)*
→ Patient-physician relationship experienced over time *(Learnt trust)*
→ Predicted behavior to trust physician through gained knowledge *(Type B Dispositional trust)*

Figure 2: Four Types of Trust

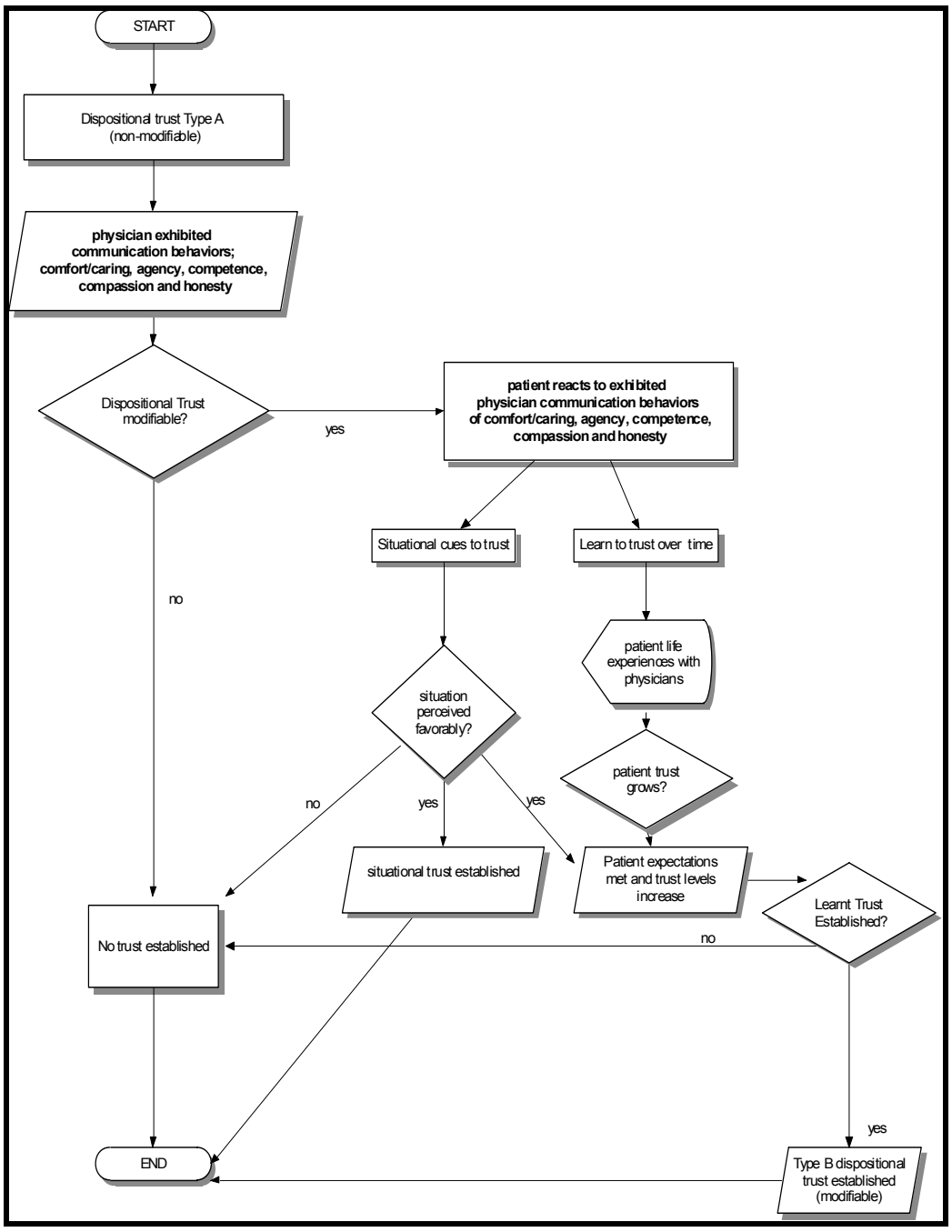

Figure 2.1: Modified Trust Model

Adapted From "On Trust" model: Dibben, M.R., Morris, S.E., & Lean, M.E.J., (2000).Situational trust and co-operative partnerships between physicians and their patients: A theoretical explanation transferable from business practice. [Electronic Version]. QJM, 93, 55-61.

In the following sections, the three levels of interpersonal trust will be discussed with the level of dispositional trust being discussed last, due to its proposed dual role in trust development in the patient/physician relationship.

Learnt Trust

Learnt trust is constructed between individuals in the early stages of a relationship and can be weighed by the individuals in terms of whether or not the outcomes of creating and sustaining the relationship are greater than the costs of severing it. Learnt trust is an individual's general tendency to trust or distrust another individual and is a trait that is learned over time or through new experiences. As the "On Trust" model indicates, learnt trust must be developed in conjunction with situational trust.

However, learnt trust, as it implies, is a learned behavior and can be linked to the patient's long-term cumulative experience. Conversely, situational trust is the amount of time needed for an individual to establish trust in a given situation and the time frame based on the individual's past contexts and experiences with other physicians. Both situational and learnt trust are building blocks in that one cannot exist without the other because it is our experiences and situations (e.g., through our culture, values, and beliefs) that teach each of us whether or not to trust another individual; thereby the effect of dispositional trust on these two other layers of trust comes to light because it directly affects patients overall trust perceptions.

Situational Trust

Situational trust is based on the amount of trust an individual maintains in a given situation and may vary considerably from situation to situation – it is interpreted through the context of any given circumstance (Dibben et al., 2000). Situational trust in the

personal context consist of a high degree of identification with the expectations/intentions of the other individual in a given situation or context. The situational decision to trust is in essence the "truster's" willingness to trust in a given situation regardless of the individual(s) involved (McKnight & Chervnay, 1996).

Dibben (2000) contends that although individuals may trust others as a whole, or dispositionally, it is in the context of situational trust that trust is established. Dibben also claims that it is situational trust that is the most important level of trust in business; as it is influenced by others' actions because it is modifiable. However, Berlinger notes the practice of medicine is not a business; it is a central role of trust that is a reminder to physicians that medicine is a "calling" and not a business. Situational trust, as Dibben et al. (2000) theorized, for example, patients being treated in the clinic setting expect that physicians will treat them for a given condition in the same manner, based on past experience in the same clinic. But personal illnesses, like situations, are varying in context and cues to trust in one instance might be perceived differently in a stressful situation, such as when a patient is given a diagnosis of a life-threatening illness (Berlinger, 2004).

In holding with Berlinger's argument in a possible life-threatening scenario of that type, a patient might have misgivings about the validity of the physician's diagnosis or the medical testing facility and not "trust" that the diagnosis is true but still trust in the physician dispositionally because the physician motivation is from caring for the patient, not a business transaction. Therefore, it would be logical to arrive at the conclusion that the situational context (i.e., situation) in which trust is being viewed by the patient will only be held firm if adequate learnt (i.e., patient past and present experiences with

physicians) and dispositional trust levels (i.e., trait to trust or distrust) are in place. As Lewicki and Bunker (1995) argued, even within the same relationship we have different encounters in different contexts with different intentions that lead to different outcomes. That is, situational trust is formed from an individual's experience in a series of similar situations in which learnt trust is established and based in part on the individual's general dispositional trust. As McKnight and Chervnay (1996) argue, situational trust, unlike dispositional trust, is the "situational decision to trust (that) does not support trusting beliefs about a specific individual" (p.38).

Dispositional Trust

Dispositional trust is cross-situational and a cross-personal construct (McKnight & Chervnay, 1996). In other words, dispositional trust exists in a variety of differing circumstances between individuals. Dispositional trust differs from situational and learnt trust in that dispositional trust is based on a general faith in humanity; whereas situational trust is formed from situational cues, learnt trust that is learned through an individual's personal experiences (Dibben et al., 2000; McKnight & Chervnay).

Personal experiences are accumulated as a person grows from infancy into adulthood where the final level of dispositional trust is achieved then shaped where one individual is comfortable enough and willing to trust another person in a given situation, "with some certainty" (McKnight & Chervnay, 1996). Dispositional trust is based on an individual's general personality, nature, or disposition, (i.e., a psychological trait to be trusting) which is believed to be a reliable indicator in determining the amount of trust a patient will have in her/his physician. Over time, dispositional trust may change between individuals on the basis of shared knowledge, therefore allowing each person to make

predictions about the other's behavior. McKnight and Chervnay argue that dispositional trust allows for prediction; so that one can depend on this prediction with some reliability, bringing a sense of balance to her/his day to day life. There are two types of reasoning for dispositional trust: 1) the individual will assume that others are generally trustworthy; 2) regardless, if others are good or bad the individual should trust them in order to have a better outcome (McKnight & Chervnay). Dispositional trust may also be broken down into two subsections, Type A dispositional trust and Type B.

Type A dispositional trust concerns the "truster's" belief as to whether other people are generally good, trustworthy, and, therefore, should be trusted accordingly. Knowing that dispositional trust is not only cross-personal but also cross-situational, McKnight and Chervnay (1996) argue that it is the secondary type of dispositional trust (Type B) that is the more "active" construct, as it concerns one's belief that irrespective of whether others are good or not, a more positive outcome can be obtained by acting "as if" he/she trusts the other person (sec. 3.5). Therefore, if Type B dispositional trust is an active construct and changes it is modifiable, whereas Type A is more an inherent, non-modifiable trait as Dibben et al. (2000) describe dispositional trust. Dibben (2000) argues that dispositional trust is the most difficult characteristic to change in individuals; therefore, it is a non-modifiable trait in individuals who have high levels of distrust. However, Type B dispositional trust may be developed and perceptions changed in patients retaining the same primary health care provider over continued interactions. Leisen and Hyman (2004) predict that patients who routinely use the services of the same provider have greater trust in that specific provider. For example, patients having low levels of dispositional trust, who, after a series of acceptable outcomes with a physician,

may lean toward the second type of dispositional reasoning by rationalizing that whether or not they like their doctor they trust her/his judgment (Lewicki & Bunker, 1995; McKnight & Chervnay, 1996). The second type of dispositional trust differs from the concept of situational and learnt trust in that it offers a more stable permanency in the patient/physician relationship; in other words, even when the patient does not perceive a personal bond with her/his physician, she/he trusts that the physician will look after her/him.

Dispositional trust may be a difficult characteristic to change in individuals, as Dibben (2000) claims, but in the patient-physician interaction where physicians engage in communication behaviors that elicit patient trust (e.g., exhibiting compassion, comfort/caring, etc…) patients' situational trust levels will increase and result in an attitude change on behalf of previously distrusting patients (Dibben et al., 2000). Dibben et al. also found that situational trust can be increased in a previously distrusting patient; therefore, the modified trust model, focused on achieving Type B dispositional trust as a positive outcome, becomes relevant. For example, a patient presenting her/himself to the physician with an onset of Diabetes Mellitus or Hypertension will be in the position of needing to learn new skills (Dibben et al.). Skills such as dietary and lifestyle adjustments, medication management, or how to self inject insulin may be necessary, and it is the physician who is instrumental in building patient confidence in her/his ability to comply. The patient will also have to learn to modify his or her habits and lifestyle in order to maintain stabilization of her/his condition and may be resistant to physician recommendations. The physician who is sensitive to the barriers the patient may face in treatment and is compassionate, as well as encouraging, towards the patient will be better

able to gain patient trust and compliance to therapy. By following the theoretical path of the modified trust model, it can be identified that communication behaviors that exhibit trust can be engaged by physicians that could feasibly change patients' attitudes and beliefs when it comes to treatment compliance. The patient/physician interaction is one of the most private and direct interactions one individual can have with another, and communication based on trust is a key factor in predicting positive outcomes. In the cross-cultural context (i.e., between the American patient from East Tennessee and a physician from Pakistan or India) trust may be more difficult to establish for a positive health outcome to occur due to uncertainty a patient may have about the provider. Therefore, when uncertainty is present in an interaction, the physician may or may not establish a successful therapeutic relationship if dispositional trust is not firmly established.

Why Develop Type B Dispositional Trust?

The potency of the modified trust model lies in its capacity to account for the development of trust over time in the form of perceived similarities and differences in both professional knowledge and individual character. To clarify, there is trust of a situation based on one's "comprehensive situational cues" (i.e. professional knowledge) and there is trust of the person in a situation that is more often based on personal knowledge of the individual (Dibben, 2000). The current idea being that trust in a patient-doctor relationship evolves from an individual's initial Type A dispositional trust, to learnt and situational trust levels, on to Type B dispositional trust.

The levels a patient may have of learnt, situational, and dispositional trust may offer some explanation for the frequent occurrence of patients who do not comply with

prescribed treatments and therapies. In such cases, clinical consequences could be seen as "malfunction" of the expected trust development process in the patient-physician relationship and a relationship of trust between the patient and the physician will be "interrupted" or possibly not occur at all (Dibben et al., 2000). A communication break-down of this nature may possibly indicate that trust levels have remained stagnant at the learnt stage and never progressed to the dispositional stage necessary for behavior to be predicted on a continuing basis. If patients perceive that there is an increase in their personal risk and/or perceive the physician as not technically competent, is uncaring, or not looking out for their best interest, then a decrease in trust levels on the part of the patient will transpire (Dibben et al.). Negative consequences to patients' health may occur if the three levels of interpersonal trust are inhibited or are 'violated' in any manner by preventing the relationship between the patient and physician from fully developing (Hall, 2001). However, the physician who exercises communication behaviors and skills that aid in rapport will stand to build Type B dispositional trust. When a positive physician/patient rapport occurs, the aspect of "trust" will become cemented into the relationship and become increasingly more difficult to destroy. It can be predicted that once the secondary dispositional trust stage is attained, it will result in an attitude change based on knowledge gained over time in the patient-physician interpersonal interaction. When learnt trust accompanied by positive situational trust has evolved into the final dispositional stage of trust, the physician has "proven" that he/she is trustworthy. It is, in essence, the core characteristic of trust that bonds the patient-physician relationship and gives the relationship "meaning, importance and substance" (Hall, p.188). Being that Type B dispositional trust is the most difficult aspect of trust to transform, it is necessary

to improve physician communication behaviors with patients that elicit trust to increase patient beliefs of efficacy in adhering to treatments for improved quality of life.

Measuring Trust

Anderson and Dedrick's (1999) research illustrates that trust is an intrinsic part of the patient-physician interpersonal relationship and developed a method of interpretation to evaluate trust. Anderson and Dedrick carried out two studies that gave preliminary support to the reliability and validity of a Trust in Physician Scale. The Trust in Physician Scale was also implemented for research conducted by Bonds et al. (2004), Hall, Zheng, et al. (2000), and Thom et al. (2001) in which they discovered that physician behaviors are related to patient trust in regard to patient gender, age, and length of relationship with the physician. In addition to the above, the Bond et al. research focused on resident physicians, and it may be noted that 22% of the resident physician whose patients were surveyed for trust were non-white, but IMG status was not examined.

Additionally, Thom administered a modified Humanistic Behaviors Questionnaire to assess which behaviors patients perceived as reflecting trust in physicians. Results were definitive that patient trust in the physician is strongly correlated with physicians exhibiting the behaviors of caring and comfort, competency, and communication (Rosser & Kasperski, 2001. p 329; Thom et al., 2001. p. 323-328). Hall, Zheng, et al. (2002) conceptualized an interpersonal, theoretical model to investigate patient trust in physicians. The researchers determined that patient trust consisted of five domains that include: agency/fidelity, competence, honesty, confidentiality, and global trust. It is important to note that there remains a general consensus that trust is an imperative and critical part in building the physician-patient relationship as validated by research

conducted by a variety of studies, (Anderson & Dedrick, 1999; Bonds et al., 2004; Hall, Zheng, et al., 2002; Leisen & Hyman, 2004; Thom & The Stanford Trust Study Physicians, 2001).

Behavioral Factors

Behavioral factors that determine how trust is established in the patient-physician relationship can be based in part on research that indicates that there is a certain set of communication behaviors necessary to elicit trust in the physician. In addition, continuity of care is also listed as being of importance in eliciting patient trust.

The physician communication behaviors noted in studies are defined as follows:

1) Competence in both technical and interpersonal skills;

2) Agency (loyalty) to act in the patient's best interest;

3) Honesty to avoid misleading or lying to patients or withholding information;

4) Comfort and caring to increase patient perceptions that physicians are addressing the patient's pain or problem;

5) Compassion showing the patient empathy in addition to technical proficiency.

In essence, these aforementioned research studies support honesty, competence, comfort/caring, compassion, and agency as all being important indicators with physicians of the patient trust that is necessary for building a long-term relationship (Bonds et al., 2004; Emanuel & Dubler 1995; Hall, 2001; Hall, Zheng, et al., 2002; Thom et al., 2001; Thom et al., 2002). In addition to the above mentioned communication behaviors, the researchers also include active listening and the length of the relationship as being indicators of patient trust.

Both the Stanford Trust Study Physicians and Wake Forest Trust in Physicians research argue that the variables of physician honesty, competence, caring, compassion, and agency (i.e., acting in the patient's best interest) are all important indicators of the patient trust that is necessary for building a long-term relationship (Hall, Zheng, et al., 2001; Kao, Green, Davis, Koplan, & Cleary, 1998; Thom et al., 2001). In each study it was discovered that trust is a key component in the therapeutic relationship between physician and patient. Research studies conducted by Bonds et al. (2004), Hall et al. (2001), and Krupat, Bell, Kravitz, Thom, and Azari (2001) are in agreement that the patient's trust in the physician is a critical component in the therapeutic relationship between the patient and physician in regard to the patient's overall psychological and physiological health. It can also be noted that patient trust in the physician has been strongly correlated with high patient satisfaction (Bonds et al., 2004; Hall, 2001; Hall, Zheng, et al., 2002; Krupat et al., 2001; Thom, Kravitz, Bell, Krupat, & Azari, 2002). As Dibben et al. (2000) explain, it is plausible that trust is a reliable indicator of a patient's overall compliance to plans of treatment. However, these behaviors have not been examined within the context of a cross-cultural physician-patient relationship and how trust can be built between the American patient and the IMG resident physician in an on-going relationship.

> There are vast cultural differences […] which are often neither acknowledged nor addressed. […] Cultural differences play a key role in the creation of trust, since trust is built in different ways, and means different things around the world (Asherman, Bing, & Laroche, 2000).

Physician Trust Scale

In both the Anderson and Dedrick (1999) and Hall, Zheng, et al. (2002) studies, the instrument of measurement was the Trust in Physician Scale. Results were conclusive that patient trust is strongly associated with patient satisfaction (p. 293-318). Findings of the Wake Forest study also suggested that satisfied patients with high levels of trust in the physician will rely on the original physician's diagnosis and not feel the need to seek out a second opinion. It is also noted that these findings are in direct contrast to studies carried out by Street et al. (2003) and Tauber (2003) that argued patients who were active participants in their health care had high levels of trust in physicians. Although findings in existing research indicate that patients do not want to be active in their own health care (Hall, Zheng, et al., 2002), this may be problematic for patients because the contemporary physician's goal for his/her patients is to have them become pro-active in their health care decisions. The findings of the Wake Forest study suggest that further exploratory research on the relationship of patient autonomy and trust levels is necessary. Although this warrants further investigation, it is not the underlying goal of this research project.

The cross-sectional survey using the Trust in Physicians Scale in the Wake Forest Study concluded that although trust in the physician was generally high for the total of all surveyed, there was a significant difference between respondents of differing ethnicities; minority individuals said that they were less likely to trust their physicians (Hall, Camancho, et al., p. 358-365) which may be related to quality of care perceptions associated with ethnicity and culture. Doescher et al. (2000) argue that physician racial and economic biases may be factored into why it is that minorities have lower self-

efficacy and perceptions in the physician. Bonds et al. (2003)[1] found that there is no association between trust and ethnicity, whereas Boulware et al. (2003) argue that there is a significant correlation between the two variables. The Doescher et al. and Boulware et al. studies also examined racial discrimination in the health care system to investigate if ethnicity was a determining factor of trust in physicians and other health care institutions, such as insurance carriers and hospitals. Measures of physician characteristics in the research conducted by Bonds et al. did not provide individual results for white and non-white physicians.

It has also been argued by Street et al. (2003) (in reference to patient attitudes) that regardless of ethnicity or gender it remains necessary for the physician to exhibit actions that include the patient, or use "engaged behavior" and positive language to encourage active involvement by the patient in their own self-care; as Street et al., (2003) observed, the patient may experience better health when engaged behavior is used (p.609). The studies by Hall, Zheng, et al. and Doescher et al. did not report whether or not the level of trust and satisfaction that a patient has in the physician is related to the ethnicity or country of origin of the treating physician. Although it is well documented that there is an identifiable set of physician communication behaviors that promote patient trust in the physician, there has been little evidence to suggest if there are any

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[1] Measures of physician characteristics: The average trust score for primary care providers was M = 42.70, out of a possible score of 50 with [SD] 6.20.

differences in the level of trust patients have in physicians from another culture and country.

It seems plausible that there may be differences in how patients communicate and respond to physicians whose ethnic and cultural background differ from their own. Berbyuk, Allwood, and Edeback (2005) state; intercultural communication is an important issue in the education of health care personnel and healthcare practices. Gudykunst and Kim (1995) observe in their research on intercultural communication that the way we communicate with another individual is, “because we are raised in a particular culture and learn its language, rules, and norms" (p. 430). As well, intercultural communication can be understood as the communication that occurs between people who have varying degrees of familiarity between them. Different cultures may have different rules and norms and, further, different rules within the subcultures. Intercultural communication begins when understanding the other's culture assists in opening a path to cross-cultural communication (Gudykunst & Kim). Therefore, attempts should be made toward encouraging a two-way dialogue between the foreign-born IMG physician and American patient where communication barriers may be overcome and a therapeutic relationship can be recognized.

Therapeutic Relationships

Research conducted by Bonds et al. (2004) concludes that trust is a key component in the therapeutic relationship between physician and patient in regard to the patient’s overall psychological and physiological health and notes that trust is difficult to establish in newly formed or transient relationships (pp. 94, 300). Fostering trust is also a central and profoundly important element and ethical obligation that physicians must

adhere to as set forth in the Hippocratic Oath (Berlinger, 2004, p. 34; Rossier & Kapperski, 2001). There is no question that patients are the vulnerable parties in patient-physician relationships and that it is the doctor's responsibility to establish patient trust while adhering to the moral and ethical standards cited in the Hippocratic Oath. Undoubtedly, patients base their perceptions of trust in physicians on how well physicians fulfill their ethical obligations; thereby, trust levels affect how well the patient will adhere to prescribed treatment (Berlinger, 2004).

Research studies conducted by Bonds et al. (2004), Hall (2001), and Krupat et al. (2002) and are in agreement that the patient's trust in the physician is a critical, key component in the therapeutic relationship between the patient and physician in regard to the patient's overall psychological and physiological health. It can also be noted that patient trust in the physician has been strongly correlated with high patient satisfaction, (Bonds et al., 2004; Hall, 2001; Hall, Zheng, et al., 2002; Krupat et al., 2001; Thom et al., 2002). It is plausible then that trust is a reliable indicator in evaluating the patient's overall compliance to plans of treatment and should be investigated further. However, if the aforementioned therapeutic relationship is not established, there can be long-ranging consequences.

Health Consequence: Patients Who Do Not Trust

When patients do not establish or are resistant in allowing a pattern of trust in physicians to emerge, they are less likely to seek medical treatment at all for new or recurring illnesses. Patient decisions may possibly be based on fear of illness, internal perceptions, or their families' history of past negative experiences concerning the medical profession. Researchers claim that distrusting, unsatisfied patients are less likely to

follow doctor's orders and treatment plans (Berger, 2004; Conlee, Olvera, & Vagim, 1993; Hall, Comancho, et al., 2002; Thom, 1997). Berger concludes that there is a considerable "human cost of nonadherence" when patients do not adhere to treatment plans (e.g., mismanagement of long-term anti-hypertensive medications) that may lead to unnecessary testing and harmful regimen changes for the hypertensive patient. Patients in the above type may conceivably also have a high degree of uncertainty in a physician's competency. Patients who are resistant to developing a relationship based on trust with their physicians are less likely to disclose sensitive information (e.g., sexual history or domestic abuse issues) necessary for proper diagnosis by the physician and patient adherence to treatment plans, (Hall, 2001; Hall, Camancho, et al., 2002). Thom et al. (2002) concluded that patients with lower levels of trust in physicians also report having lower levels of satisfaction with care received from the physicians.

When patients have low levels of trust and satisfaction, they also feel that physicians who are unresponsive to patient needs are not providing necessary patient services (Thom et al., 2002, p.476). Hence, if patients feel physicians are unresponsive to their needs, they may become suspicious about the physician's competence. Once patients become suspicious and begin to question the technical abilities and competence of physicians, the suspicion manifests into distrust and the relationship is over (Berger, 1987; Dibben et al., 2000). Further, patients who mistrust and have a general sense of distrust toward the medical profession as a whole may be discouraged from seeking medical care (Berger, p.34) possibly until the prognosis is grim and the damage to their health is irreversible. Distrust in the medical profession by the patient could explain the often mentioned phenomena as to why some patients may only seek out a physician for

the first-time in the fourth and final stages of metastatic cancer, when there is nothing that can be done to sustain their lives (Burnett, Steakley, & Tefft, 1995).

The findings based on the literature that will guide this study, suggest the following questions be asked:

RQ1: Is there a difference between non-IMG and IMG physician communication behaviors of comfort/caring which promote patient trust?

H1**:** There is a significant difference in patient perceptions of comfort/caring based on physician IMG status.

RQ2: Is there a difference between non-IMG and IMG physician communication behaviors of agency which promote patient trust?

H2: There is a significant difference in patient perceptions of communication behaviors denoting agency based on physician IMG status.

RQ3: Is there a difference between non-IMG and IMG physician communication behaviors of competence which promote patient trust?

H3: There is a significant difference in patient perceptions of communication behaviors denoting competence based on physician IMG status.

RQ4: Is there a difference between non-IMG and IMG physician communication behaviors of compassion which promote patient trust?

H4: There is a significant difference in patient perceptions of communication behaviors denoting compassion based on physician IMG status.

RQ5: Is there a difference between non-IMG and IMG physician communication behaviors of honesty which promote patient trust?

H5: There is a significant difference in patient perceptions of communication behaviors denoting honesty based on physician IMG status.

RQ6: Do patients who are of a different culture/ethnicity than the foreign-born physician report experiencing lower levels of trust than in American- born physicians?

H6: Patients will report having lower levels of trust in foreign-born resident physicians whose culture/ethnicity differs from that of patients than do those patients and physicians who do not have cultural/ethnicity differences.

RQ 7: Is physician culture/ethnicity associated with patient perceptions of satisfaction?

H7. There is a significant difference in patient perceptions of what constitutes satisfaction from a physician whose culture/ethnicity differs from their own than when a physician shares a common culture/ethnicity with the patient.

RQ8: Is there a relationship between non-IMG and IMG physician communication behaviors of satisfaction that promote patient trust?

H8: There is a significant correlation between patient trust of the physician and patient satisfaction.

RQ9: Is there a relationship between patient compliance and physician communication behaviors which promote patient trust?

H9: There is a significant correlation between patient compliance and trust of the physician.

CHAPTER 3

METHODS

Trust Survey

The research was guided by a modified trust model grounded in Information Systems Theory. The "On Trust" model designed by Dibben et al. (2000) was modified and used to guide the research to test the hypotheses that certain physician communication behaviors elicit interpersonal trust in the patient. The five communication behaviors tested in a variety of past studies were found to be reliable predictors of eliciting patient trust. In the current study, communication behaviors denoting comfort/caring, agency, competence, compassion, and honesty were once again tested to determine the significance these physician behaviors have in overall patient perceptions of trust, using two concepts of dispositional trust (Type A and Type B), situational, and learnt trust in IMG and non-IMG physicians.

Studies preformed by Wake Forest and the Stanford Trust Study researchers, among others, (Anderson & Dedrick 1990; Kao et al., 1998; Hall, Zheng, et al., 2002; Krupat et al., 2001; Thom et al., 2000) developed and validated multi-item scales based on the Trust in Physicians Scale (Anderson & Dedrick, 1999) and the Physicians Humanistic Behavior Questionnaire (developed by the American Board of Internal Medicine, 1989) that quantify the level of patient trust and human behavior (disposition) and have applied these instruments in a number of different settings. The 25-item Physicians Humanistic Behaviors Questionnaire (PHBQ) was developed from patients' statements about important humanistic behaviors using a five-point Likert Scale. The

mean PHBQ scores were significant at 4.46, on a scale of 1 to 5) in the clinic and hospital settings (Weaver, Walker, & Deganhart, 1993).

Results from Thom and The Stanford Trust Study Physicians (2001) using a modified 11-point Trust in Physicians Scale and PHBQ noted that the aforementioned communication behaviors were significantly associated with trust ($p<.001$) by using Pearson correlation coefficients. Patients ($N=414$) were surveyed about trust perceptions immediately after their visits and then surveyed again at 1 month ($r = 0.46$) and 6 month intervals ($r = 0.64$). The Wake Forrest study on trust (Hall et al., 2001) measured trust using Pearson (r) correlations to measure general trust in the physician and other variables, such as patient satisfaction. The 25-item survey was given to patients ($N=502$) via telephone, resulting in an overall score for interpersonal trust in specific physicians, $r = 0.31$ ($p=0.001$) and a reported mean ($M = 42.7$). The highest correlations in the overall scale came from two items that use the word "trust": "you completely trust doctors' decisions about which medical treatments are best" and "all in all, you have complete trust in doctors".

Satisfaction Survey

A separate survey was developed by East Tennessee State University Department of Family Medicine Interview Study Group (ISG) members to measure patient satisfaction (Appendix B). The satisfaction survey was administered in conjunction with the trust instrument for use in both the Trust and the Satisfaction studies. The satisfaction survey was measured using a nine-point Likert scale to increase sensitivity, with a score of one being the least satisfied and nine being significantly more satisfied. Question A of the satisfaction survey also addressed one of the communication behaviors that elicit

patient trust. Question A addressed comfort and caring on the part of the resident physician. The data gathered from question A were analyzed in conjunction with the trust survey to examine if there was a correlation between patient satisfaction and trust.

Instrumentation

Instruments used to measure patient trust were items combined from the Trust in Physicians and the more recently modified version, the Wake Forest Physician Trust Scale. In order to ascertain further the degree of trust that patients have in their physicians, items from the Humanistic Behaviors Questionnaire developed by the American Board of Internal Medicine were also used. The resulting trust survey, using a combination of the two above-mentioned instruments, was measured on a five-point Likert scale from strongly agree to strongly disagree to assess patient perceptions of physician behaviors that predict patient trust (Appendix A). For example, sample Physician Trust Scale statements included in the Trust survey were: "My doctor will do whatever it takes to get me all the care I need," gauging patient perceptions of the communication behavior of agency, and "I completely trust my doctor's decisions about what treatments will be good for me," gauging patient perceptions of physician honesty.

Three additional items to evaluate patient trust were developed by this researcher in cooperation with the Department of Family Medicine Interview Study Group to address the issues of patient perceptions of physician communication behaviors on patient compliance and to give further support to patient perceptions based on physician ethnicity. The three questions added to gauge patient perceptions of physician ethnicity and patient compliance were as follows:

- My doctor's country of origin is of no concern to me as long as I receive the care that I need. (physician ethnicity)
- Even if I can understand my doctor's accent, I might not trust that she/he is giving me adequate care. (physician ethnicity)
- Because I trust my doctor, I do everything possible to follow her/his recommendations. (compliance)

Design: Participant Selection

Following IRB approval to begin, the surveys were distributed by this researcher and another data collector engaged by East Tennessee State Family Medicine. Eligible subjects (N=162) were selected at a Northeast Tennessee Family Practice clinic over a 2-month period in the summer of 2005. Patients of eligible residents who were entering their second year (PGYII) and third year (PGYIII) of their residency were sought to be recruited for survey participation. Participants were selected in cooperation with the clinic office manager 24 hours prior to patient appointments to determine which patients were then to be approached and asked to volunteer. Patients who were not previously scheduled or with urgent medical needs were not included, nor were patients seeing the attending physician at the facility per the determination of the primary investigator of the research.

English speaking subjects over the age of 18 were recruited at the on-site facilities with patient demographics consisting of race and gender. The 5-10 minute self-report surveys were conducted on a volunteer basis from patients at the clinics for routine office visits and patients being seen by IMGs and non-IMG resident physicians who were at the PGY II and PGY III levels. The patient demographics collected included patient gender

and race as well as resident physician seen and if the patient was a new or an established patient at the clinic.

Survey Protocol

To eliminate any privacy concerns, patients were approached in the exam rooms before seeing the resident physician for the office visit and asked for consent participating in the study. One of two research assistants engaged for the study approached the individual subjects in alternating exam rooms and gave a brief outline of the trust and satisfaction studies being conducted. The subjects were informed that there was not to be any monetary compensation for their participation in the study, and consent was obtained following IRB requirements for approval of the study. Patients were informed that the research studies on Trust and Satisfaction were part of research for a master's thesis and also part of research being conducted by the Department of Family Medicine.

Post-visit, those patients who had given voluntary consent to participate in the survey were then escorted to a private area away from patient exam rooms where the surveys were completed. Consenting subjects who were unable to read due to visual or literacy challenges were read the surveys by one of the two research assistants. Each survey was then collected, noting the resident physician who had treated the patient, and then placed in a secure area within the office of primary investigator of the research project to await analysis.

A tally was calculated of resident physicians and the number of patients surveyed daily in an attempt to keep the number of patients surveyed for each resident as even as possible. Nine of the 12 PGY II and PGY III residents at the Johnson City clinic were

non-IMG physicians and the goal set was a minimum of seven patients surveyed for each resident (foreign-born IMG: N = 3, and American-born non-IMG: N = 9). This was done in order to increase the reliability of the results and to assist in addressing the factors of physician communication behaviors and particularly the factor of physician ethnicity. At the end of the survey time period, raw data were entered by a statistician from the Department of Family Medicine. At this juncture, this researcher was then able to run the statistical analysis pertinent to the Trust in Physicians study.

Data Analysis

In contrast to those prior studies conducted (e.g., Hall et al., 2002; Thom et al., 2001; Weaver et al., 1993), perceived patient trust levels were tested for any differences between IMG and non-IMG residents. The relationship between patient perceptions about physician communication behaviors and perceptions of trust in the physicians themselves were analyzed with SPSS 13.0 software (2004). Analysis consisted of independent t-test at ($p < .05$) significance level and bivariate analysis of Pearson's Correlation using ($p < .01$) significance level.

The communication behaviors previously identified as exhibiting comfort/caring, agency, competence, compassion, and honesty were tested via independent sample t-test with Levene's test for equality of variances (Table 1). While the main independent variables of interest in predicting patient perceptions of trust in the physician was the primary goal of this research project, there was also an assessment to see if there was a relationship between patients' perceived trust and satisfaction. Independent sample t-test with Levene's test for equality of variances was also used to examine if patients perceive any difference in patient perceptions of trust and satisfaction between IMG and non-IMG

resident physicians (Tables 2, 3). Lastly, a Pearson's Correlation was employed to examine whether or not patients' responses indicated a relationship between the variables of trust and satisfaction and patient compliance and trust.

CHAPTER 4

RESULTS

The analysis was divided into the following three sections: a) Twelve "Trust" items taken from the 'Trust in Physicians Scale' and 'Humanistic Behaviors Questionnaire' testing patients' perceptions for the communication behaviors of agency/fidelity, competence, honesty, comfort/caring, and compassion; b) two culture and one compliance statements; c) and one statement taken from the Satisfaction surveys testing comfort/caring.

A review of the research questions are as follows:

Do the following physician communication behaviors promote patient trust?

Q1. comfort/caring

Q2. *agency*

Q3. competence

Q4. compassion

Q5. honesty

Is physician country of origin associated with…?

Q6. patient trust in the physician

Q7. perception of satisfaction

Is patient trust correlated with…?

Q8. satisfaction

Q9. compliance

Do Physician Communication Behaviors Promote Patient Trust?

Research Questions 1-5 Results

The first hypothesis claimed that there was a significant difference in patient perceptions of communication behaviors denoting comfort/caring based on physician IMG status. With equal variance not assumed in patients [t (157) = 1.95, p = .06] the first hypothesis stating that there is a significant difference was rejected [IMG: M= 89, SD = 16.22] and [non-IMG: M = 79, SD = 27.11]. However, the second through fifth were supported: agency, competence, compassion, and honesty.

The second hypothesis stated that there was a significant difference in patient perceptions based on physician IMG status in the communication behavior denoting agency was supported [non-IMG: M= 88, SD = 11.53] and [IMG: M = 79, SD = 17.91] with patient perceptions of equal variance not assumed [t (160) = 2.46, p = .02]. There was also a significant difference in patient's reported perceptions between IMGs and non-IMGs resident physicians in the exhibited behavior denoting competence addressed in the third hypothesis. With equal variance not assumed with patients [t (160) = 2.91, p < .001] the third hypothesis was supported [non-IMG: M= 85, SD = 13.46] and [IMG: M = 75, SD = 17.91]. Patient perceptions indicated a significant difference in physician exhibited behavior denoting compassion between non-IMGs and IMGs, supporting the fourth hypothesis [non-IMG: M= 91, SD = 11.94] and [IMG: M = 80, SD = 20.70] with equal variance not assumed [t (160) = 2.68, p = .01]. Lastly, the patients' perceptions of physician exhibited behavior denoting honesty being significantly different between non-IMG and IMGs, [non-IMG: M= 88, SD = 14.09] and [IMG: M = 81, SD = 18.46] with equal variance assumed [t (160) = 2.27, p = .02] was also supported.

The research results of this study indicate that there is a significant difference in patient perceptions of trust in IMG and non-IMG resident physicians in exhibiting communication behaviors denoting agency, competence, compassion, and honesty as being indicators of patient trust in the physician with a mean difference no greater than 10. Conversely, the results of patient perceptions of resident physicians exhibiting the communication behavior of comfort/caring indicate that there is not a significant difference in patient trust levels for this particular behavior in the foreign-born IMG and the American-born non-IMG resident physicians (Tables 1, 2).

Research Questions 6-9 Results

The sixth hypothesis, stating that there was a significant difference in patient perceptions of trust levels between IMG and non-IMG residents was supported [non-IMG: M= 87, SD = 11.23] and [IMG: M = 78, SD = 16.38]. With equal variance not assumed in patients with [$t(160) = 2.80$, $p < .001$] (Tables 1, 2). The seventh hypothesis tested if there was a significant difference in patients' reported satisfaction between IMG and non-IMG residents [non-IMG: M =88, SD = 16.25] and [IMG: M = 77, SD = 24.88]. With equal variances not assumed with patients [$t(158) = 2.30$, $p = .03$] the seventh hypothesis was supported as well (Tables 1, 2).

The data supported that there was a relationship between patient trust and satisfaction with the physician. There was a significant correlation between trust and satisfaction [$r = .73$, $p < .01$]; therefore, the eighth hypothesis also was supported. The final hypothesis examined if there was a relationship between patient compliance and trust in the physician. There was a significant correlation between patient compliance and trust [$r = .53$, $p < .01$]; therefore, the ninth and final hypothesis was supported.

Table 1

Independent Samples

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Comfort/Caring	Equal variances assumed	19.306	.000	2.670	157	.008	10.21810	3.82701	2.65902	17.77717
	Equal variances not assumed			1.953	32.606	.059	10.21810	5.23140	-.43016	20.86635
Agency	Equal variances assumed	12.491	.001	3.237	160	.001	8.54680	2.64003	3.33300	13.76060
	Equal variances not assumed			2.460	33.234	.019	8.54680	3.47379	1.48120	15.61239
Competence	Equal variances assumed	4.133	.044	3.420	160	.001	9.95592	2.91119	4.20662	15.70523
	Equal variances not assumed			2.918	35.788	.006	9.95592	3.41211	3.03441	16.87744
Compassion	Equal variances assumed	8.737	.004	3.752	160	.000	10.67669	2.84527	5.05756	16.29582
	Equal variances not assumed			2.682	32.178	.011	10.67669	3.98138	2.56864	18.78475
Trust score (% of 55),11 items	Equal variances assumed	9.220	.003	3.558	160	.000	8.96552	2.51966	3.98943	13.94161
	Equal variances not assumed			2.806	33.962	.008	8.96552	3.19479	2.47266	15.45838
Satisfaction sco (% out of 72)	Equal variances assumed	10.257	.002	2.950	158	.004	10.84898	3.67744	3.58571	18.11225
	Equal variances not assumed			2.303	33.807	.028	10.84898	4.71054	1.27401	20.42395
Honesty	Equal variances assumed	3.122	.079	2.273	160	.024	6.96655	3.06477	.91393	13.01918
	Equal variances not assumed			1.914	35.451	.064	6.96655	3.63994	-.41955	14.35266

Table 2

Group Statistics

Group Statistics

	img	N	Mean	Std. Deviation	Std. Error Mean
Comfort/Caring	No	130	89.1453	16.22088	1.42266
	Yes	29	78.9272	27.11020	5.03424
Agency	No	133	87.8571	11.53528	1.00024
	Yes	29	79.3103	17.91469	3.32667
Competence	No	133	85.3008	13.46656	1.16770
	Yes	29	75.3448	17.26532	3.20609
Compassion	No	133	90.6767	11.94657	1.03590
	Yes	29	80.0000	20.70197	3.84426
Trust score	No	133	87.2727	11.23704	.97437
	Yes	29	78.3072	16.38477	3.04258
Satisfaction score	No	131	87.8605	16.25615	1.42031
	Yes	29	77.0115	24.18646	4.49131
Honesty	No	133	88.3459	14.09817	1.22247
	Yes	29	81.3793	18.46312	3.42851

CHAPTER 5

DISCUSSION

The research study on patient trust was guided by a modified trust model encompassing Type A dispositional, learnt, situational, and Type B dispositional trust in conjunction with survey items from both the 'Trust in Physicians Scale' (Anderson & Dedrick, 1999) and the Physicians Humanistic Behavior Questionnaire (American Board of Internal Medicine, 1989). The Trust in Physicians Scale was employed in previous independent research studies on patient trust levels (e.g. Wake Forest and Stanford) and found to be a valid indicator of patient perceptions of trust. A modified trust model added a final layer to the prior Dibben et al. (2000) model, adding Type B Dispositional Trust to complete the circle of trust that will theoretically become complete when a physician displays trust eliciting actions through use of the communication behaviors that denote comfort/caring, agency, competence, compassion, and honesty. Findings in this study of the patient reported behaviors exhibited by physicians denoting comfort/caring, agency, competence, compassion, and honesty are reliable indicators of trust in the physician based on previous research studies (Bonds et al., 2004; Emanuel & Dubler, 1995; Hall, 2001; Hall, Zheng, et al., 2002; Thom, 1997; Thom et al., 2001). As well, the PHBQ also supported the use of the same set of communication behaviors in predicting patient trust.

Patient reported responses of the physician communication behaviors exhibiting, agency, competence, compassion, and honesty indicated that there is a significant difference in patient perceptions of trust levels in the IMG and non-IMG resident physicians. As predicted, the majority of the communication behaviors that are believed

to elicit patient trust do have a bearing in the construction of a trusting patient/physician relationship in regards to resident physician IMG status. There is the exception of comfort/caring, however, in which survey participants (N =162) did not report a difference in perceptions between IMG and non-IMG resident physicians of this communication behavior. In summary, the Levene's test for equality of differences used to answer the first hypothesis addressing comfort/caring was rejected, while the second through fifth hypotheses addressing the patient reported patient communication behaviors denoting agency, competence, compassion, and honesty were all supported.

What Makes Comfort/Caring so Different?

One possible explanation for patient perceptions of the communication behavior denoting comfort/caring is that the type of communication training that non-IMG and IMG medical residents may have previously received in medical school. It may also be the type of residency program and environment that the IMG and non-IMG resident physicians are exposed to currently. The family practice residency program in this research study is based, in part, on residents developing adequate communication skills during their residency. Skills such as encouraging active listening, addressing patient feelings, and reaching "common ground" (i.e., establish a foundation of mutual understanding) between the resident and patient (Lang, McCord, & Anderson, 2004) are focused on in this particular program. Perhaps it is as Rotter (1967) argues in that rational expectations draw from two sources: specific expectancies and general expectancies. In reaching "common ground" comfort/caring might be suggesting that patients are comfortable and expect an unequal power differential between the physician and themselves due to the elevated profession. As Hofstede's (2003) dimensions of

culture and power distance indicate, when applied to the patient/physician relationship, a high power distance may be present akin to that of the teacher and the student (p. 79-83).

Knowing that interpersonal communication is a large part of developing rapport and a relationship between the patient and physician, each resident is required to take periodic communication exams called OSCEs (Objective Structured Clinical Exams). The OSCEs require the resident to apply a wide range of clinical skills to a simulated clinical case on which the resident is tested. The program includes several components and modules that all family practice residents must complete and pass before she/he finishes the residency requirements. By years three and four, resident physicians' have acquired the ability to develop rapport and reach common ground with patients (Lang et al., 2004). This ability is partially attributed to "standardized patients" (i.e., actors who portray patients during an interview and physical examination) who have been recruited by the Department of Family Medicine to aid in the development of resident physicians' communication skills;

This particular residency program is one that not only has a strong communication emphasis but also focuses on the on-going process of building patient/physician relationships. Because it is known that interpersonal communication emphasis for this program is strong in a number of areas, such as rapport building, addressing patient feelings, and active listening (Lang et al., 2004), this might have been a significant influence in determining patients' perception of no difference in comfort/caring between IMG and non-IMG resident physicians.

Foreign-born IMG and American-born non-IMG physicians will predictably bring their own personal views and beliefs to the hospital or clinic settings, whether they are

medical residents or long-practicing attending physicians. Patient reported perceptions of differences between foreign-born IMGs and non-IMGs in the study results for agency, competence, compassion, and honesty raises another question: Why do patients perceive IMG and non-IMG resident physicians differently when it comes to the four above mentioned communication behaviors when the training received by both the IMGs and non-IMGs (e.g., rapport building, active listening, OSCEs) are the same in the current residency program? There could be a number of possibilities to attribute the difference between non-IMGs and foreign-born IMGs when it comes to trust and satisfaction. Nevertheless, it should be noted that the communication training mentioned above does not include the type or amount of communication training received by these particular residents as part of their previous medical school curriculum and was an unknown element in this study.

The trust levels based on the communication behaviors denoting agency, competence, compassion, and honesty are supported by the sixth and seventh hypotheses indicating that there is a relationship between patient trust and patient satisfaction in regards to ethnicity/culture. The relationship could feasibly be rooted in a patient's prior ethnic or racial prejudices or it could perhaps simply come from a lack of cultural competence on the part of the patients surveyed. Nonetheless, if the results are indeed from lack of cultural competence, however subtle it may be, there will still be a negative impact on the patient/physician relationship. Another possibility may be from the difference in prior communication training, or lack thereof, in the training foreign-born IMGs received in medical school.

Whatever the cause(s) - prejudice, cultural competence, or differences in medical school communication training - they still present a barrier in building a relationship of trust. The aforementioned behaviors of comfort/caring, agency, competence, compassion, and honesty have been found to be valid indicators of patient trust in the physician. As well, it has also been proven statistically in this study that patients perceive lower levels of trust in the foreign-born IMG physician in general. Patient perceptions of ethnicity/culture and patient trust and satisfaction will need to be addressed in some manner if the foreign-born IMG is to build a thriving relationship with her/his patients. There has also been added support to the argument in a variety of research studies (Berger, 2004; Bonds et al., 2004; Conlee, Olvera, & Vagim, 1993; Hall, Camancho, et al., 2002; Krupat et al., 2001; Thom et al., 2002) that there is a significant relationship between patient levels of trust and satisfaction and a significant relationship between patient compliance and trust levels as addressed in eighth and ninth hypotheses.

As discussed, with the exception of comfort/caring, the communication behaviors denoting agency, competence, compassion, and honesty have been perceived by patients as being different between the non-IMG and IMG and reliable indicators of gauging patient trust. But, is there an underlying reason why patients report a significant difference between IMGs and non-IMGs for compassion, agency, competence, and honesty?

One explanation might be the difference between the low context communication styles displayed by the individualistic culture of Western-born residents and the high context communication exhibited by the collectivist culture of the Eastern-born IMGs. In the low context culture, meaning is found in words, whereas meaning in a high context

culture is expressed according to the situation and/or the relationship (Tsing-Toomey, 1992). In other words, the Western patient is more accustomed to the direct approach of open discussion, whereas the Eastern patient is more accustomed to the indirect method of communicating where certain things are just "understood" and accepted without overt discussion.

American-born non-IMGs have an advantage in communicating with patients because, for one, there is not normally a language barrier (other than geographically defined accents.) Therefore, they may find it "easier" to develop rapport with someone who shares the same language and in a larger sense, the same culture; whereas, foreign-born IMGs must not only bridge the language barrier but also the cultural barrier. However, one question remains to be answered: When comfort/caring are perceived by patients as being the same in the foreign-born IMG and non-IMG, why is it that the amount of that compassion is not similarly perceived when these two communication behaviors are very similar on the surface?

What of Compassion?

Patient perceptions of trust did indicate that there is a significant difference between foreign-born IMGs and American-born non-IMGs when it comes to compassion. By looking at select definitions of the words comfort, caring, and compassion, the differences seem minute. According to the Encarta Dictionary (2006):

> Compassion - sympathy for the suffering of others, often including a desire to help.

Comfort - somebody or something that provides relief from pain or anxiety.

Caring - 1. showing concern; 2. relating to profession looking after people; provision of medical or other types of care, either professionally or in general.

It could be argued then, by applying the above definitions, that patients might tend to perceive a physician's demonstrated comfort/caring as simply 'expected' by virtue of the professional role of those in the health care field (i.e., doctors and nurses) or associated with existing power differentials in the relationship. It may be assumed by patients that physicians exhibiting comfort/caring is to be expected in the same way as they expect to see many of those health-care professionals in lab coats or scrubs. Conversely, compassion may be interpreted on a much more personal level, where a connection between the two parties must be established and the physician overtly demonstrates sympathy and a desire to help the patient, which goes beyond what the patient would normally expect. The words, compassion, comfort, and caring share many synonyms, although two notable exceptions associated with compassion are 'sympathy' and 'empathy' – both of which are very personal behaviors that require one individual to have a certain degree of emotional intimacy with the other individual who is suffering. It may be concluded that the difference may rest in the ability of the American-born non-IMGs low-context communication norms, which allow them to freely exhibit sympathy and provide the patient with a sense of shared feelings, thereby creating a "connection" and gaining patient trust; something an IMG born to another ethnicity/culture and country may not feel as "free" or as "comfortable" doing because it is not part of her/his high context communication norms.

As already mentioned, there is evidence that suggests that patient race, ethnicity, and language have substantial influence on the quality of doctor-patient relationships, satisfaction, and patient compliance (Ferguson & Candib, 2002); therefore, it is a logical conclusion that physician culture and ethnicity are key factors in determining patient trust levels as well. If this is in fact the case, what can the IMG resident physician do to reduce and ultimately eliminate these barriers? In the case of the foreign-born IMG from an Eastern culture, the challenge is one of shifting from a culture that is 'high context' to one that is 'low context,' and a society where patients have been accustomed to a more open mode of communication (i.e., where non-verbal cues and actions, may at times speak louder than words). However, verbal cues remain of great importance; "When collectivistic people come to individualistic cultures, they should learn to share more information, to self-disclose, to seek information more openly, and to seek to reduce uncertainty more than they normally would" (Tsing-Toomey, 1992, sec. 31). Therefore, a shift in communication is not only necessary to create understanding between the resident physician and the patient, but also imperative to prevent an "interruption" in communication with the patient.

If there is an interruption in communication between the IMG and the patient (due to a lack of cultural knowledge), establishing trust may be delayed temporarily. But the IMG is not the only physician at risk for an interruption in communication to occur – the non-IMG may easily experience the same difficulties; an interruption in communication may occur at any time because communication is challenged in any newly formed or transient relationship (Bonds et al., 2004). This transient relationship can be best applied to many patient/physician relationships seen in medical residency

programs where PGYIII residents are regularly replaced by PGYIs. However, once PGYIII residents complete their residency programs and begin to establish their own medical practice, relationships tend to be long-term. It is then plausible to consider that although trust in an initial contact between the patient and physicians of differing cultures/ethnicities may, at times, be lower than the non-IMG physicians, it may ultimately be overcome in the relationship. As learnt trust becomes cemented through the ongoing relationship and the patient perceives satisfaction with the quality of care received, trust will occur.

As discussed, the modified trust model Type A and Type B dispositional trust is affected by learnt and situational trust; therefore, a patient who may have initial low trust levels will develop rapport and a relationship with an IMG resident physician who continually exhibits the behaviors of agency, competence, compassion, and honesty (Bonds et al., 2004; Emanuel & Dubler 1995; Hall, 2001; Hall, Zheng, et al., 2002; Thom, 1997; Thom et al., 2001). The five communication behaviors when exhibited ad infinitum will stand to have a positive impact upon the patient's Type B dispositional trust, ultimately improving the patient's overall health and compliance to treatment. Whether or not the lower levels of trust are results of general dispositional trust or Type B dispositional trust in an ongoing patient/IMG relationship remain to be examined in future studies.

As theorized by Leisen and Hyman (2004), trust increases as the relationship develops over time; the patients' situational trust levels are likely to increase as the IMG continues to exhibit communication behaviors believed to elicit trust. Patient trust is elicited through continued practice of these communication behaviors thereby predicting

an increase in patient trust levels. Theoretically, by following the modified Trust Model, both the foreign-born IMG and the American-born non-IMG exhibiting said behaviors, should lead to improving patients' perceptions of trust in physicians and ultimately improve the patients' overall health.

Limitations and Future Directions

There were four minor limitations to the trust study: First, the brevity of the research time and the inability of this researcher to do 3- and 6- month follow-ups of patient perceptions to follow continued patient/physician relationships. Second, it was not recognized pre-survey, and recorded, that there was a relatively large proportion of the patient population who were illiterate and had comprehension difficulties that may have possibly affected patient responses. Surveys were read out loud to a number (unrecorded) of participants; therefore, a social response bias might have occurred with participants answering questions of trust and ethnicity in the way they felt was socially "appropriate" instead of their own beliefs.

Third, due to the patient race demographics being over 92% Caucasian and approximately 7 % African American/Black, the results have the possibility of being skewed. Fourth, because the communication behavior of comfort/caring was not included on the five-point Likert scored trust survey but on a nine-point Likert scale on the satisfaction survey, there is a question in the reliability of results. That may be one explanation of patients' perceptions not indicating any significant difference in the amount of comfort/caring exhibited by either the foreign-born IMG or the American-born non-IMG resident physicians. Although it is unknown if this finding was an anomaly in the research due to the communication behavior of comfort/caring being part of the

satisfaction survey as opposed to the survey on patient trust, if the results were indeed reliable as tested, both IMGs and non-IMGs ability to exhibit the communication behavior of denoting comfort/caring creates a solid foundation for trust to be established. With comfort/caring as not being significantly different for the IMG and non-IMG this could feasibly encourage the IMG to practice the communication behaviors exhibiting agency, compassion, competence, and honesty to focus on changing patient attitudes and perceptions of situational and learnt trust toward physicians of differing cultures/ethnicities.

Future directions and areas for study, for interpersonal communication researchers would be to include a more extensive and long-term following of future patient/IMG relationship progression to assess if there is an increase in patient perceptions of Type B dispositional trust as rapport is developed as the IMG engages in trust-building communication behaviors. Second, future research should strive toward bringing in more minority patients as participants and also include the education and literacy levels of all future participants. Another area of interest for academic researches should include investigating qualitative aspects of patient perceptions of trust through patient interviews to determine, in order of relevance, how patients rank the five communication behaviors. Lastly, an attempt should be made to uncover why it is patients report no significant difference in comfort/caring communication behaviors exhibited by foreign-born IMGs and American- born non-IMGs but perceive a significant difference in regard to compassion.

Conclusion

A literature review on communication behaviors eliciting patient trust uncovered an area that had not been researched: the American patient's perception of trust in foreign-born international medical graduates. Of these foreign-born IMGs, physicians of Indian decent are by far the most prominent of the IMG physicians practicing in rural communities currently and this number is expected to increase. It is the conclusion of this researcher that the development of interpersonal communication between that of the foreign-born IMG resident physician and patient from differing cultures/ethnicities is of vast importance in our ever changing, multicultural medical marketplace. It is then crucial for those foreign-born IMGs to be equipped with adequate knowledge about the culture into which they have been immersed, so that each of these IMGs is better able to craft his/her communication behaviors to meet Western expectations of interpersonal interactions in the exam room on a day-to-day basis. With any learned communication behavior, the vast majority of foreign-born IMGs, will, over time, establish a productive relationship with their patients. However, the process will be expedited if the foreign-born IMG resident physician is equipped with the appropriate communication skills from the early stages of her/his medical training onward. The transition culturally from Eastern to Western patient expectations and needs will be far smoother for both the IMG and the patient if the communication behaviors of comfort/caring, agency, competence, compassion, and honesty are exhibited and rehearsed on a continuing basis. Once the practiced communication skills are learned, a foundation of trust may be established at an earlier point in the relationship and Type B dispositional trust may be cemented into the patient/physician relationship.

The significance of differences reported in patient perceptions of differences between foreign-born IMGs and American-born non-IMG in trust building behaviors denoting comfort/caring, agency, competence, compassion, and honesty needs further investigation. The results presented in this study were based on a moderate sample (N = 162) and it is recommended that longitudinal studies be executed to expand on the current research.

Although other researchers have made steps toward discovering what it is in a relationship that will elicit patient trust in the physician in regard to patient ethnicity, it has not focused on the relationship of trust between the American patient and the foreign-born IMG. Considering the ever-growing number of foreign-born IMGs practicing in rural communities of the U.S., it is a crucial area of study if cultural barriers to improving patient care can be overcome. However, one reality remains the same when it comes to improving overall patient health; no matter what country and culture a physician comes from, verbal and nonverbal communication behaviors that elicit patient trust will lead to the establishment of a healthy patient-physician relationship and improved patient health.

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APPENDICES

APPENDIX A

Trust Survey

Date _____

Physician today: _____

(Please circle one)

First visit with this physician: yes no

Are you: Male Female

Race:
Caucasian/White African American/Black Hispanic Asian Multiracial Other

Clinic location: Bristol Johnson City

Please circle the letter of the statement that most closely reflects how you feel.

1. My doctor will do whatever it takes to get me all the care I need.
    a) strongly agree
    b) agree
    c) don't know
    d) disagree
    e) strongly disagree

2. Sometimes my doctor cares more about what is convenient for him or her than about my medical needs.
    a) strongly agree
    b) agree
    c) don't know
    d) disagree
    e) strongly disagree

3. My doctor's medical skills are not as good as they should be.
    a) strongly agree
    b) agree
    c) don't know
    d) disagree
    e) strongly disagree

4. I completely trust my doctor's decisions about what treatments will be good for me.
    a) strongly agree
    b) agree
    c) don't know
    d) disagree
    e) strongly disagree

5. My doctor is totally honest in telling me about all the different treatment options available for my condition.
    a) strongly agree
    b) agree
    c) don't know
    d) disagree
    e) strongly disagree

6. Sometimes my doctor does not pay full attention to what I am trying to tell him or her.
    a) strongly agree
    b) agree
    c) don't know
    d) disagree
    e) strongly disagree

7. My doctor's country of origin is of no concern to me as long as I receive the care that I need.
    a) strongly agree
    b) agree
    c) don't know
    d) disagree
    e) strongly disagree

8. Although my doctor might speak with an accent I trust that she/he is giving me adequate care.
    a) strongly agree
    b) agree
    c) don't know
    d) disagree
    e) strongly disagree

9. Because I trust my doctor I do everything possible to follow her/his recommendations.
    a) strongly agree
    b) agree
    c) don't know
    d) disagree
    e) strongly disagree
10. My doctor takes time to discuss my concerns.
    a) strongly agree
    b) agree
    c) don't know
    d) disagree
    e) strongly disagree
11. My doctor encourages me.
    a) strongly agree

b) agree
c) don't know
d) disagree
e) strongly disagree

12. My doctor checks my progress.
a) strongly agree
b) agree
c) don't know
d) disagree
e) strongly disagree

13. My doctor encourages my questions.
a) strongly agree
b) agree
c) don't know
d) disagree
e) strongly disagree

14. My doctor answers me clearly.
a) strongly agree
b) agree
c) don't know
d) disagree
e) strongly disagree

APPENDIX B

Satisfaction Survey

Constructive Feedback from Patient to Physician

Getting constructive feedback from patients is one of the ways doctors improve. Your honest and thoughtful answers will help your doctor. The information will not be used in any negative ways to punish or find fault with your doctor. Thanks for your help.

Use the following scale in rating your doctor's performance in the following areas:

	On today's visit, the doctor named above:	9	8	7	6	5	4	3	2	1
A	Showed real concern for me. For example asked about me as a person, or praised me for what I knew or what I was doing.									
B	Encouraged me to bring up EACH AND EVERY ONE of my health concerns.									
C	Let me talk at my own pace and tell everything, rather than asking too many questions, too fast.									

D	Was VERY interested to find out my ideas about my condition. For example what I thought was going on, what was my greatest concern, what I expected from the visit.									
E	Said SPECIFIC things that let me know that my feelings are important.									
F	Explained things in words that I could easily understand.									
G	Really involved me in the development of a plan.									
My overall satisfaction with this doctor on this visit:										
What is/are the most important things that your doctor DID and should keep on doing?										
What is/are the most important things that your doctor should do differently or should do more often?										

VITA

LINDA E. BAMBINO

Personal Data: Date of birth: September 18, 1961

Place of Birth; Bristol, Tennessee

Marital Status: Widowed

Education: Public Schools, Bristol and Bluff City, Tennessee

Slater Center, CETA Adult Education, Bristol, Tennessee;
Licensed Practical Nurse, 1983

East Tennessee State University, Johnson City, Tennessee;
Public Relations, B.S.S.S., 2003

East Tennessee State University, Johnson City, Tennessee
Professional Communication, M.A., 2006

Professional Experience:

Nurse, Bristol Healthcare, Bristol, Tennessee 1983-1984

Nurse, Med-One Bristol, Tennessee 1984-1986

Nursing Manager, Doctor's Care, Johnson City, Tennessee 1986-1987, Med-One Bristol, Tennessee 1987-1988

Business Developmental Director, Med-Choice Kingsport, Tennessee 1988-1998

Educational Experience:

Public Relations Intern, Kingsport Area Chamber of Commerce, Kingsport, Tennessee, 2003

	Graduate Assistant, East Tennessee State University, Department of Communications, 2004-2005
	Research Assistant, Department of Rural and Community Health, East Tennessee State University, 2004
	Research Assistant, Department of Family Medicine, East Tennessee State University, 2005
Honors:	Dean's List (1998-2003)
	PHI Gamma Mu (Honors Society)
	Alpha Sigma Lambda (Honors Society)