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# A Guide to Patient-Provider Interactions in Women's Healthcare

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in Women's Healthcare

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BY

Emma Welton

**THESIS**

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Creative Thesis Project: A Guide to Patient-Provider Interactions in Women's Healthcare

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**PART ONE: Introduction**

**My Approach:**
It is nearly impossible to remain up-to-date on the newest articles. research and trends within a specific field. Most of us are not fortunate enough to spend a majority of our time simply perfecting our craft. In the medical field this remains truer than ever. Healthcare providers are in high demand between their patients. coworkers. and other administrative duties. It is possible that healthcare providers are missing opportunities to grow their expertise in regard to best practices for healthcare communication. particularly when communicating directly with patients. Providers see so many patients every day that it is difficult to attend to the diversity and breadth of communicative behaviors that exist.

This toolkit acknowledges that providers are spread thin. In response. it offers a compilation of health communication resources, broken down to provide the most important points for consideration without requiring providers to spend their time outside of patient care reviewing each of these areas of research in full. The toolkit also recommends communicative behaviors providers can incorporate in their daily practice without significantly extending the time spent with each patient.

**Intended Audience:**
This toolkit will assist any provider who interacts with young women ages 17-25. Nurses. nurse practitioners. doctors. and other individuals working in a healthcare setting will be able to glean practical recommendations from this toolkit. Women ages 17-25 are in an impressionable and transformative time in their lives. Some go to college. start working full-time. start a family. and many more possibilities. All young women have one thing in common – their bodies are evolving. and they may need some assistance understanding that evolution. Though the age range may be the same – these women are diverse. Women's perceptions of their bodies depend on many different factors such as age. education level. past experiences. support systems. socioeconomic status and personal histories. A nineteen-year-old woman in her sophomore year of college may have a much different understanding of her body than a nineteen-year-old mother working full-time. Additionally. not everyone is at the same level of health literacy. We must acknowledge the different background and experiences of the patients that impact their literacy level. To assume each woman is starting at the same level would be a disservice to the patients. Interactions between patient and provider are vital to a patient's overall health and well-being and must take into account these complex factors. This toolkit was made with the providers who see women aged 17-15 in mind. but it is not restricted to that age group. Recommendations found in this document are applicable to providers working in women's healthcare.

**My Background:**
I have a professional and personal interest in health communication. In the past few years. I have completed a bachelor's degree in Communication Studies with a focus in Corporate Communication. This allowed me to take many courses in communication while learning the workings of organizational communicative behaviors and the impact

they have. More recently, I have been pursuing my master's degree in Communication Studies in Interpersonal Communication Processes. I have been able to focus my interests specifically on health communication. I also served as a Health Promotion Coordinator on my university's campus where I had first-hand experience educating college-aged women on a wide variety of topics such as nutrition, sleep, and sexual health. I taught courses to students where they were able to ask questions and learn evidence-based information. I am currently working in the prevention field as an Assistant Director for alcohol, other drug and violence prevention in higher education. This opportunity allows me to work with the professionals who deal with this toolkit's target audience such as university clinic, counselors, health educators and many more fields related to health and wellness in higher education. Throughout these years I have become interested in health communication, but a five year struggle with communication in women's healthcare interactions of my own while dealing with personal health issues has driven my interest and turned it into a passion. I am hoping to contribute to the conversations regarding women's healthcare in college-aged women.

**Strengths of This Toolkit:**
This toolkit offers current and relevant research and recommendations from communication scholars. It is a resource that is built with the best practices for communication between providers and patients. It looks at these interactions through a communicative lens, which will allow for providers to blend their expertise with relevant communication functions. This toolkit will assist care providers with realistic practices that will benefit both patient and provider. The toolkit is designed to promote discussion and guide a clinic comprised of different healthcare workers such as doctors, nurse practitioners, and nurses to be able to take these recommendations and apply tangible alterations to their daily practices. I respectfully created this toolkit while being mindful of a provider's schedule. Healthcare providers are extremely busy with their patients, research, administrative duties and personal lives. Because of this, the toolkit will be succinct and insightful. It will leave providers with tangible tasks to implement. By doing so, providers will gain innovative ways to interact with patients.

**PART TWO: Understanding Health Literacy**

The Patient Protection and Affordable Care Act (2010) states health literacy is defined as the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions.

It is usually thought that health literacy is in regard to the patient. What they know, what they can understand, and how they are able to communicate their concerns, etc. However, health literacy does not completely fall on the shoulders of the patient. It is important for providers to maintain a health literate healthcare organization. The Institute of Medicine (2012) compiled ten attributes that sustain a health literate healthcare organization:

1. Has leadership that makes health literacy vital to its mission, structure, and operations.

2. Incorporates health literacy into planning, evaluations, patient safety, and quality improvement.
3. Prepares the workforce to be health literate and monitor progress.
4. Keeps the audience in mind when designing, implementing, and evaluating health information and services.
5. Satisfies the target audience with health literacy skills while avoiding stigmatizing.
6. Implements health literacy strategies in interpersonal communication interactions and confirms understanding from all patients.
7. Facilitates access to health information and services.
8. Creates all media content that is easy to comprehend.
9. Addresses health literacy in high-risk situations.
10. Communicates financial conversations with audience.

Let's look at these ten attributes more closely to see how each can result in concrete actions on the part of the healthcare organization and providers themselves.

First, a healthcare organization needs leadership that makes health literacy vital to its mission, structure, and operations. Organizations need to consider the following recommendations:

- Create a culture that values the patient's perspective and emphasizes the importance of a dialogue between patient and provider with equally important roles.
    - One way to work towards this would be to create a credible and evidence-based way to attain feedback from the patients regarding their perspective of the clinic's practices and culture.
    - Most healthcare organizations already use patient surveys, however, I recommend putting more of an emphasis on the patient's perception of their provider's interpersonal skills because this is an important component of overall patient satisfaction.
        - Surveys should assess the provider's ease of communication, clarity, and empathy.
    - Some typical survey questions follow. These utilize Likert scale responses: excellent – good – fair -- poor:
        - The comfort of the examining rooms.
        - The courtesy of the staff.
        - The amount of time spent with the provider.
        - The communication with your provider.
        - The quality of care you received during your visit.
    - These are not "bad" questions, but it is possible to use other survey questions to attain detailed information about communication that can be useful for the organization.
    - The American Board of Internal Medicine constructed questions that target the patient's perception of the provider's effective communication skills. Some of these questions include – Does your provider:

- Treat you like you are on the same level and never talk down to you?
- Let you tell your story while listening careful and offering choices?
- Ask you for your opinion?
- Encourage you to ask questions while answering them clearly without lecturing?
  - These questions can be answered on the same four point scale as the prior questions, but they will address the provider's interpersonal communication skills rather than answering one question that combines all the communicative interactions between patient and provider.
  - These questions may be intimidating to ask of patients due to how the patients will respond. However, it is beneficial to gain this information regarding patient and provider communication.
  - o Lastly, these surveys are useless until you have a team dedicated to using the collected data to improve the overall patient experience.
- Form a committee with individuals who focus on health literacy within that organization.
  - o Compile this group with members who hold different positions within the clinic. This will allow for a diverse committee with lived experiences that can contribute to the success of the committee.
- Consider your workplace atmosphere and make changes if needed to maintain a space where patients are able to quickly locate resources and relax as much as possible in this typically stressful situation.
  - o Be mindful of the educational resources, magazines, and tv channels that are all being displayed throughout the clinic. Information that is displayed on these mediums can be common knowledge for some and confusing or intimidating for others. Every woman in that waiting room will be coming from a different background and that will impact the way they perceive these messages that are displayed. Also, design a space that supports effective communication. This can be done by allocating space for certain circumstances, such as private and quiet rooms for counseling or support away from exam rooms.
  - o Every detail must be appropriate from start to finish for the patient. For example, I recently visited a women's health clinic for a scheduled appointment and there was a television in the waiting room. This is common, but the show that was being played was off putting. *Dr. G: Medical Examiner* was playing with the sound on. This dramatized medical show follows a doctor as she performs autopsies on the deceased. Even though it is dramatized, I do not believe that a show that is detailing a person's death and autopsies is appropriate for the waiting room.

Second, healthcare organizations should incorporate health literacy into planning, evaluations, patient safety, and quality improvement by considering the following recommendations:

- Incorporate health literacy into all planning activities.
  - Be mindful of patients' differing levels of literacy when creating a campaign or promotional materials.
  - The previously mentioned committee, tasked with focusing on health literacy, would be a great asset to assist in this.
- Make resources readily available to patients in different environments
  - For example, I was in an OBGYN examining room that had a wall with 15-20 different brochures on various topics including birth control methods, menopause, pregnancy, HPV, etc. Having these resources in the exam rooms allows for women to grab them before or after the exam while they are alone in case they are afraid that others may see them, which can deter them from doing it in the public waiting room.
- Continuously collect data to measure successful health literacy practices.
  - This is a task that should be assigned to the committee mentioned above.
  - Incorporate questions on the patient satisfaction surveys that relate to the resources that are available for the patients.
  - Look at handouts/brochures/flyers that patients see. Request feedback on their effectiveness and make changes based off of that feedback.
  - This could be done on a quarterly basis.
- Pay attention to what is not working and make note of it for the future.
  - Being able to reflect on what works and what does not is crucial to this process. Allocate time during staff meetings to reflect on the successes and areas for improvement.

Third, healthcare organizations should prepare their workforce to understand and identify health literacy and monitor progress by considering the following recommendations. Below are tips to ensure that healthcare workers are able to understand health literacy as it relates to patients. These points will help them identify literacy levels of patients and know how to respond accordingly.

- Create a diverse work team.
  - Build a staff made up of diverse individuals. This will allow for staff members to learn from one another.
- Partake in health literacy training.
  - Consider adding literacy training to in-service or staff meetings as well.
- Consider adding health literacy training into orientation for new employees.
  - Individuals, who are new to your clinic, or the profession itself, can benefit by learning from providers who have been in the field and have treated these individuals. Helping new employees be able to identify a patient's health literacy will benefit the provider and patient.

Fourth, keep the audience in mind when designing, implementing, and evaluating health information and services.

- Ask for feedback and listen to patients.
  - If a patient discloses that a certain provider or employee made them feel uncomfortable, then you should pay attention to this. Look further into the situation. It is possible that the patient was confused or there was

miscommunication, but it should not be pushed to the side. On the other hand, if you have a patient who is praising to staff for their friendly culture and informative ways, this should also be shared with the rest of the staff. Celebrate what is positive and follow up with the criticisms to maximize patient satisfaction.

- Consider forming a coalition with the community.
    - o  Community coalitions can be positive for everyone involved. This will allow for collaboration between your organization and the community. Community members will bring a variety of diverse perspectives to the table. Be sure to include community members who work with the target population, such as those involved with health and wellness organizations in a campus town.
    - o  Reaching out to the closest higher education institution can increase the diversity in this coalition. Consider contacting professional and peer health educators, majors and faculty in health-related programs such as health communication, health studies, etc. These individuals will be an asset because they are a part of the target audience or work closely with that audience. They will be able to offer an important perspective.

Fifth, healthcare organizations should satisfy the target audience with health literacy skills while avoiding stigmatizing.
- Create an environment that is welcoming and does not require high levels of health literacy.
- Avoid using jargon on any patient handouts or posters.

Sixth, health organizations should implement health literacy strategies in interpersonal communication interactions and confirm understanding from all patients.
- Foster an environment that understands the importance of every interaction.
- Allow time for each interaction.
- Question patients about preferred communication practices.
    - o  If your office utilizes various communication mediums, you may want to ask the patients what their preferred method is. Individuals may prefer email, phone calls, or texts as mediums of communication for different instances. This information can be collected at the patient's first visit and logged in their charts. Information like appointment reminders, test results, and provider recommendations may be best with different outlets. For example, receiving text message reminders for appointments is my preference, but I tell my providers that they can leave test results on a voicemail. It is a good idea for patients to be able to give their preferences if you have the resources to do so.
- Make no assumptions about a patient's prior health knowledge.
    - o  Be cautious of assuming that patients know about a certain health issue because they have experienced it. For instance, a woman who has had reoccurring yeast infections is not an expert because of this. Assuming that she knows what to do and what to avoid could harm the overall health of

that patient. Attempt to cover all bases while avoiding condescending phrases such as, "you do know that…" or "you are supposed to be doing…"

- Be mindful of information overload.
    - o Pay attention to the patient's expressions and body language. If they start to look overwhelmed with the information you are giving them, then you may want to consider slowing down or asking questions such as "did that make sense to you?" or "am I moving too fast?" Use your best judgement and keep in mind that patients may not have the courage to speak up and tell you to slow down.
- Use your interactions with patients as learning opportunities for both you and the patient. Get to know the patient so that you can better assess their level of health literacy. Without patronizing the patient by "dumbing down" information too much or insulting their lack of understanding, make sure you leave every interaction having answered all questions and providing any information necessary for the patient's continued growth, self-management, and decision-making. Patients should always leave feeling informed and empowered.
- Also keep in mind that you don't have to know every answer to every question the patient may have. If you don't know the answer, be honest with the patient and direct them to resources that can help them further.

Seventh, healthcare organizations should facilitate access to health information and services.
- Facilitate the patient's visit by having helpful directions and maps of the organization.
- Train the staff to effectively assist patients in directions throughout the clinic and the building. Make sure exists and receptionists are easy to locate and walk them to the desired location if need be.
- Help patients and their families understand healthcare benefits.
    - o Have an updated list of resources available.
    - o Collaborate with other departments if you are located in a large organization and be aware of the resources that are available for patients in the community.

Eighth, healthcare organizations should make all media content easy to comprehend.
- Think of educational materials as an addition to in-person communication.
    - o Educational brochures are beneficial to the patient and serve a purpose. However, they do not replace interpersonal interactions between patient and provider. These educational materials can be the take aways of the interaction. Important dates and facts may be listed in them for vaccines or birth control methods, but it is the provider's job to lead them in the right direction. Educational materials are not as useful if the providers are not supplying additional information and connection with the patient to make sure the materials are right for them.
    - o In my experience, I have had a provider communicate with me and offer her expertise and her suggestions, and she also printed off credible articles

regarding the topic and research that has been completed. She first assessed my health literacy level by learning about my educational background, listening to my past experiences, and asking me what I know about the condition. Credible sources with medical terminology were appropriate for me because I expressed my literacy level during our interaction. If the provider would have just handed me a printout referencing research without communicating with me to assess my literacy level, then I could have been confused or intimidated by the material.

- Maintain up to date educational materials.
  - ○ Up to date materials are important because the patient will view anything they receive from the provider as accurate, evidence-based, and reliable.
- Seek feedback on educational materials from individuals with different levels of health literacy.
  - ○ Consider giving the patient a few minutes to look over the material while they are in the office and ask follow up questions to assess their understanding. Or, ask them for their feedback when they return. They will be able to tell you if they found it useful or if it was too difficult to understand.

Ninth, healthcare organizations should address health literacy in high-risk situations.
- Realize that certain topics may require more attention and time.
  - ○ Topics that are commonly misconstrued may require more attention. For example, STIs and the fact that 80% of people who contract one have no symptoms, is not common knowledge. It is widely assumed that individuals who contract an STI experience itching, burning, or discomfort. This is a great learning opportunity for the patient and it may require extra time to discuss.
- Send patients home with easy to understand materials.
  - ○ Give hand outs and educational material that are appropriate for that patient as stated above. This is important because patients may feel overwhelmed during the interaction. This allows for them to go home and decompress before referencing the materials, but also stops them from looking at unreliable sources, such as certain places on the internet.
- Assist the patient in coming up with a plan.
  - ○ Realize that they may need assistance with how to move forward after leaving the interaction with the provider.

Tenth, healthcare organizations should communicate financial conversations with audience.
- Provide easy to understand information regarding coverage and benefits. If you are unsure of the answer – direct them to someone for help.
  - ○ This is just as important as knowing the answer yourself. It's okay to not have all of the answers as long as you can refer them to someone who can help.

One of the most crucial considerations for the providers of young women is to acknowledge the demographics of these patients. Young women are going through many life transitions. Providers must remember that it might be the first time the patient has been to see a provider without their guardian accompanying them or they may be so consumed by obligations that their mental health is suffering.

Even the most eloquent patient can struggle under certain circumstances. Certain circumstances, such as a new diagnosis. can leave any patient feeling overwhelmed and anxious regardless of their education or literacy level.

The perceived health literacy of the patient can be skewed if they are experiencing these feelings. Remember that these interactions may be second nature to a provider, but it can be new territory for young women. Uncertainty and other emotions accompany individuals when they are doing something that is out of their norm. Overall, avoid jumping to conclusions about the patient's literacy, because they may be experiencing high levels of anxiety. In turn, this can cause them to seem less literate or confident in themselves.

Think back to a time when you experienced issues when communicating or receiving health information. This does not mean that you were ignorant, yet you potentially felt that way due to the language being used within the situation. Overall, it is best to use simple and clear language to avoid misunderstanding.

Below is a list of potential red flags that may communicate a low literacy level:
- Incomplete or misprinted registration forms
- Missed appointments
- Non-compliance with medications and recommendations
- Asks fewer questions
- Unable to give a descriptive and coherent history

It is important to note that the list above is not claiming health literacy causes the flagged behaviors. Rather, it allows us to make a more educated assessment of a patient's health literacy level by looking for these indicators. which are frequently correlated with health literacy. Health literacy impacts so many aspects of patient/provider interactions. This is a theme that will be evident throughout this toolkit.

*Activity: Compile your most utilized educational materials (handouts, flyers, brochures, etc.) and analyze them by checking these five elements (See Pfizer Principles for Clear Health Communication, 2004 for more information):*
- *Explain the purpose of the document from the patients' viewpoint.*
- *Focus on the desired patient behavior change and describe tangible actions that the patient could take.*
- *Use common words with an active voice that is read as if the voice is talking to someone.*
- *Make the material visually pleasing and less intimidating by leaving white space, contrast, and cues to key points.*

- *Use realistic graphics that are appropriate for the target audience with captions that clarify the point.*

*This will allow you and your cohort to ensure that these materials are easy to comprehend for a wide range of literacy levels. If your materials do not follow these guidelines, then you may want to alter them to ensure that all patients will understand the information. Patients typically will read these materials when they are at home, so they will need to be able to understand the information without a provider explaining it to them.*

## PART THREE: Tips for In-Person Interactions

In addition to literacy level, there are additional aspects related to the patient-provider interaction that can be improved upon (see Buckman, 2010 for additional information).

Tips for one-on-one patient communication:

- Greet the patient so that they will feel comfortable.
  - Shaking the patient's hand is recommended. This is a personal choice, but it can help the patient feel that you are making an effort to connect with them.
  - Using the patient's name at the beginning of the interaction can also help to connect with them. It is also good practice to ensure that you are seeing the right patient and didn't enter the wrong exam room.
  - Introduce yourself to the patient.

- Try to remain at eye level with the patient.
  - This will help the patient feel more comfortable. If they are sitting and the provider is standing, they may perceive that the provider will not be spending much time with them. Standing should be fine if the patient is sitting on the high exam table. Patients will occasionally be seated in the normal height chair before the provider enters the room, so the provider should sit if possible so they are not towering over them.

- Write things down for patients instead of listing things off.
  - Listing off names of over the counter medications or products to buy, steps in which to use a topical medication, or potential ideas for future treatment can confuse the patient and cause them to not retain the information that is given to them. Limiting this confusion by writing information down for the patient can benefit both the provider and the patient. This will reduce the likelihood that the patient will forget information and incorrectly follow recommendations or need to call the provider's office for clarity after the fact. Another option would be providing paper and a writing utensil to the patient during the interaction. The patient may not have thought to bring one or was too shy to ask – providing these tools can allow for the patient to leave the visit feeling competent with the information the provider has given them.

- A personal anecdote
  - Recently, a provider was listing dos and don'ts for me and I began to panic because I hadn't written anything down. I asked her if I could grab my phone to take notes, and to my benefit she said that she would type everything in my visit summary and send me home with a copy. This helped me lower my anxiety and allowed me to be present with the provider rather than scrambling to take notes.
- Use language to connect with the patient rather than creating a divide.
  - Try and use plain language as much as possible while still getting the point across. One way to do this is to add emphasis on points that demand a great deal of attention. It is important that patients get all of the information they need, but it will be beneficial for the patient if the providers reiterate the most important information by verbally telling them what is crucial to their treatment. For example, it is important to tell a woman who is being treated for a UTI and currently taking birth control pills for contraception that the antibiotics may cause diarrhea or throw off the patient's balance of bacteria thus causing a yeast infection. However, it might be more vital that the provider emphasize the effect of antibiotics on birth control. This information may be common knowledge to those working in the health field, and especially women's healthcare, but it might be unheard of by the patient. This is a prime example why we cannot assume a patient' health literacy level.

- Use empathic responses.
  - This is a way to acknowledge a patient's emotions in a fast and easy manner with a three step response. It lets the patient know that you are paying attention to their portrayed emotions throughout the conversation. Follow these steps:
    1. Identify one of the emotions.
       There is no answer key when it comes to human displays of emotions. We all show anger, fear, distress, or denial in different variations of body language, facial expressions, and words. However, one emotion should be chosen and focused on. Let's say that you told a patient that they have a STI and they begin to cry. Crying may be the most evident emotion if they are not verbalizing their feelings. Pick the emotion that you are most certain is taking place and name it in your head. For example, "this patient is upset" and this will be helpful for the rest of the response.
    2. Identify the cause of the emotion.
       It is likely that the emotion was caused by something you had just said. A topic that was addressed and elicits the emotion should be what you focus on next. Providers must assume that this is the cause of the emotion because it is impossible to know if it is something outside of the interaction.
    3. Respond in a way that shows you have made the connection between step 1 and 2.

Verbalize to the patient that you have made the connection between what was said and the emotion it provoked. Empathetic responses will typically address that the provider can empathize with the patient by stating the connection between the two pieces.

o Some empathetic response examples include:
"This is obviously a big shock"
"I can see this is upsetting for you"
"I know that this is scary for you"
"I know this isn't what you wanted to hear"

o Responses to avoid:
"Don't worry"
"You don't need to panic"
"It's not that bad"

o Using an empathetic response will let that patient know that you are taking their feelings seriously. Normalizing the patient's interaction will show them that you are not judging them. Telling the patient to "calm down" would show the patient that you think they are overreacting. This also allows the patient a platform to feel these emotions. Acknowledging the emotion and its cause will show that you are willing to talk with this patient and be there for them. Bringing up the emotion will help you to redirect the conversation from the diagnosis to the patient and how they feel at this moment as a reaction to the diagnosis. Providers who don't try and acknowledge the patient's feelings may be perceived by the patient as rude or cold.

*Activity: Implement steps to create an effective action plan during the patient interaction (See the Implementation Guide for Patient-Centered Interactions. 2013. for additional information.)*

*These steps will be helpful when interacting with a patient. This will allow you to remain focused on the goal. Also. it will provide clear details for the patient throughout the interaction. Below are the steps to use when facilitating conversations.*

Let's say there is a young woman who comes in and is having concerns or questions about her current birth control method she is using. She is currently on the pill. but wants to learn more about other options that do not require daily attention (the shot. patch. IUD. Nuva Ring) etc. The patient expresses interest in the shot and you decided to give further information. Use the steps below to create an action plan for this interaction.

**Step 1**: Base the plan on a collaboratively set goal with the patient. This goal should be something the patient wants to do and motivates them.
**Step 2:** Make sure behaviors mentioned are specific.
**Step 3:** Define every detail (what. where. when. and how much or often.)
**Step 4:** Anticipate barriers or push back.

**Step 5:** Assess the confidence of the patient in completing the plan and adjust if need be.

You will need to define a clear goal, give specific behavior information regarding the shot, unpack every detail (such as the amount of time in between shots), explain the potential side effects and any hesitation that these may cause, and communicate with the patient to assess their confidence in the new method to ensure satisfaction.

For instance: There is a patient who repeatedly comes in with the same set of symptoms. This includes vaginal pain upon urination and moderate physical activity. Tests have concluded that there is no bacterial or viral issue. So, this patient needs a care plan to continue searching for relief.

**Step 1:** Communicate the desire to help the patient reach the goal of finding relief for the pain she is experiencing. Clarify that this is the goal that the patient wants to achieve.
**Step 2:** Offer the patient specific behaviors that they can partake in such as applying a cool wet towel that can assist in immediate relief.
**Step 3:** Be sure to use specifics when offering recommendations. Say "be sure to use unscented soaps and laundry detergent, wear only cotton underwear with the white cloth on the inside, and do not use any feminine products that say they are made for vaginal issues such as *Rephresh*" rather than saying, "Do not use anything that could irritate the skin."
**Step 4:** A patient who has been seen repeatedly with few conclusive results may resist any new ideas because they feel discouraged. Anticipate this reaction and be able to elaborate on the importance of trying new things to find answers.
**Step 5:** Ask the patient if they understand the action plan and adjust certain steps if they are not confident.

## PART FOUR: The Role of Stigma on Self-Perceptions of the Patient

The interaction is an important piece of women's overall healthcare. Negative experiences can be detrimental to a healthy patient/provider relationship (DuPre, 2017). These negative interactions can induce stress and anxiety, which leads to the individual not partaking in preventive care. Patients who have a negative experience are likely to find another provider or quit treatment completely. Patients need to be satisfied with their visit so that they will cooperate with recommendations and follow-up.

As a professional in the medical field, medical jargon, diagnoses, and other serious health concerns become second nature. It is quite common to become desensitized to certain topics. If a provider has seen 15-20 patients a day, there is a good possibility that they have seen the same condition and diagnosis multiple times. This makes it more likely that providers will normalize the interactions that most people outside of the medical field would deem difficult conversations.

Patients, on the other hand, may have never thought about the information that you are delivering to them. Topics such as sexually transmitted infections (STIs), menstruation, and less common conditions, are not everyday topics for them.

STIs are a very sensitive topic regardless of how common they are. Women in our target patient population, ages 17-25, may be uneducated on sexual health as a result of their prior education system. Because of this, having a provider bring up a potential diagnosis of an STI can be damaging to the patient's overall health and self-perception. In this case, it is best to educate the patient without information overload. Depending on the patient's literacy level it may be best to wait until test results can confirm or deny conditions. Consider this patient/provider interaction that took place with a 19 year old junior in college:

*Provider: So, what seems to be the issue?*
*Patient: I've been experiencing a burning pain.*
*Provider: Can you tell me a little more?*
*Patient: When urinating, it burns and there's a sharp pain.*
*Provider: OK. How often?*
*Patient: Always – but there are days better than others.*
*Provider: Are you sexually active?*
*Patient: Yes.*
*Provider: It sounds like a potential herpes case.*
*But that's not a sure thing. Let's take a look.*

Nonchalantly mentioning a diagnosis that sounds scary and stigmatizing to the patient can cause extreme fear and anxiety. Discussing this type of diagnosis without any proof will impact the patient's self-perception. The stigma that is attached to STIs can be more hurtful than the condition itself. This is a product of the narrative that STIs happen to promiscuous people, and that those who have them are considered dirty. The patient in this interaction started to feel automatically judged and that the assumptions being made about her followed this narrative. Let's continue with the interaction that occurred during the examination:

*Provider: Yep, this right here. Does it hurt?*
*Patient: No – that has been there forever.*
*Provider: Well, there's a possibility you've had it longer.*
*Patient: Are you sure? That's not where the pain is.*
*Provider: I will swab to test. But I'm positive. What pharmacy do you use?*
*Patient: CVS. (cries with loss of breath).*
*Provider: Nothing to be sad about. It's like a canker sore in your mouth.*
*Very common. I'll call you with the results. Pick up your Acyclovir.*

The patient in the scenario above fell into the mindset that society tends to hold regarding sexual health. She began to blame and question herself. When test results came back normal the provider still insisted that this was the correct diagnosis and attributed the negative test to a faulty swab. Because of this, the patient sought a new provider, who was able to assure her through multiple blood tests that Herpes was not the correct diagnosis. The patient in this real-life example is still impacted by her experience years later.

This scenario would have been a perfect time for the provider to use an empathetic response, as was discussed earlier. Saying it is very common did not address the emotion that the patient was feeling. Instead, the provider could have said, "I can see that this is very upsetting to you" and continued acknowledging the patient's emotions.

A routine appointment that this provider experienced daily can have a lasting effect on the patient. In this moment, the patient was terrified, confused, and overwhelmed. This provider diagnosed the condition without testing, did not listen to the patient, who stated that what the provider was pointing out had been painless and permanent, and continued to discredit the patient.

The likely explanation for this provider's behavior relates to the assumptions that are made of young women. Because she was young and a college student, she was likely stereotyped as a promiscuous teen who is partaking in risky sexual behaviors. Stereotypes and assumptions about young women and sexual promiscuity increase the chances of a potential misdiagnosis.

Some providers' remarks may indicate judgement or opinions. Providers who convey judgement may not mean to come from a negative place but end up having a negative lasting effect on the patient. Stigma is something that we all fall victim to, and healthcare providers are not immune. Stigmas surrounding women's healthcare are a driving force in the spread of misinformation and affect patient care and wellbeing.

Stigma occurs in interpersonal process where an individual, or group, is divided from others and is connected with a negative evaluation due to conceptions that may be real or perceived (Crocker, Major & Steele, 1998). The stigma surrounding sexually transmitted infections is a barrier for prevention and treatment. Two types of stigma are typically seen within this group of individuals (Corrigan & Penn, 1999) Perceived stigma involves the fear of attitudes and discrimination that can come from others based of a particular trait. Self-stigma is the negative attitudes that an individual will feel regarding themselves. Self-stigma stems from the views that society holds on the trait. Popular culture is filled with jokes and references to sexually transmitted infections that leave those with infections feeling shameful and isolated. Individuals who have contracted one, or fear that they may have, will internalize the negative stigma.

STIs are stereotypically associated with being dirty, promiscuous, or lesser than those who do not have one, so it is important to acknowledge that this is the misconception that most women will be equipped with prior to speaking with a provider. Here is where providers have a chance to make the most out of a negative situation. Knowledge is power, especially when it comes to the human body, and these women who come in scared or ashamed need someone to empathize with them while delivering accurate facts without judgement. Many of these infections are curable, and all symptoms are treatable, yet the stigmatization of these infections has a lasting impact on the views of the individuals that contract them. Stereotypes can have negative impacts on the patients when discussing these issues with a provider. They can ultimately affect the patient's

trust in the provider, her own self-worth, and her views of medical professionals in general, including whether she will seek help in the future.

Providers must find a balance when using their past experiences with patients that allows the provider to merge these experiences with the current patient's condition. Ascribing a patient's issues to past experiences where other patients who have encountered similar symptoms can be damaging to the relationship and overall health success. This can create tunnel vision for the provider where they are not open to what the patient is saying but instead engage in selective perception, only seeking confirmation of existing biases.

To eliminate this tunnel vision, try starting out the interaction with the patient by asking them to describe the exact issues they are having at that moment, to avoid any clouded judgement due to their medical history and your own presumptions.

For example, a woman who has been feeling pain and discomfort in the vaginal area for over five years will have a lot to say with all of the providers she has been to prior. However, discussing past treatments or diagnoses may negatively impact the provider's thoughts of that patient. Instead of the patient starting with when the issue started, every treatment they have tried, and other concerns, the patient should share exactly what they are feeling at that moment. Medical history of the patient is still important, but may impact the provider's lens.

*Here are some tips for conducting these complex conversations (See the National Coalition for Sexual Health for additional information):*
- *Avoid assumptions about the patient based on age, appearance, expected literacy level, or any other factor.*
- *Rephrase a question or describe the reasoning behind the question if the patient seems uneasy.*
- *Be aware of your own nonverbals.*
  - *If you are uncomfortable discussing these topics, the patient will be also.*
  - *Try to look relaxed. Trying to look calm and in control of the situation can help the interaction even if you are not relaxed.*
  - *The neutral body posture is a concept that many providers use. You put your feet flat on the floor, with ankles and knees together and hands palm down on your lap. This will avoid signals of anxiety or defensive.*

## PART FIVE: Best Practices for Complex Cases

Countless women seek treatment for urinary tract infections (UTIs) and yeast infections each year. These conditions are simple in the sense that there are blatant symptoms that the women will experience and there are tests to easily diagnose them. However, not every case is so simple. This section is dedicated to those hard-to-crack cases where there is no simple answer. Sometimes, patients present symptoms or issues that are not easy to diagnose. Their symptoms may be similar to a condition, but it is not exactly the same. Here, providers must be able to find a healthy balance between using their past experiences and the patient's words to drive the interaction. It is crucial to listen to the

patient as they are the experts of their body. It is possible that a woman is experiencing a common issue, but is not able to communicate this effectively because of her health literacy level. If this is the case the interaction will need additional time to unpack what the woman is experiencing and to gather crucial information to create a plan.

There are also many conditions that are quite common, but not commonly discussed. Endometriosis and Vulvodynia are two examples of conditions that affect millions of women, but can take years to diagnose and treat. Many women with pelvic pain report difficulty communicating their symptoms and experiences to their gynecologists. They leave their appointments feeling more uncertain and disappointed than they were prior. Hoffmann and Tarzian (2003) state that some of the women in their study reported that they were given over thirty different diagnoses to explain their cause of pain, but some providers would tell the patient that there is nothing wrong with them because no cause could be identified.

Below is a list of recommendations for dealing with the patient in these cases:
- Give the patient the right amount of information.
  - Give enough information to reduce uncertainty, but not too much to overload the patient. Consider their literacy level.
  - Ask them how much information they would like to know during that visit may help the patient avoiding being overloaded.
- Believe patients.
  - If all tests are coming back negative and the patient is still experiencing pain or discomfort – believe them.
- Don't attribute the issue to things that are completely out of their control.
  - Example: Saying stress must be the cause of the issue.
  - The stress is most likely worsening the condition, but this will not benefit the patient. Most stressors, such as school, work, personal issues, and this mystery condition itself, are inevitable and cannot be voluntarily stopped.
- If there is suspected psychological or emotional distress – ask questions.
  - Do not suggest this to them without any additional information or plans. Be sure to offer assistance or a solution for this. Consider a referral rather than just saying, "This could be caused because of the anxiety you are experiencing" This will cause more anxiety.
- Think outside the box.
  - If a patient seems to still be suffering, then they will most likely be open to any suggestion or idea – no matter how "crazy" it is.
- Know when to say you cannot help.
  - Once you have done everything within your scope of knowledge you must know when it is time to tell the patient.
  - It is extremely difficult as a patient to hear a provider say that they cannot help you. However, admitting that to yourself and the patient will benefit both parties. Be sure to offer suggestions with practical solutions.
  - Referring the patient out may be the best option for the patient at this point.
- Be empathetic.

- o Research shows how impactful empathy from the provider can be to women who are suffering from chronic conditions (see Kim, Kaplowitz, and Johnson 2004).
- o Assuring the patient that these conditions, such as endometriosis or vulvodynia, are not as uncommon as society makes it seem.
- o Unfortunately, most patients with these issues have to find different ways to help themselves as there is no one quick fix.
- o Talk long term prognosis and plans with the patient.

In cases such as these, providers may have a difficult time with these conversations. Below are two typical reasons why giving bad news may be difficult (For additional information see Buckman, 2010).

- Delivering bad news can provoke strong emotions from the patient. These emotional reactions may be an uncomfortable interaction that leaves the provider feeling helpless. Nonpsychiatric specialties have limited training in dealing with patients' emotions, so emotional interactions may be difficult.

- A feeling of professional failure may become apparent when giving bad news or realizing that you are not able to help your patient. As stated before, it is important to know when you must tell the patient that you are out of ideas for solutions. It is likely that providers will feel a sense of failure when they are met with a condition that is incurable or unfixable. Logically, providers know that they are doing everything they can to give the patient the best care possible. There is a fear that many providers experience because they think that there may be another provider out there with the answer.

*Activity: Practice these conversations with colleagues. These conversations can be difficult to conduct, but it is important to conceal those feelings and make the patient think you are comfortable. Practicing with a colleague, or even in the mirror, can help you feel more comfortable, become aware of your body language during the conversation, and ensure that you are perceived as empathetic. These conversations may not happen every day, so practicing these difficult or uncomfortable conversations can assist in authentic interactions with patients. Practicing ways of asking appropriate questions to assess if the patient is experiencing emotional distress, for example, can help providers be aware of their communication and what works and what does not.*

## PART SIX: Promoting Self-Advocacy among Patients

If a patient has a high health literacy level, then there is a fair chance that they will also be an effective self-advocate. According to DuPre (2017), self-advocacy includes seeking information and being comfortable talking about health issues. Self-advocates are typically well educated and feel confident in their knowledge. The patient's demographic and socioeconomic status can complicate the patient's likelihood of being a self-advocate. It is important for women to find their voice when they are in this transitional life stage. A society that assists young females in achieving a fundamental understanding

of their bodies' physical functions and allows them access to information will form women that are able to be self-advocates in their own healthcare.

Patients are often intimidated by communicating with providers. They typically have more education and experience than the patient, and are seen as experts. With this being said, patients can be intimidated and afraid to sound ignorant or to embarrass themselves by sharing information. It is also difficult for patients to ask questions because they are afraid to be judged.

For example, a woman who is experiencing pain will call her women's healthcare provider and schedule an appointment. In the meantime, that patient may try researching the symptoms on her own. The patient could potentially do helpful research with credible information. It is also possible that the patient will type the symptoms into Google.com and take the first thing that pops up as truth. This will depend on that patient's literacy level.

We should never discourage patients from looking for information and answers for themselves. Making patients feel ashamed of this will result in them not sharing details, potentially looking for a new provider, or relying on the research they find without consulting their provider. Instead, guiding the patient on how to conduct credible research is something providers should be doing. Warn the patients of the potential dangers of looking in the wrong places for medical information and recommend places where credible information can be found.

*Activity: Take advantage of this teachable moment. This may be done in an in-service/staff meeting, between different small groups/departments etc.*

*Create a list of credible sources (webpages, support groups, books) for the patient to get their information. This is especially crucial for the women who are suffering with the conditions that are not mainstreamed. Be sure to acknowledge that they should never self-diagnose based off of the information on these sites. Instead, teach them to use these resources to their benefit by reading about other's experiences and potentially finding new ways to manage pain or discomfort.*

## PART SEVEN: A Piece of the Puzzle

Women's healthcare providers have a wonderful opportunity to contribute to young women's well-being and development. Providers are helping these women through transitional stages in their lives such as puberty, menstruation, and pregnancy. We know that communication is crucial regardless of the condition of the patient. It guides the interactions and can help you to understand the patient, which creates or strengthens a connection between you and allows for positive care outcomes. Historically, the provider's job was to deliver a correct diagnosis and cure whatever was ailing the patient. However, we have learned of the importance of effective communication in the healthcare process. Patient's perspectives and emotions are being taken into consideration now more than ever before. Trust between the patient and provider is important and can

be built through positive interactions that incorporate some of the behaviors that were discussed throughout this toolkit.

Young women experience significant uncertainty during these transitional years. Providers who see these patients are able to ease unfortunate circumstances or reduce uncertainty through their interactions. Offering a space where young women can receive compassionate and consistent care will lessen one burden that they may experience.

I say these closing remarks with certainty because I am one of these women. I've had terrible experiences with providers. I've left an interaction feeling alone, judged, and furious. I have also met some of the most respectful and invested providers who have sustained my faith in myself and my health, which has led me to not give up in my search for answers regarding my personal health issues. Many parts of my experience have been scary, but having a provider that cheers me on and guides me through these challenges has nurtured my passion for sharing information about effective communication with others in healthcare. Looking at the patient-provider interaction using a communicative lens has allowed for the collaboration of practical medicine and effective communication functions. I respect providers who dedicate their lives' work to women's healthcare and I have met so many individuals in the field who have touched my life in a positive way. Many professionals would spend an hour with each patient if they could; however, this is not possible in most clinics. Thus, we have to work within the system that we have of seeing many patients a day and make the time as useful as possible. Hopefully, this toolkit will serve as a guide or starting point for providers and their cohort. We all must work with the resources that are available and produce the best outcome that we can. This toolkit combines research and recommendations fueled by communication scholars and healthcare organizations to bring providers suggestions and best practices for patient/provider communication.

References

Buckman, R. (2010). *Practical plans for difficult conversations in medicine: Strategies that work in breaking bad news.* Baltimore: John Hopkins University Press.

Corrigan, P. W. & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American psychologist. 59* (9), 765-776.

Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In D. T. Gilbert & S. T. Fiske (Eds.). *The handbook of social psychology* pp. 504-553. Boston, MA: McGraw Hill.

DuPre, A. (2017). *Communication about health: current issues and perspectives.* New York, NY: Oxford University Press.

Hoffmann, D., & Tarzian, A. (2003). The girl who cried pain: a bias against women in the treatment of pain. *Journal of law, medicine, and ethics. 29*(3), 13-27.

Kim, S. S., Kaplowitz, S., & Johnson, M. V. (2004). The effects of physician empathy on patient satisfaction and compliance. *Evaluation & the Health Professions. 27*(3), 237-251. DOI: 10.1177/0163278704267037

National coalition for sexual health. (2016) *Sexual health and your patients: A provider's guide.* Washington, DC: Altarum Institute.

Office of the Legislative Counsel (2010). *Compilation of patient protection and affordable care act.* Retrieved from http://housedocs.house.gov/energycommerce/ppacacon.pdf

Pfizer. (2007). *Pfizer clear health communication program.* Retrieved from www.pfizerhealthliteracy.com/physicians-providers/chc-principles.html

Safety net medical home initiative. (2013). *Implementation guide: Patient-centered interactions engaging patients in health and healthcare.* Retrieved from http://www.safetynetmedicalhome.org/sites/default/files/implementation-guide-patient-centered-interactions.pdf

The Institute of Medicine. (2012). *Ten attributes of health literate health care organizations.* Retrieved from https://nam.edu/wpcontent/uploads/2015/06/BPH_Ten_HLit_Attributes.pdf

**Academic Reflection Paper**

**A Guide to Patient-Provider Interactions in Women's Healthcare**

Remaining current with the newest research in one's field is complicated for individuals regardless of their profession. We are all stretched thin within our professions, with multiple responsibilities and never as much time as we would like. In the health fields, providers must divide their time between seeing patients, assisting colleagues, engaging in continuing education, and other administrative duties. Because of the immense responsibilities placed on healthcare providers, their education is most heavily focused on the medical and scientific aspects of their professions, with communication unfortunately falling by the wayside. For example, while medical schools are beginning to recognize the importance of health communication, they also struggle to find ways to incorporate communication training into their already full curricula. du Pre (2017) states that for providers already in the field, their continuing education and review of new research again most commonly focuses on scientific developments in their field. Communication, because it is so commonplace and because providers are strained for time, tends not to receive significant attention in any of these educational contexts. Yet we know that interactions between patients and providers significantly impact patients' overall health outcomes.

Because of this, I have created a toolkit that addresses the need for effective communication between patients and providers while offering practical recommendations that can be applied within the healthcare setting. This toolkit was created in an attempt to respect the limited amount of time healthcare providers have to review research. It condenses the most useful health communication resources and recommendations that

providers can incorporate into their daily work before, during, or after the patient visit. These realistic recommendations are designed to alter behaviors within the patient interaction without significantly increasing the time spent with each individual patient.

This resource was created for any provider who works with young women ages 17-25. Women during this age are in a transformative time of their lives, encountering various turning points as they transition from teenager to adult. For example, some are starting college and are experiencing independence for the first time, working a full-time job, or starting a family of their own. One thing that these women have in common is that their bodies are experiencing change due to menstruation, puberty, hormones, or pregnancy. Poleshuck and Woods (2014) say that the transitional stages of a woman's life, like puberty and pregnancy, are transformative periods for young women who are new to the experience. These periods can become complicated by various acts such as, trauma, fertility issues, uncommon conditions, and stigmas associated with sexually transmitted infections. With these complex issues there is a need for extended care that reaches outside of the biomedical sphere.

These instances call for more of a biopsychosocial approach to healthcare. George Engel (1977) looks at the need for this change in medicine. The biomedical model focuses on physical bodily health, drawing a demarcation between mind and body, and viewing health as the complete absence of identifiable attributes of illness like disease, pain, or defect. In contrast, the biopsychosocial model recognizes the importance of biological, psychological, and social ideologies in human health. Here, the concept of health is balanced between these three areas. In the more uncommon and complex instances in women's healthcare, like trauma and stigmatization, the biopsychosocial

model is one that must be utilized but still remains absent in many patient – provider encounters.

While young men at this age are also experiencing transformation and transition. they do not typically engage with the healthcare system at the same rate as young women. Due to the need for birth control. screening for pelvic cancers. and the medicalization of other processes related to the maturing female body. women are socialized to and expected to begin seeing their doctors regularly at this age. Because women in this transitional period of life are engaging more frequently with healthcare providers. providers should be versed in best practices for communicating about topics that are of concern to this important patient demographic.

Women of this age group may be experiencing some common concerns. but may perceive and experience those concerns in different ways due to their divergent backgrounds. Women's perceptions of their health depend on many factors such as age. race and ethnicity. education level. socioeconomic status. and the value systems they espouse. So. while this toolkit will provide recommendations for best practices. it is important to acknowledge that women. even within a particular generation. will not all have the same experiences and should not be treated as though they do. Another contributing factor for how patients perceive and experience their health is health literacy.  All of the aforementioned factors (age. race. education. etc.) can have an effect on the patient's health literacy.  In other words. the patient's ability to access. understand. and make educated decisions based upon relevant health information is influenced by numerous personal factors and. in turn. influences her participation in the healthcare process. In fact. research points to health literacy as a better predictor of patient health

outcomes than any other single socio-demographic factor (Council of Scientific Affairs, American Medical Association, 1999). Both this paper and the toolkit take care to acknowledge the importance of understanding health literacy and assessing a patient's individual communicative needs based on various factors, including health literacy.

The toolkit offers relevant research and recommendations from a communicative approach. It has been built with the best practices for interactions between patients and providers. This will allow the providers to merge their expertise with relevant communication elements. In addition to being able to read the toolkit on their own, a goal of this toolkit is to promote discussions within the clinic setting where a group of colleagues can work together to set organizational goals and improve organizational practices while also working on their individual communicative behaviors.

The effectiveness of patient provider interactions is crucial for overall success in healthcare. And negative interactions are detrimental to a healthy doctor-patient relationship. Overall, patient satisfaction with a provider predicts whether they continue care from that provider. In a study conducted by Woolley, Kane, Hughes and Wright (2004), patient satisfaction was predicted by four variables: patient expectation, the continuity of care, satisfaction with outcome and doctor-patient communication. Retention rates of the providers can be linked to the patients' satisfaction with their experiences. The patients' experience also influences whether a woman will continue to seek treatment. du Pre (2017) discusses how patients who have a negative experience may stop seeking treatment and not seek out another provider. Patients who are stigmatized or have negative experiences are likely to distrust and fear the healthcare system. Therefore, they are less likely to follow a provider's recommendation. Also, they

experience more stress and do not partake in preventive care. which can lead to negative health outcomes.

An article by Diane Hoffmann and Anita Tarzian (2003) delivers a compelling argument about how western medicine discounts female pain expression. Healthcare providers are trained to rely on objective evidence of disease or injury. However, the subjective nature of pain or discomfort means providers must trust and respect the patient. Stereotypes or assumptions about women and their behavior add to the undertreatment and distrust. Hoffmann and Tarzian found that women with pelvic pain reported difficulty communicating their symptoms and experiences with their gynecologist. They would leave the appointment feeling more uncertain and disappointed than they were prior. Some of the women reported that they were given over thirty different diagnoses to explain their cause of pain. but some providers would tell the patient that there is nothing wrong with them because no cause could be identified. More than half of the women in the study reported feeling that the doctor was not taking their pain seriously. Also. many of these women were diagnosed with histrionic disorder. which is characterized by excessive emotional and attention seeking behavior. These findings are consistent with many studies that report female patients are less likely to be taken seriously than their male counterparts.

The book *Our Bodies. Ourselves* (Swenson. 1998) discusses the many factors that predict the overall success of patient treatment. Research shows that the patient's trust. stress level. likelihood of disclosure and follow-up with a provider have a great impact on the success of treatment. One way that providers can ease anxiety while working to eliminate assumptions about the patient is to take each patient's unique perspective into

consideration. Providers can discover important aspects of a patient when looking past their medical chart. They must acknowledge that patients are made unique by their own personal experiences as well as their sociocultural experiences related to gender, class, race, and religion. Recognizing the importance of all aspects of a patient's identity leads to a greater likelihood of holistically understanding the patient and better assessing her concerns.

It is not realistic to ask a provider to spend more time with patients because that may not be an option, but we can tailor our preparation and conversations with patients to attain the necessary information and contribute to success of the treatment. Using an empathetic response, as Buckman mentioned his book (2010), will allow for providers to concentrate on one of the emotions that a patient is feeling during the interaction and assist them accordingly. Validating their feelings and avoiding common phrases such as, "don't worry, it's not that bad" will show them that you are not belittling their concerns. Buckman (2010) claims that something as simple as changing our language when we try to comfort a patient who has been given difficult news can increase the patient's trust and likelihood of follow up with the provider.

Sandra Harding a prominent theorist of Standpoint Theory, focuses on the importance of acknowledging that an individual's perspective is informed by their social and political experiences (Harding, 2004). The theory discusses the notion that less powerful members of society have different realities than those with more power. Oppressed or marginalized members have their own perspective while having to account for the perspective of those in the dominant groups as well. Thus, Standpoint Theory claims that the oppressed have a sharper and less biased view of social reality. This

becomes important when we acknowledge the power difference inherent in healthcare interactions between patients and providers. Doctors, due to their education, socioeconomic status, and place in the social and professional hierarchy, are typically perceived as having more power than their patients. However, according to Standpoint Theory, the privileged social position of doctors relative to their patients may result in a clouded or less clear understanding of their patients' lived realities.

Harding (2004) states that medical and health research are concerned with preserving life, easing pain, or treatments that are parallel to individuals' values. However, the cultural or religious values of some providers may defy this way of thinking. For example, providers who do not personally agree or support abortions should still treat each patient with the patient's personal values in mind. Also, Rocque and Leanza (2015) state that women of the LGBTQA+ community have reported being the targets of rude or inappropriate remarks by providers regarding their sexual orientations. These patients feel as though their values and beliefs have been judged or dismissed in the healthcare setting. For example, a provider who is a member of a religion that does not support the LGBTQA+ community may create a hostile environment for a patient where they feel their care is at stake. Harding points out that this does not mean that we should give up on researching or helping others with differing values.

Swigonski (1994) discusses how standpoint theory involves paying attention to an individual's social location. In provider and patient interactions, especially in women's healthcare, patients may be lumped into categories based on their diagnosis or symptoms without much attention to their standpoint. Objectivity, a central focus of most providers trained in modern western medicine, is a concept that views facts as independent of

cultural, gendered, or social assumptions. In the world of medicine, there is an emphasis on data and test results to determine a plan for a patient's treatments. However, Swigonski concluded that information about the patient's standpoint may shed light on aspects of the patient's needs and care that would not have otherwise been considered. This ultimately improves the care plan for the patient and the patient-provider relationship by increasing the provider's understanding of the patient's lived experience and therefore enhancing trust and rapport with the patient.

The standpoint of the patient comes into play when assessing the patient's health literacy level. Providers must facilitate interactions with patients that will leave the patient feeling valued. The toolkit places emphasis on health literacy and ways to assess it. Also, it offers suggestions on how to interact with individuals based on their literacy level. Recommendations for the clinic, educational materials, and in-person interactions can be found throughout the document that will offer providers an insight from an individual with personal experience and a communication studies background. The toolkit focuses on health literacy because much of the interaction is influenced by what the patient is capable of comprehending. A patient that has a low literacy level may not understand the conversation, feel comfortable asking questions, or follow the provider's recommendations if the provider is not aware of the gaps in understanding and does not address them as necessary.

Research reviewed above highlights the viewpoint of individuals of a different race or sexual orientation, for example. The interactions with patients are highly situational. Because of this, the toolkit is composed of best practices that I believe will help providers with interactions with a diverse patient pool. I was able to incorporate my

perception and experiences as a woman who frequently visits women's healthcare

providers in the toolkit. However, it is important to note that my standpoint is not

inclusive of every other woman in the target audience of ages 17-25.

Another key feature that aids in the analysis of patient-provider interactions in

women's healthcare is looking at how women's bodies have been medicalized through

history. To define medicalization, Conrad and Schneider (1980) state that medicalization

occurs when a social situation or an experience that an individual has personally is

constructed into a medical issue that requires attention from a medical professional. One

concrete example where this occurs is experiences women have before, during, and after

their menstrual cycles. In Carol Tavris' (1992) book titled, *The Mismeasure of Woman*,

Tavris discusses how the physiological changes women experience throughout their cycle

vary and variations in pain and discomfort are completely normal, do not require medical

intervention, and are not in any way related to them being moody or irritable, as it has

been socially constructed.

Tavris also claims that this association with cycles women go through, such as

menopause and menstruation, constructs the dominant discourse that women's

physiology is othered in society, faulty, and abnormal. Also, it contributes to the idea that

females are designed entirely for reproduction. When the female body is perceived as

failing at these tasks, such as with infertility, this is considered a problem that has been

socially constructed as devastating, causing women to feel lesser than females who are

fertile. Women have also been dismissed or accused of psychosomatic whining in the

eyes of society and medical professionals in the past. Yet the medicalization and socially

constructed abnormalities experienced by women precipitate their increased usage of the

healthcare system. This medicalization also influences the way providers view their patients' concerns and the way those concerns are discussed during patient provider interactions. Providers fall prey to socially constructed stigmas in the same way laypersons do. Tavris points out that the moods or attitudes that are associated with women's hormones depend on many more factors than menstruation, including expectations, personal history, situational factors, and immediate issues. Tavris states that it is beneficial to empower women to understand the changes that occur with their bodies. Thus the toolkit addresses the importance of patient empowerment and of providers utilizing greater sensitivity when discussing socially stigmatized topics with patients.

Oudshoorn (1994) also emphasizes the social construction to which the female body has been subjected. She states that the constructs are defined through scientific research and that scientific facts are formed in a social context and become embedded in popular beliefs throughout society. However, health professionals lack attribution to these social constructs when discussing women's bodies. The topic of sexually transmitted infections is a prime example of these socially constructed perceptions of women's and sexual health. Many of these infections are curable, and all symptoms are treatable, yet the stigmatization of these infections has a lasting impact on the views of the individuals that contract them. These social constructs can have negative impacts on the patients when discussing these issues with a medical professional. They can ultimately affect the patient's trust in the provider, her own self-worth, and her views of medical professionals in general, including whether she will seek help in the future.

Offman and Kleinplatz (2004) examine how a list of symptoms women experience in their menstrual cycle had been labeled as Premenstrual Dysphoric Disorder

(PMDD) and argued that PMDD is a socially constructed diagnosis rather than a psychiatric disorder. They claim that the issue that exists with PMDD is not the women that report emotional shifts, but the diagnosis itself. Diagnosis of a condition defines the condition, defines what it is not, and attaches meaning to it. This idea of the diagnosis being the issue relates to Oudshoorn's (1994) discussion of social constructionism. The naming of PMDD allowed women's personal experiences of menstrual-related instances to be marginalized, negated, or labeled as abnormal.

The medicalization of women's bodies and the discourse surrounding women's health has shaped society's views of menstruation and all of women's reproductive health. Beausang and Razor (2000) talk about how young girls are heavily influenced by societal beliefs that menstruation is linked to negative physical effects and emotional instability. A society that assists young females in achieving a fundamental understanding of their bodies' physical functions and allows them access to information will form women who are able to be self-advocates in their own healthcare. Having medical professionals that offer support, information, and empathy will improve the provision of biopsychosocial care that will result in overall health and wellness rather than biomedical care, which focuses only on the acute physiological outcomes.

The toolkit addresses how discussions can be perceived by the patient as dismissive or nonchalant, which can upset the patient. It is important for providers to acknowledge the social constructs and stigmas in regards to the female body. For example, sexually transmitted infections are common and providers may be faced with having conversations about them on a daily basis. However, a discussion regarding STIs can be shocking to a young woman who may have never had any education on the topic

prior to the interaction. Some patients may experience anxiety when interacting with a provider and the mention of STIs may be enough to upset the patient further. Because it is a sensitive subject for some, providers must be mindful of our presence and difference in perspective during the interaction.

The toolkit also discusses the impact of nonverbals and how to better them throughout the patient provider interaction. These small alterations can allow the patient to become more comfortable, which will assist the provider in the discussion. Any medical issues related to sexual activities and the genitalia are perceived by our society as being shameful, dirty, or negative in some way. Because of this, the topics regarding sexual health are avoided throughout our society. A provider has a special opportunity to educate the patient and breakdown common myths regarding sexual health. There is a good chance that the patient will be under the same impression that society holds about STIs and sexual health, so it is crucial that a provider handles the interaction with care by using the recommendations in the toolkit.

Edley and Battaglia (2016) unpack some of women's health concerns, such as chronic pain from endometriosis or vulvodynia; issues that women face that often become invisible to others, including medical professionals. They proclaim that women with ongoing or chronic conditions can only fully comprehend their identities and relationship with their healthcare through taking action in treatment and disclosure of their experiences. Edley and Battaglia (2016) urge communication scholars to create an open dialogue around illness, so that we may "coalesce over shared meaning, synthesize, and emphasize" (Edley & Battaglia, 2016, p. 45). Communication scholars, compassionate medical professionals, and allies give voice to those who are dismissed by

societal norms, social constructs, and members of the health field. Women are able to construct their identities and find empowerment through these interactions, which increases both public understanding and tolerance for those living with women's health conditions.

Swenson (1998) states that the relationship existing between a female patient and a provider illustrates inequality on many levels. There is a power imbalance that exists in many client-based professions. This is more evident in a male provider/female patient instance in women's healthcare, but also exists female to female. Racial and social class differences of the patient-provider relationship are not dismissed when considering the power distance in these relationships. In a relationship, such as that of patient and doctor, where women are perceived as less powerful based on characteristics such as education, age or race, they will evaluate the situation in regards of their own behavior rather than the provider's. This means that the female patient is more likely to consider the knowledge gap or the miscommunication her fault. For example, if the provider is using medical terminology and jargon that the woman cannot clearly understand, then the woman may feel inadequate or intimidated. Swenson (1998) claims that this will result in the patient not speaking up and asking for clarification or limiting disclosure of information that is relevant to her healthcare. This is linked to the discourse, as mentioned previously, that providers are superior, experts, and not to be questioned.

Interactions with patients may become so routine to a provider that the provider may not be aware of their use of problematic language or other behaviors. Thus, the toolkit provides information on how to handle situations where the patient may perceive that there is a power struggle or that they are not being valued. Perceived empathy from

the provider can allow women to express their true feelings without hesitation or judgement. This is particularly important for the women who have complex cases or seem to be repeat visitors due to some persistent or chronic health issue. The toolkit offers activities and suggestions for clinics to implement that will bridge the gap between patient and provider while encouraging patient advocacy. For instance, it is suggested that the providers compile a list of credible resources that patients can use to acquire information regarding women's health topics. Listing credible websites, books, or other resources on birth control options or vulvodynia, for example, can benefit the interaction in two ways: it allows the provider to use this as a teachable moment and instill advocacy by offering resources that can be reached at any time from the comfort of their home and it gives them reputable sources to avoid looking in places with false information or scare tactics. The information in this document will benefit both the patient and the provider by working towards an effective interaction, which leads to over health success.

Overall, there is significant evidence of the need for adequate and effective communication from provider to patient in women's healthcare. The experience of the patient will impact their overall satisfaction, their likelihood to follow up, and their trust of the provider. The standpoint and health literacy of a woman that is seeking healthcare is something that must not be dismissed. Also, it is crucial to understand how the medicalization of women's bodies has negatively impacted society's perceptions of women, their normal physiology, and their interactions with providers.

This toolkit addresses the greater need for understand and improved patient/provider communication in women's healthcare. It targets women's healthcare providers who treat young individuals ages 17-25. It will benefit health professionals

because it is a succinct document with research-based realistic suggestions that take the provider's busy schedules into consideration. This toolkit is not a step-by-step manual; however, it does offer suggestions that should be implemented when appropriate. Clinics have different resources, staff, and funds that may alter the likelihood of these practices being used. Keeping this in mind I aimed to keep most suggestions time sensitive and inexpensive. The content covered in each section displays the importance of the topic and practical suggestions for implementation.

Women's healthcare providers have the opportunity to assist the women that they treat in their development and health maintenance. These women are going through transitional stages of their lives, which can cause uncertainty, confusion, and discouragement. Providers can guide these women through situations such as menstruation, pregnancy, and puberty in a way that offers comfort and empathy while maintaining the care and treatment of the patient. Effective communication is important in the healthcare process. The perspective of the patient and her emotions must be valued during the interaction. This will lead to the patient trusting the provider. The patient will be more likely to understand the provider who has met them at their literacy level, feel comfortable enough to ask follow up questions, and be more likely to listen and follow the provider's recommendations. My personal experiences as a young woman who repeatedly has these interactions with providers started my passion for health communication. I've had good and bad experiences, which led me to the creation of this toolkit. Looking at the patient/provider interaction using a communicative lens has allowed me to apply effective communication functions to practical medicine. We must

collaboratively use the resources that are available to produce positive and effective

interactions between patients and providers to achieve the goal of overall health.

References

Beausang, C., & Razor, A. (2000). Young western women's experiences of menarche and menstruation. *Healthcare for women international. 21*(3), 517-528.

Buckman, R. (2010). Practical plans for difficult conversations in medicine: Strategies that work in breaking bad news. Baltimore: John Hopkins University Press.

Conrad, P., & Schneider, J. (1980). *Deviance and medicalization: From badness to sickness.* St Louis, MO: C.V. Mosby.

Council of Scientific Affairs (Feb 10, 1999). Report of the Ad Hoc Committee on Health Literacy for the Council on Scientific Affairs, AMA. Journal of the American Medical Association.

du Pre, A. (2017). *Communication about health: current issues and perspectives.* New York, NY: Oxford University Press.

Edley, P. P., & Battaglia, J. E. (2016). Dying of dismissal: An autoethnographic journey of chronic illness, feminist agency, and health advocacy. Women & Language. 39(1), 33-48. Retrieved from https://www.womenandlanguage.org

Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. *Science 196*(4218), 129-136. DOI: 10.1126/science.847460

Harding, S. (2004). Introduction: Standpoint theory as a site of political, philosophic, and scientific debate. In S. Harding (Ed.). The feminist standpoint theory reader: Intellectual and political controversies (1-20) New York: Routledge.

Hoffmann, D., & Tarzian, A. (2003). The girl who cried pain: a bias against women in the treatment of pain. *Journal of law, medicine, and ethics. 29*(3), 13-27.

Offman, A., & Kleinplatz, P. (2004). Does PMDD belong in the DSM? Challenging the medicalization of women's bodies. *The Canadian of human sexuality, 13*(1), 17-27.

Oudshoorn, N. (1994). *Beyond the natural body: An archaeology of sex hormones.* New York, NY: Routledge.

Poleshuck, E. L., & Woods, J. (2014). Psychologist partnering with obstetricians and gynecologists. *American Psychologist 69*(4), 344-354. DOI: 10.1037/a0036044

Rocque, R., & Leanza, Y. (2015). A systematic review of patient's experiences in communicating with primary care physicians: intercultural encounters and a balance between vulnerability and integrit. *Public Library of Science 10*(10), 1-20. DOI: 10.1371/journal.pone.0139577

Swenson, N. M. (1998). *Our bodies, ourselves.* New York, NY: Simon & Schuster, Inc.

Swigonski, M. (1994). The logic of feminist standpoint theory for social work research. *Social work, 39*(4), 387-393.

Tavris, C. (1992). *The mismeasure of woman.* New York, NY: Touchstone.

Woolley, F., Kane, R., Hughes, C., & Wright, D. (2004). The effects of doctor-patient communication on satisfaction and outcome of care. *Social science & medicine. Part A: medical psychology & medical sociology, 12*(7), 123-128.