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Relationship Between Patients of Low Socioeconomic Status with Multiple Sclerosis and Health Care Providers

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Abstract

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MHA, Park University, 2017

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

Many health care initiatives seek to improve patient–provider experiences and relationships to support patient satisfaction rates and health outcomes. However, a small amount of published research has examined the perceptions of low socioeconomic status (SES) patients diagnosed with multiple sclerosis (MS) regarding their relationship with their health care provider and how these perceptions affect patient outcomes. Prioritizing communication and approachability between the health care provider and a patient can be instrumental in creating and fostering an authentic relationship. The research question for this study was designed to understand the relationship between participants of low SES who had been diagnosed with MS and their health care provider. The relationship-centered care theory served as the theoretical framework for understanding the development of authenticity in the relationship between a patient and health care provider. A pilot study of five participants that met the same criteria as the main study, confirmed reliability of the interview guide. Interviews were transcribed, and after transcription, a thematic analysis was performed. Thematic analyses indicated that authentic approachability and communication were key in creating and fostering an authentic relationship between the participant and their health care provider. The findings from this study have the potential for social change by improving the relationship between a patient and their provider by imparting an awareness of how the patient and provider relationship can directly affect patient satisfaction, the delivery of care, and patient health outcomes.

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Dedication

This work is dedicated to my children, Analeise, Gavin, and Evelynn. Analeise, your optimism, and servants’ heart was always the light on my darkest days. Gavin, your empathy, and compassion were always there to encourage and guide me. Evelynn, your ability to see the beauty in everything around you reminded me constantly to slow down and enjoy the little things. To the three of you: thank you for all that you have taught me and continue to teach me. Lastly, thank you for always loving me unconditionally.

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Thank you to my mother, Janice. You provided me with the drive to finish this study and the motivation to succeed. I would also like to thank my father, Pete, for reminding me that I am strong and resilient. Lastly, to my brother Nick, thank you for allowing me to be your big sister and teaching me how to love unconditionally. To the three of you: thank you for always reminding me of who I am and for inspiring me to be greater.

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Chapter 1: Introduction to the Study

A healing environment encompasses a relationship of comfort between patients and health care providers (Sakallaris et al., 2015). Patient relationships with their health care providers are a focus in health care to improve the patient care experience and provide information the physician may need for appropriate patient treatment for best outcomes. Prioritizing appropriate communication without a bias between health care providers and patients is significant to developing an authentic relationship to better support patient health outcomes (Rieckmann et al., 2018). For individuals with multiple sclerosis (MS) to receive comprehensive care, a collaborative and authentic relationship between individuals with MS and health care providers is needed (Golla et al., 2014). A lack of communication could weaken the authentic relationship and create barriers in maintaining trust and satisfaction with the care being delivered (Golla et al., 2014), leading to negative patient health outcomes. The lack of authentic relationships may help explain perceived inadequacies of healing relationships between patients and their health care providers (Grinberg et al., 2016). This study was thus conducted to evaluate the lived experiences of relationships between patients and their health care providers, which was essential to understand what a collaborative and authentic relationship between individuals of low socioeconomic status (SES) who had been diagnosed with MS and their health care providers entails.

Although many studies have addressed the impact of a patient’s SES on the health care delivery provided to the patient, there was a lack of research focused on the experiences within the patient diagnosed with MS of low SES and health care provider relationship. The lack of specificity in research and the gap in literature led to the desire to examine whether challenges existed in the patient and health care provider's relationship related to low SES. The basic qualitative research methods used in this study focused on understanding how authenticity within the relationship and a participant's low SES influenced the experiences of MS patients' relationships with their providers. The remaining sections of Chapter 1 includes the background, problem statement, purpose of this study, the research question, theoretical framework, and the nature of the study. The chapter concludes with the definitions of terms used within the study, assumptions, and limitations of the study, scope and delimitations, and the significance for social change.

Background

Several initiatives have supported improved patient satisfaction, adequate health care delivery, and positive patient health outcomes. One main strategy to meet all three of these goals is to improve the relationship between the patient and their health care provider. Providers need to include authentic communication, trust, and approachability in the relationship with their patients for them to feel significant. Authenticity in the patient–health care provider relationship can be described as responsive, informative within the limits of science, identifying symptoms through comprehensive conversation, and both parties' ability to arrange follow-up care and show trust (Weiss & Swede, 2016). The productive interaction and perception of authentic behaviors creates a positive forum for collaboration and engagement between the patient and their health care provider (Weiss & Swede, 2016). The patient will ultimately base their health decisions on how their provider listens to their concerns (Soundy et al., 2016). If patients encounter a positive experience with their provider’s behaviors, they are more likely to be motivated, engaged in the relationship, and active in health management discussions with their health care provider (Grinberg et al., 2016). Patients who perceive a lack of engagement from their provider are often given the wrong diagnosis and treatments because they do not trust their health care provider enough to divulge information on symptoms (Soundy et al., 2016). Further, patients who lacked information from their provider experienced an increase in poor health outcomes because authentic communication was not present within the relationship.

The overarching theme in research for enhancing patient care is improving the relationship between the patient and their health care providers, but the steps to complete this objective are broad and generic. With research geared toward generic populations and themes, it is unclear how the application of the current literature directly helped patients of low SES who are diagnosed with MS. More specifically, authentic communication and authentic approachability are not addressed in studies focused on improving the relationship between a patient and their healthcare provider. Though the research on general patient populations may provide information to assist in patient satisfaction, the delivery of care, and health outcomes, the lack of specificity in patients and the absence of practical approaches created a gap that needed to be explored.

This study helped identify that creating sustainable and authentic relationships between the patient and the health care provider can produce favorable foundations for improved care through the delivery of quality health care. This research study’s results provide insight into how implementing the relationship-centered care (RCC) theory could improve patient and health care provider interactions by creating authenticity in the relationship. Through these results, patients of low SES diagnosed with MS can experience improved relationships with their health care providers and seek treatment that included open communication and the necessary follow-up resulting in higher positive health outcomes.

Problem Statement

The United States has spent more than any other developed country on health care but ranks 27th globally for health outcomes (Fuchs, 2012). Research in recent years had recognized that a lack of actionable planning and a poor understanding of human behavior are two key barriers to improving patient care (Strong, 2021). Understanding human behavior and creating actionable planning could help identify the connection between decreased authenticity in relationships and poor health outcomes that result in lower life expectancies (Arpey et al., 2017). Further, patients believe that a barrier exist based on their SES, which directly affects how health care providers interact in the relationship and impacts the ability to create an authentic relationship with their provider (Cadden et al., 2018). Despite protocols slowly being adopted to minimize the disparity barriers in health care due to SES (Adler & Newman, 2002), there needs to be a strong foundation of understanding human behaviors and creating actionable and collaborative planning for patient care. Ensuring that patients have an authentic relationship with their health care provider is important to facilitating improved patient satisfaction rates, proper delivery of care, and better patient health outcomes.

Without collaboration and authenticity between a patient and provider, individuals diagnosed with MS will not receive comprehensive care (Golla et al., 2014). However, research addressing the impact of SES on the authentic quality of the relationship between individuals diagnosed with MS who were of low SES and their health care provider has been minimal. Exploring participants' lived experiences is important to closing the gap in knowledge because it provides interpretations of the communication and approachability within the relationship with their health care provider from the patient's viewpoint. The RCC theory was applied while evaluating the interview data to discover if an authentic relationship was present between the study participants (SPs) and their health care providers. Data were analyzed using the RCC theory and exploring the participants' lived experiences provided more specificity on assisting this patient population group and created closure in the lack of literature on this subject.

Purpose of the Study

Further research was needed to address the gap between this specific patient population and their health care provider. The purpose of this basic qualitative study was to explore the lived experiences of low SES individuals diagnosed with MS related to the authenticity of their relationship and their health care providers. This research is unique because it addresses an under-researched topic of these individuals' lived experiences in creating authentic relationships with their health care providers. Qualitative research allowed for focus to remain on the lived experiences of the selected participants. This approach focused on the positive and negative factors that contributed to forming an authentic relationship between the participant and their health care provider based on the participants' perception of the impact of their low SES.

Research Question

Research question: What are the lived experiences of low SES individuals diagnosed with MS in developing authentic relationships with their health care providers?

Theoretical Framework

The theoretical framework for this qualitative study was driven by the Pew-Fetzer Task Force's (1994) RCC theory. The Pew-Fetzer Task Force recognized that the purpose of health care is to respond to the patient's needs, which can be better understood if health care focuses on developing the relationship, trust, and communication between the health care provider and the patient. The RCC theory allows for a closer look at how authenticity in the relationship between a patient and a health care provider affects the patient's experiences and outcomes (Soklaridis et al., 2016). RCC theory was founded on four principles:

1. Personhood matters are highly regarded in the relationship between the health care provider and the patient. Personhood is the quality or condition of that individual patient.
2. Affect and emotion displayed by the health care provider are essential in the relationship with the patient.
3. Relationships do not occur in isolation and need constant nurturing and fostering between health care providers and patients.

4. Maintaining an authentic relationship is necessary for health and recovery of the patient. (Soklaridis et al., 2016)

The principles are only successful if both the patient and the physician practice authentic communication and openness in the relationship (Suchman, 2011). If there is a disruption within any RCC theory principles, the patient’s primary goal of a dynamic, authentic patient and health care provider relationship will fail (Bernheim et al., 2008). Authenticity is present in the relationship if there are active efforts to build and sustain a nurturing and therapeutic relationship through establishing the foundation of trust and positive communication between the health care provider and the patient (Soklaridis et al., 2016). If implemented correctly by health care providers, the RCC theory could help humanize health care and improve patient health (Soklaridis et al., 2016), which can lead to more significant outcomes such as maintaining healthy behavior changes, higher patient satisfaction, greater treatment adherence, better patient physical and mental health, and fewer health care visits. The RCC theory aligned with the goal of this study, which was to discover if SES affected creating an authentic relationship between a patient and their health care provider.

Nature of the Study

The nature of this study was a basic qualitative method. Using a basic qualitative approach allowed the me to study patients’ lives and experiences of the relationship with their providers. Qualitative studies enable researchers to investigate the following questions:

1. How did the patients interpret their experiences?

2. How did the patients construct their worlds based on those experiences?
3. What meaning did they attribute to their experience? (Merriam & Tisdell, 2015)

During the interview process with the 12 participants, the primary goal was to learn about the experiences that low SES individuals diagnosed with MS had with their health care provider. The primary interview goal was accomplished by asking relevant ethical interview questions (IQs) that focused on the participants' ability to discuss their experiences with their health care provider freely. All interviews were conducted at a time of the participants choosing via Zoom audio conferencing. The interview was manually transcribed with the assistance of Descript transcription software and emailed to the participant for their review and approval. After the participant reviewed the transcript and approved the narration, a thematic analysis was performed by me by using six key thematic analysis guidelines.

Data familiarization involved becoming immersed in the transcriptions and comparing key points with notes in the interview journal. For example, if an IQ provoked emotions from the participant, the note of the emotion was compared to the respective response in the transcript. The coding process began after the data had been analyzed. Coding the data involved highlighting key terms or phrases that described the content of the interviews. Phrases such as "I don't know" that were repetitive within the transcript were identified as the participant's uncertainty and coded as such. From the codes, the next steps within the thematic analysis of the data were to generate, review and name the themes based on similar codes. If a participant's interview had coding categories such as "inability to be open" and "unheard or ignored", the codes were classified as the theme of authentic communication. Finally, thematic analysis findings provided a clear understanding of the participants' experiences and answered the study's research question.

Definition of Terms

This section provides definitions of the terms and acronyms used throughout this dissertation. Terms operationalized by this study include:

Affect: A state of emotion experienced by an individual. Affect emotions could be either reflexive or reflective of the individual's situation. Affect emotions are psychophysiological responses to recurrent situations that hold significance in a person's past (Loewenstein, 2007).

Authenticity: Authenticity has three characteristics: full awareness of the moment, choosing how to live one's life at that moment, and taking full responsibility for the choice made (Starr, 2008). Authenticity requires that individuals consider how they want to live and have their values, motivations, and life plans reflect this consideration.

Emotion: A mental state of a person that includes feelings of anger, disgust, fear, joy, sadness, and surprise (Cabanac, 2002).

Lived experiences: Understanding research subjects, human experiences, choices, and options, and how they affect their livelihood, mental capacity, or overall health (Given, 2012). Lived experiences also account for the person and unique perspective of the research subjects and their experiences shaped by the subjective factors of their specific identity. In this study, their identity was their SES or class.

Multiple sclerosis (MS): MS is a chronic inflammatory disease characterized by central nervous system lesions that eventually leads to severe physical or cognitive disabilities (Ghasemi et al., 2017).

Relationship-centered care (RCC): The RCC theory provides a closer look at how authenticity in the relationship between a patient and a health care provider affects the patient's experiences and outcomes (Soklaridis et al., 2016).

Socioeconomic status (SES): SES measures an individual's economic and social status (Baker, 2014).

Assumptions

An assumption is an unexamined belief resulting in interferences in a study (William F. Ekstrom Library, 2021). The first assumption for the study was that all participants were candid in their responses regarding their interaction with their provider and were honest in how they felt in the belief that their SES affected the relationship's authenticity. Participants were reminded that their interviews were anonymous before the interview, and assurances to the participants of their anonymity allowed for the assumption of candid responses to remain true. Another assumption was that data would be transcribed accurately and that the thematic analysis posed no issues in discovering themes amongst the data. Due to the familiarity with manual transcription and coding, the assumption was that transcription and coding would be accomplished without transcription or interpretation issues. It was also assumed that the study would not rely on the use of Descript and NVivo software as a primary source for transcription and coding, but rather as a secondary tool to provide clarity, understanding, and verification of the manual efforts made by myself. The reviewed participant experiences addressed the research study’s assumption that a participant’s low SES impacted the creation and sustainability of an authentic relationship with their health care provider. These experiences also assumed that MS participants of low SES experienced a lack of authenticity in the approachability and communication from their health care provider, which directly affected the participant’s health outcomes.

Scope and Delimitations

Previous research has connected disparities between low SES and health care delivery, but the association between individuals diagnosed with MS with low SES and disparities had not been made. Previous research had identified a link between low SES and delivery of care, but it was unclear if individuals who had been diagnosed with MS and were of low SES had experienced the same lack of delivery from their health care provider based on their SES classification. Due to the small size of 12 participants for the study, there was the potential transferability as participant experiences did not represent most of the population’s experiences. Social constructivism requirements within the basic qualitative approach allowed a clear understanding of how the participants’ experiences and interactions with their provider affected their relationship with their providers and overall health outcomes, ultimately answering the study’s research question. It was important to bring awareness of these experiences to health care providers’ attention to provide a clear understanding of their impact on the relationship from the participants’ perspective. Future studies can provide solutions to the findings and deliver appropriate suggestions for better relationships between participants and health care providers.

Limitations

Semi structured data gathering methods do have limitations that could potentially hinder the research process. One limitation was researcher bias. A researcher's preconceptions and biases can influence decisions and actions throughout qualitative research (Johnson et al., 2019). I have experience with an individual of low SES who has MS and could not let this personal knowledge interfere with exposing the study's reality. Keeping the idea of biases at the forefront of the research process prevented me from including my personal experiences within the interviews with participants and in presenting the data. To keep this potential bias controlled during the onset and duration of the research, a journal of any occurrences of personal experiences during participant sessions and research evaluations was kept.

Another limitation was the design flaw of the IQs. A field test was conducted to minimize the effect of flaws within the research design (see Merriam & Tisdell, 2015). Research outreach was posted on open forum websites that required minimum to no permission to post. Barriers to using open forum websites included that the use of interview checklist and participant criteria stifled the diversity and multiplicity (Johnson et al., 2019) of practices that become a part of achieving quality and consistency within the basic qualitative paradigm. If the participant did not feel comfortable answering a specific question, the participant was allowed to skip the question. But requiring the participant to answer each question according to strict guidelines did not allow for full autonomy of answering the researcher's questions (Johnson et al., 2019). Overcoming the limitations, challenges, and barriers of interviewing each participant involved careful considerations while asking questions to the participant. Letting the participants drive the study allowed their answers about their experiences to be fluid and honestly represented within the study results.

Another limitation related to qualitative was the need for the researcher to respond to concerns of credibility (Merriam & Tisdell, 2015). In this study, participants were asked to provide experiences related to their relationship with their health care provider regarding their MS treatment. Credibility was maintained by preserving internal validity through participant recruitment. Participant recruitment was another limitation of this study. However, limitations in recruitment regarding the number of participants were addressed by keeping the participant population small with no more than 12 participants. The limitations regarding transcribing and interpreting data were addressed using transcribing software called Descript. Descript was a platform that I had previously used to transcribe interviews. However, it did not accurately depict the interview if the participant had a strong accent or unrecognizable speech. In the situations in which speech was unrecognizable, the interview was played and manually transcribed by me. After the interview was complete, all participants received a copy of the interview transcript for review via the email they provided. A copy of the transcript was sent to the participant within the 72-hour time frame. If any interview information needed to be clarified, a follow-up clarification interview was scheduled with the participant.

Significance and Social Change

This research helped identify if individuals diagnosed with MS who were of low SES experienced a lack of authenticity in the relationship with their health care providers due to their low SES. The findings helped understand the MS patients' experiences of their low SES and authentic relationships with their health care providers. Through this research, there was an opportunity to create social change for these patients by creating an understanding of possible bias factors especially related to their SES that affects the authenticity in the relationship between a patient and the health care providers. Health care administrators may use this research to improve health care with attention to the relationships between the provider and patients at their health care facility.

Summary

Chapter 1 discussed how the relationship between a patient of low SES diagnosed with MS and their healthcare provider could suffer if it were not founded on authentic interactions. Previous studies have identified that patients who felt that their provider was not communicating information regarding questions did not trust their provider, leading to poor patient health outcomes. Previous research had identified a specific link between patients of low SES and the delivery of health care, but there was minimal research related specifically to the experiences of low SES individuals diagnosed with MS. Thus, it was important to research the relationship between patients of low SES who had been diagnosed with MS and the health care provider. More importantly, the study allowed participants to provide their experiences regarding the authenticity in the relationship with their health care provider to create sustainable and authentic relationships with their patients.

Chapter 2 offers a detailed look into the theoretical framework and literature review supporting the study topic. Chapter 3 contains information on the study's research methodology and includes specific components such as the study’s design, research questions, rationale, study variables, the design’s relationship to the research questions, and the design’s limitations. Chapter 4 will include the results of the experiences of participants of low SES who had been diagnosed with MS regarding the authenticity in the relationship with their provider. Chapter 4 will also detail the pilot study processes, participant demographics, data collection methods, trustworthiness of the evidence provided, and the study findings. Lastly, Chapter 5 will present the interpretations of the research finding, recognize study limitations, recommendations, and conclude with the study’s findings.

Chapter 2: Literature Review

The purpose of this study was to understand the lived experiences of individuals of low SES with MS and their authentic relationship with their health care provider. Over time, barriers in authenticity between patients and health care providers decrease the relationship. There are efforts in the health care industry to minimize barriers in creating an authentic relationship due to differences in SES (Cadden et al., 2018); however, individuals with a lower SES still experience a decrease in authentic relationships with a provider, which then lead to worsened health and lower life expectancies. Patients with low SES have felt disconnected from health care providers, which hindered communication and approachability and affected patient health outcomes (Cadden et al., 2018).

Chapter 2 provides detailed information on the authenticity within relationships between patients and their health care providers. After describing the search strategy used to secure the articles and the theoretical concepts important to this research, I present an exhaustive investigation into the available peer-reviewed articles about low SES patients diagnosed with MS and their health care providers. The literature review includes information on low SES patients and MS, authentic relationships between patients and health care providers, and the RCC theory in application. Lastly, Chapter 2 explains the gaps in the literature that were addressed in this research.

Literature Search Strategy

The publications used in this review include scholarly peer-reviewed articles published within the last five years and non-peer-reviewed publications applicable to the topic. Significant works were located through the following databases: Thoreau, SAGE, Google Scholar, EBSCOhost, and PLOS One. Some of the literature reviewed was outside of the 5-year timeframe due to the lack of literature explicitly related to MS patients regarding the lived experiences of the relationship with their provider. The keywords searched were *low SES*, *the patient lived experiences*, *delivery of care*, *patient-provider relationship*, *p-p relationship*, *RCC care*, *MS experiences*, *MS patient experiences*, *health care delivery, SES influences*, *MS*, *health care disparities, physician attitudes*, *patients*, *SES*, *RCC theory*, *SES disparities*, *societal influence on health care*, *low SES patients*, *delivery of care*, *authenticity in patient-provider relationships*, *challenges with patient-provider relationships*, *patient experiences with their health care providers*, *patient experiences within health care*, and *patient attitudes towards physicians*.

Theoretical Framework

The theoretical framework was based on the concepts of the Pew-Fetzer Task Force (1994) RCC theory, which recognized that the purpose of health care is to respond to the patient's need for quality relationships with their health care providers and provide adequate delivery of care. Trust and communication within the relationship allows patients to feel open and forthcoming about communicating their needs to their health care providers (Pew-Fetzer Task Force, 1994) in addition to enabling health care providers to be more self-aware of the patients' needs (Soklaridis et al., 2016). Self-awareness of the patient's needs further allows providers to evaluate based on their patient's communication rather than solely relying on the physical exam.

The RCC theory operates under the paradigm of four primary principles necessary to procure a successful relationship between the patient and the provider (Suchman, 2011). The patient (a) needs to feel honored and respected, be satisfied with the health care services, have lower anxiety while interacting with their health care provider, and be able to trust their health care provider; (b) patients need to adhere to their physician-prescribed treatment plans; (c) patients should remember the advice and guidance given by their health care provider; and (d) patients should be actively engaged and collaborate with their health care provider in the treatment process (Beach et al., 2014). The RCC theory principles are an integrative process between the patient and health care provider and therefore cannot be carried out solely by one party. The RCC theory principles are only successful if open and collaborative interactions exist between patients and providers (Suchman, 2011). If the RCC theory principles are disregarded, there is a higher chance for the relationship between the patient and their health care provider to suffer due to the lack of authentic communication and approachability (Bernheim et al., 2008). Creating a consistent team-like dynamic between the patient and the provider ensures that the RCC theory principles are followed, resulting in greater satisfaction and health outcomes for the patient.

Unlike other theories, the concept of authenticity in the RCC theory places value on the relationship between the patient and their health care provider (Beach et al., 2014). Authenticity-related criteria in the RCC theory includes the communication and relationship dynamics between the patient and the health care provider, the provider’s self-awareness of the patients’ needs, and specific partnership behaviors. Behaviors specific to the foundations of the relationship between the patient and their health care provider include open communication and approachability (Suchman, 2011). For example, patient-centered care focuses on the patient as an individual only, not the patient’s emotional needs. Patient-centered care evaluates the patient’s needs based on the patient’s goals and treating the “whole patient” but does not address the underlying relationship that the patient and health care provider had a cohesive plan (Beach et al., 2014). When the Pew-Fetzer Task Force evaluated the patient-centered care theory, the task force concluded that looking at the interactions between the patient and providers would be more beneficial in understanding relationships between patients and their health care providers (Beach et al., 2014). The RCC theory expanded to include the patient as an individual and provided clarity on how the relationship between the patient and their health care provider is the foundation for creating a well-rounded health care model (Suchman, 2011). The RCC theory creates an understanding of authenticity through trust and communication within the relationship between the patient and their health care provider. The RCC theory emphasizes that the authenticity of communication and approachability between the provider and the patient is the foundation of the relationship (Suchman, 2011).

When choosing a theoretical foundation, it is best to choose a theory aligned with the study’s purpose (Burkholder et al., 2016). Using the RCC theory as the theoretical framework, I was able to emphasize the experiences of low SES MS patients to support that the relationship is the foundation between patients and health care providers. Participants’ perceptions of their interactions with their health care providers and how their SES affected the relationship drove the research to provide social change for other patients who may experience the same issues. This creates a better understanding of the possible bias factors surrounding the patient and provider's authenticity in relationships, in turn creating better health outcomes for low SES patients who were diagnosed with MS and a higher level of satisfaction ratings for organizations regarding the provider performances. The RCC theory helped to discover if SES directly affected the authenticity of the relationship between a patient and their health care provider.

Literature Review Related to Key Concepts

Socioeconomic Effects

A critical underlying factor affecting the authenticity of the patient and health care provider relationship is SES (Adler & Newman, 2002). Diminished authenticity in patient and health care provider relationships lead to the deterioration of overall health and lower life expectancies for lower SES patients (Adler & Newman, 2002; Becker & Newsom, 2003). Authenticity includes keeping open communication regardless of the patient's SES (Becker & Newsom, 2003). Effective doctor–patient communication is a central clinical function in building a therapeutic doctor–patient relationship, but a continual rotation of physicians for a patient means a relationship cannot be established (Fong Ha, 2010). Constant rotation of physicians does not allow for an authentic relationship to be established with lower-income respondents, creating patient dissatisfaction (Becker & Newsom, 2003). There has been substantial research to support that lower SES individual' health outcomes were jeopardized due to the inability for physicians to establish an authentic relationship with their patients. Lower SES patients who experienced a lack of consistent physicians were unable to keep an appropriate line of communication open with a short-term physician, and many patients grew tired of retelling their symptoms to new physicians (Becker & Newsom, 2003). In many situations, the rotation of physicians was not due to the physician’s lack of desire to treat their patients, but the perception the patient had of the relationship based on the interaction with that provider. Between 2005 and 2015, the density of physicians to population size decreased from 46.6 per 100,000 to 41. Four per 100,000, with the most significant impact located in rural areas (Basu et al., 2019). The lack of communication and constant rotation of providers made patients feel as though physicians were inattentive to the patients’ issues and did not explain processes or treatments well.

Patients’ income level has also affected the ability to create and sustain a proper relationship with their health care provider. A patient’s inability to pay for services affects their health and results in higher mortality rates due to not understanding what services are available to them (Smith et al., 2017). Further, in relation to patients of a higher SES, patients on the lower hierarchical end of the spectrum have received poorer health care delivery, poor provider–patient interactions, and diminished access to services. The inability to pay for specialty services can cause a strain in the relationship between the patient and the health care provider by diminishing communication between the two (Smith et al., 2017). Physicians have shown aggravation with their patients, causing patients to withdraw and feel their health care provider was not approachable. The lack of approachability was directly related to the patients’ low SES and an inability to pay for services, which ultimately led to higher mortality outcomes.

Health care provider bias regarding SES can also influence the authentic relationship between the health care provider and their patient (Arpey et al., 2017). A relationship founded without bias consists of authentic open communication and approachability between the patient and the health care provider (Arpey et al., 2017). But health care providers' perceptions of their patients' socioeconomic characteristics directly interfere with the relationship (Van Ryn & Burke, 2000). Providers' perceptions affect their assessment of their patient's intelligence and feelings of connection toward the patient, which hinders the communication and delivery of care provided to the patient (Van Ryn & Burke, 2000). If the health care provider has a negative perception due to the patients' low SES, the providers are less likely to engage in open communication due to a perception that the patient would not understand their dialogue, and patients are less likely to approach their health care provider with new or existing concerns because the patient felt belittled by their provider. Thus, there is a direct influence between a patient's low SES and the health care provider's perceptions, practices, access to care, and the ability to develop an authentic relationship between the patient and the health care provider. Disruption of authenticity in the relationship between the patient and health care provider eventually will result in diminished delivery of care and poor health outcomes for patients.

In addition to affecting care and relationships with providers, low SES affects the health care provider–patient satisfaction ratings (Haviland et al., 2005). Patients in low SES groups have exhibited lower satisfaction ratings than groups living at or above the poverty line. The differences within the low and high SES patient groups provided a direct connection between patient satisfaction ratings and a patient’s SES (Haviland et al., 2005). Health plans should apply appropriate engagement strategies to foster satisfaction within the health care community, identify disparities, and improve health outcomes (Haviland et al., 2005).

Participant and Health Care Provider Interactions

Collaborative interactions between the patient and their health care provider allowed the patient to openly communicate their preferences in the treatment process and for the provider to communicate available treatment resources openly. When there was an authentic relationship between the patient and health care provider, the health outcomes for that patient were positively affected (Soundy et al., 2016). Patients were more apt to follow the guidance of their health care provider if they felt as though they were able to openly communicate and approach their health care provider with questions regarding their health care plan. If a patient was not comfortable openly communicating new symptoms or concerns with their health care provider, the provider could not advise how to remedy their ailment (Soundy et al., 2016). Authenticity in the patient and health care provider relationship was described as responsive, informative within the limits of science, identifying symptoms through comprehensive conversation, and both parties’ ability to arrange follow-up care and show trust (Soundy et al., 2016). Through open communication, providers listened to their patients’ concerns, identified new symptoms, and established a proper treatment plan. If open communication and approachability were authentic within the relationship, each symptom was carefully approached with proper follow-up care, leading to greater patient satisfaction in the relationship with their health care provider (Soundy et al., 2016). Higher patient satisfaction with their health care provider and the authenticity in the relationship resulted in better health outcomes for the patient.

Mistrust in the relationship began to form when patients communicated questions or concerns regarding their health situation and their health care provider did not acknowledge the patient. Patients felt that a trusting relationship could be established when their health care provider could identify health concerns and health care problems and efficiently answer patient concerns. Patients felt that a trusting relationship would be established if their health care provider could accurately and efficiently identify their health care problems (Soundy et al., 2016). The two common outcomes expressed by patients interviewed regarding the relationship with their provider were: (a) the expectations vs. experiences of patient and health care provider interactions, and (b) the factors that influenced the authentic relationship. Trust was identified as an instrumental element in creating an authentic relationship between the patient and provider. If the element of trust was not present within the health care provider and patient relationship, the patient did not feel they could approach their provider regarding care and the ability to communicate concerns openly. When patients experienced unanswered questions about the patient's health from health care providers, this caused mistrust within the relationship. In low SES individuals diagnosed with MS, patients were given the wrong diagnosis and treatments due to not trusting their health care provider (Soundy et al., 2016). Patients who did not trust their health care provider failed to communicate new symptoms or changes in current symptoms during their exchange with their health care provider. Due to the lack of open communication and approachability, there was a decrease in communication between the patient and their health care provider, an increase of diminished health outcomes, and a decrease in the authentic relationship between the patient and their health care provider.

Though disparities associated with lower SES were identified through past published research, a 2016 survey published by the Council of Accountable Physicians Practices identified that most Americans were not receiving a level of health care that resulted in better patient health outcomes. Although the survey examined the overarching population of patients, the 2016 survey release did not address expectations and desires related to the relationship between the patient and their health care provider. The lack of information on this research prompted the council to readminister the survey in 2017 (Council of Accountable Physician Practices Focus Group, 2017). The purpose of the 2017 study focused on the expectations of the relationship between the health care provider and the patients (Council of Accountable Physician Practices Focus Group, 2017). Both versions of the survey supported the theme of how authentic relationships affected patients’ health outcomes and brought forward an awareness that most patients were not receiving the care needed to sustain a healthy life. The focus on the relationship between a patient and their healthcare provider aimed at providing a better understanding of patients’ expectations of their health care provider and what physicians wanted for their patients. The study’s emphasis was focused on the quality and delivery of the health care services received by the patients.

Relationships between patients and their health care providers were founded on authentic communication and approachability (Soundy et al., 2016). Patients were expected to engage in open approachability and communication with their health care provider and to receive quality health care (Council of Accountable Physician Practices Focus Group, 2017). The perception of the expectation of open communication and approachability within the relationship with the health care provider was important for the patient to experience because this was how the relationship was founded. Without authentic communication and approachability as the foundation of the relationship, the patient and health care interactions suffered from closed-off collaborations and interactions.

Open communication and approachability in the relationship between the patient and the health care provider directly affected the delivery of care provided to the patient. The relationship between the patient and their health care provider was critical in delivering health care and was the foundation for creating healthy relationships built through establishing authentic communication and approachability (Harbishettar et al., 2019). Open communication and approachability within the relationship were only established when the health care provider engaged in the conversation using terms the patient could understand and trust, and the patient could then, in turn, approach the provider with questions they had regarding their treatment (Council of Accountable Physician Practices Focus Group, 2017). The main components of an authentic relationship between a patient and health care provider were built on trust, open communication, and approachability, without these components, the relationship will fail, and patient health outcomes will suffer (Harbishettar et al., 2019). If the relationship between the patient and their health care provider was not founded on an authentic relationship, patients were more apt to frequently change their health care providers due to the lack of engaging interaction related to their health care, resulting in diminished health outcomes (Harbishettar et al., 2019). The lack of interaction between patients and their health care providers created a disconnect in establishing an authentic relationship, which affected the delivery of care and ultimately resulted in a decline in health outcomes for patients. Recovery and patients' adherence to treatment plans were higher if an authentic relationship was formed that consisted of open communication and approachability between patients and their health care provider.

The communication interaction between the patient and their health care provider determined the level of authenticity within the relationship. The patient was the expert in the mutually interdependent interaction with their health care provider, and patients needed to be involved in making a collaborative treatment care plan to achieve positive health outcomes (Harbishettar et al., 2019). The patient's role in the relationship was influenced by their perception of how open the communication was with their health care provider. The communication between the patient and the health care provider could directly jeopardize or enhance the patient-providers bond based on the patient's experience. An authentic relationship and positive treatment goals were attainable if both the patient and their health care provider were invested in keeping an interaction-based open communication and approachability present within the relationship.

Relationship-Centered Care

The RCC theory was a framework for conceptualizing health care that recognized that health care relationships’ nature and quality directly influenced the development of patient and health care provider authentic relationships and patient health outcomes (Soklardis et al., 2016). According to the RCC theory, an authentic relationship between patients and their health care provider was the foundation for creating healthy outcomes. The RCC theory should be the center of patient health management by health care providers and an integral theory used in developing and maintaining relationships with their patients (Nundy &Oswald, 2014). The RCC theory definition was slightly updated from the original Pew-Fetzer Task Force (1998) description by Nundy and Oswald (2014) in that, although the relationship between the provider and patient was foundational, three other types of relationships that needed to be built by the health care provider for the benefit of their patient. The three types of associations that the provider could focus on to better the relationship with their patients were: (a) other health care workers involved in the care of the patient, (b) other health care providers providing input to the care of the patient, and (c) the community involved with the patients care or treatment processes (Nundy & Oswald, 2014). The three relationships included the patient and those directly involved in their patient’s care. Those directly involved encompassed nurses (health care workers), other specialists (health care providers), and family members (community) (Nundy & Oswald, 2014). To establish a healthy relationship with their patient, health care providers need to value improving the relationship by providing authentic communication and approachability with their patients and all those included in the patient’s care. Nundy and Oswald suggested that all four components of the RCC theory were needed to produce a comprehensive paradigm that strengthened the patient and health care provider relationship, provided a greater delivery of care, and ultimately greater patient health outcomes.

Like other published works, relationships between providers and patients directly affected critical functions and activities within the health care field (Beach et al., 2014). Authenticity was defined as the trusting and open exchange of information between the patient and health care provider, the ability for cohesion in choosing proper treatment plans, and the collaborative evaluation between the patient and health care provider on health outcomes for the patient (Beach et al., 2014). Authenticity within the relationship cannot be carried out solely by the patient or the health care provider. Nundy and Oswald (2014) asserted that the four principles of the RCC theory relied heavily on the patient, the health care workers, the health care provider, and the community, another theory provided by Beach et al. (2014) provided further expansion on the RCC theory concepts. The four core principles of the RCC theory were: (a) relationships in health care needed to include dimensions of personhood, (b) affect and emotion were essential components of relationships in health care, (c) all health care relationships occur in the context of reciprocal influence, and (d) the RCC theory needed to adhere to a moral foundation (Beach et al., 2014). The subcategories associated with building authentic relationships between a health care provider and their patient were (a) knowledgeable answering the patient’s questions and addressing concerns, (b) having a collaborative approach, philosophy, and attitude towards health outcomes and treatment plans; (c) recognizing and having open communication and approachability regarding behaviors experienced in the relationship, (d) having an open communication regarding health and treatment outcomes (Beach et al., 2014). For example, a patient’s account of their symptoms was the best way for the health care provider to gain knowledge and insight into their patient. When the health care provider openly communicated and listened to the patients’ recounts, this showed the patient that their health care provider placed value in the relationship. Value translated to mutual respect between the patient and their health care provider. Mutual respect resulted in the building of between the health care provider and patient; it created lower anxiety and helped both parties be actively engaged in the relationship (Beach et al., 2014). Implementation of the four principles of Beach et al.’s RCC theory led to the development and the ability to sustain authentic relationships between the patient and the health care provider.

The most cited definition of the RCC theory derives from the Pew-Fetzer Task Force (1998), but it had been adapted to provide a more explicit focus on the central role of relationships between patients and health care providers. When applied to the concept of health care delivery, the RCC theory was an acceptable alternative to the patient-centered care model. Patient-centered care models focused solely on the patient and their involvement in their care (Soklaridis et al., 2016). The RCC theory was designed to specify how to examine the relationship between the health care provider and the patient. The RCC theory provided a closer look at how authenticity in the relationship between a patient and a health care provider affected the patient’s experiences and outcomes. Unlike the Pew-Fetzer Task Force (1998) Model, the updated RCC theory was founded on four principles: (a) personhood mattered in the relationship between the patient and their health care provider, (b) affect and emotion were essential to the relationship, (c) relationships did not occur in isolation and (d) maintaining an authentic relationship was necessary for patient health and recovery (Soklaridis et al., 2016). Authenticity focused on building and sustaining nurturing and therapeutic relationships for patients with their health care providers, and when implemented correctly, the principles of the RCC theory helped humanize and improved patient health care (Soklaridis et al., 2016). Health care improvements resulting from a positive relationship between the patient and the health care provider led to more significant favorable outcomes for patients. Auspicious outcomes included that:

- Patients made good choices and maintained their healthy behaviors.
- Providers saw higher patient satisfaction ratings and health outcomes.
- Patients adhered to their treatment plans.
- Patients experienced better physical and mental health.
- Patients required fewer health care visits.

Relationships between patients and health care providers were not always performed in a face-to-face environment. With the advancements of technology and the uprise in telehealth services, it was just as important to create a good foundation of an authentic relationship between the patient and provider. The use of mobile health applications and teleconferencing services could influence authentic relationships between health care providers and patients by creating a virtual and very impersonal environment (Qudah & Luetsch, 2019). The use of mobile applications to access health care services provided another reason why the application of the RCC theory was important to the patient and health care provider relationship. Building psychological and emotional bonds between patients and health care providers was another definition of how an authentic relationship was formed (Qudah & Luetsch, 2019). Psychological and emotional bonds included the essential interpersonal communication elements, such as non-verbal and verbal cues and behaviors. The study of the role of technology use in health care delivery was unique because it evaluated how using mobile services to collaborate and communicate affected the relationship between the patient and health care provider. Whether the patient was visiting in person or virtually, the underlying theme that an authentic relationship needed to be built and sustained through open communication and approachability remained constant. Visits conducted within a virtual environment suffered because they lacked the appropriate building blocks of affect and emotion in the relationship between the patient and provider (Qudah & Luetsch, 2019). Affect and emotion is essential components in a health care provider and a patient relationship and when these attributes are not appropriately met, this damages the psychological and emotional bond (Qudah & Luetsch, 2019). Based on this finding, the relationship between the patient and health care provider became dehumanized, and as such, there was a decrease in the authenticity of the relationship.

There was a need to create health care education focused on mastering technical skills and the human dimension of care through relationship formation and sustenance. The RCC theory offered the conceptual basis for building relationships focused on such concepts (Weiss & Swede, 2016). Weiss and Swede identified the four principles of the

RCC theory needed to create the education to build a foundation based on authenticity. Those principles are classified as:

1. Self-awareness,
2. emotional presence and empathic responses,
3. reciprocal influences, and
4. cultivating a good relationship was a moral obligation.

The RCC theory emphasized that a patient and health care provider's relationship exceeded the health care provider's technical skills training (Weiss & Swede, 2016). Those involved in the patient's care cultivated respect for the patients' dignity and worth, their right to self-determination, and their capacity for self-healing (Weiss & Swede, 2016). Health care providers providing services to their patients must remain non-judgmental in a patient's recount of their illness and must commit to establishing an authentic, collaborative, and long-term relationship with the individual (Weiss & Swede, 2016). Standards such as adherence to maintaining a non-judgmental. The four principles identified cultivated healing partnerships between the patient and health care provider, allowing for better training on how health care providers should interact with their patients.

The definition of the RCC theory used by Weiss and Swede (2016) surpassed the concept of patient-centered care and interprofessional teamwork to focus on the reciprocal human interactions at the micro, mezzo, and macro levels. Micro, mezzo, and macro levels related to the RCC theory described the different interaction levels between the health care provider and the patients (Weiss & Swede, 2016). Micro levels describe the most common interactions between the patient and the health care provider. An example of a micro-level was the interactions in the appointment participants had with their health care provider. Micro levels are different from macro levels in that micro levels involve the direct relationship between the participant and the health care provider, and micro levels are related to the institution. The institution is defined as the business that employs the participant's health care provider. Mezzo levels are how the health care provider applies the RCC theory principles to those considered to be the participant's family unit or all the different physicians involved in the patient's direct care. For example, if the participant has a general practitioner as their primary health care provider, the Mezzo level is their health care provider and any specialist that helps maintain that participant's treatment. Lastly, macro levels describe those not considered directly responsible for the patient's care but still influence the health care provider and patient relationship. Examples of macro levels consist of the institution where the patient receives care or other larger groups such as insurance affiliations.

Gaps in Literature

Several studies evaluate the patient and health care provider relationships within the health care field and how this affects treatment goals or patient health outcomes. The relationship's effects remain contentious between providers and patients, few studies focused on the lived experiences of low SES individuals diagnosed with MS in developing authentic relationships with their health care providers. Evaluating the challenges within the patient and health care provider relationships was essential to creating a collaborative, authentic relationship between patients with MS and health care providers. Regardless of SES status, forming collaborative relationships without a bias between the health care provider and the patient is essential to creating authentic relationships between the patient and health care provider (Rieckmann et al., 2018). Comprehensive care must include the presence of an authentic relationship between the patient and their provider (Golla et al., 2014). If the patient and health care provider relationship experiences issues, these issues weakened authentic relationships and create barriers in maintaining trust and follow-up care, which result in poor health outcomes for the patients.

Summary

The research listed within the literature review for this study highlighted information that supported the need for further research on the lived experiences of low SES individuals diagnosed with MS. Chapter 2 also contained the theoretical framework that served as the oversight in the study to interpret results**.** The theoretical framework focused on the RCC Theory, which rooted the study. Applying the RCC theory allowed a better understanding of the development and sustainability of authentic relationships between low SES MS patients and their health care providers**.** Chapter 2 also contained a comprehensive literature review related to the socioeconomic effects within the patient and provider relationships, participant, and health care provider interactions, and the RCC theory, as it applied to this study**.** Lastly, Chapter 2 discussed the gaps in the literature related to the experiences of patients of low SES who had been diagnosed with MS and the perception of how SES affected the relationship with their health care provider.

Chapter 3: Research Method

This study focused on the experiences of individuals diagnosed with MS of low SES and the development of authentic patient–health care provider relationships**.** Individuals of a lower SES who experience decreased authenticity in the relationship with a health care provider experience worsened health problems and lower life expectancies (Arpey et al., 2017). Although many studies have addressed the impact of SES on health care delivery, there was a lack of research on the lived experiences of individuals diagnosed with MS who were of low SES and their perception of the authenticity in the relationships with their health care providers. Evaluating the challenges in patient–health care provider relationships is essential to providing a solution on how providers could create collaborative, authentic relationships with their patients who had been diagnosed with MS and were of low SES.

Chapter 3 is a comprehensive look at the research methods that provided the foundation for the study. The chapter includes the research design, methodology, and rationale that drove the study's design as the researcher's role within the process. Participant selection processes are extensively discussed, along with the instrumentation and the plan for the study's data analysis. To identify the trustworthiness issues in the study, Chapter 3 provides the credibility and dependability of the data processed. A pilot study was performed to ensure that the interview processes and questions were designed to ensure research preparedness, and the outcomes of the pilot study are outlined in Chapter 3. Lastly, Chapter 3 concludes with the study's ethical considerations.

Research Design and Rationale

Basic qualitative principles guided the study to answer the research question, which focused on understanding the lived experiences of individuals diagnosed with MS of low SES and the development of authentic patient–health care provider relationships. The study’s basic qualitative research method focused on data sources, such as interviews, to understand the participants’ lived experiences (Creswell & Creswell, 2018). The research approach allowed me to study the participants’ experiences and how they interpreted them (Merriam & Tisdell, 2015). Because the purpose of this study was to understand the patient and health care provider relationship, the basic qualitative method was ideal in attempting to understand the experiences of the individuals of low SES diagnosed with MS.

Qualitative measures were chosen over quantitative methods and mixed-method approaches. The quantitative analysis did not lend well to this research because quantitative analyses would not provide in-depth capabilities to understand social phenomena through the patients’ lived experiences (Merriam & Tisdell, 2015). Another reason the qualitative method was chosen over non-qualitative methods was the data analysis structure. Qualitative data analysis is largely inductive, allowing meaning to emerge from the data, rather than the more deductive, hypothesis-centered approach favored by quantitative researchers (Castleberry & Nolen, 2018). Mixed method approaches were also not chosen due to the time constraints placed on the study and the overall cost to perform these approaches. A basic interpretive qualitative approach exemplified all characteristics of qualitative research in that I was interested in understanding how patients make meaning of a situation or phenomenon, but they seek to discover and understand a phenomenon, a process, the perspective, and worldviews of the people involved (Merriam & Grenier, 2019).

Role of the Researcher

I served as the primary researcher in this qualitative study. As the researcher, I conducted the interviews with participants identified as having MS and low SES. A critical point of bias acknowledging that I had a personal experience with an individual of low SES who had MS and not let this knowledge interfere with exposing the study's reality. Any individual diagnosed with MS and of low SES, personally known by me, was excluded from this study. Researcher bias was also addressed in the following three ways:

1. After the interview was complete, all participants received a copy of the interview transcript for review and approval within 72 hours. They received the copy via the email they provided.
2. Subject matter experts reviewed the initial protocol instruments and research questions for bias exclusion. They were also asked to determine if the IQs were appropriate for understanding the participants' experiences and answering the research question.
3. Monetary incentives were not offered to the participants to avoid the appearance of influencing participants' responses.

Methodology

Participant Selection Logic

Participants were selected through a purposeful sampling method, which aided the management of bias and kept the integrity of the results collected within the study (Patton, 2015). Purposeful sampling is used when the investigator wants to discover, understand, and gain insight on a specific population; therefore, they select a sample from which that most could be learned (Merriam & Tisdell, 2015, p. 96). I intended to provide results related to the relationship between patients who had been diagnosed with MS and were of low SES and their health care providers and determine whether patients experienced that their relationship with their health care provider was authentic. Purposeful sampling helped gather information about this population and achieve the intended goal of better understanding authentic relationships between individuals of low SES who were diagnosed with MS and their health care provider.

Participants were recruited using a recruitment flyer posted on social media outlets such as Twitter, Facebook, LinkedIn, and Instagram. The inclusion criteria for this study included individuals who self-identified as being diagnosed with MS, over 18 years old, and located throughout the entire United States. The socioeconomic question in the participant survey determined the SES status of each participant. There were no metrics set for calculating the population size within the qualitative analysis because the sample size was determined by the methods used and the constraints noted (Patton, 2015). Saturation was met with the sample size of 12 individuals, but had it not been, an increase of five more participants was considered. The sample size could not be predetermined due to the inability to predict data saturation.

Instrumentation

Specific open-ended questions unique to this study that aligned to the research study and the order they were presented were determined ahead of time to maintain a structured interview format. Using IQs as the instrument for this qualitative research, the objectives of the interview were:

1. To describe participants' experiences with their health care providers
2. To describe how their experiences of the relationship with their health care providers made them feel
3. To describe how the participants' experience with their providers influenced their decisions related to their health care.

The questions were validated through a pilot study before being used for the main study, and the participants were allowed to elaborate on each question with autonomy.

Interviews were conducted via videoconferencing methods to aid with observation. The observation was vital to the study because observational data represents a firsthand encounter with the phenomenon of interest rather than a secondhand account obtained in an interview (Merriam & Grenier, 2019). In addition, videoconferencing interviews allowed participants to disclose sensitive information more freely and render more suitable research interviews (Novick, 2008). There were some concerns in using this method, but the methodological strengths of conducting qualitative interviews by videophone include perceived anonymity, increased privacy for respondents, and reduced distraction (for interviewees) or self-consciousness (for interviewers) when interviewers take notes during interviews (Drabble et al., 2015). Journal notations of emotional affect through tone and response time also allowed me to complete an observation on the participant during the interview. Allowing the participant to speak with minimal interruption showed the participant that I was interested in hearing their experience completely and without disregard. The interest shown by myself helped enticed the participant to expand on their thoughts without undue bias from me (Burke & Miller, 2001). The interview goal was to answer the study's research question: What were the experiences of low SES individuals diagnosed with MS involving their health care provider?

Procedures for Recruitment, Participation, and Data Collection

Subject recruitment began once full approval from the institutional review board (IRB) was received (approval no. 03-12-21-0967037). Upon approval, all research products, such as the social media posting, were disseminated in a fashion that allowed minimal time to lapse between the IRB approval and data gathering. Being prompt in the participant gathering process, I focused on the pilot study and worked with the first five test participants (TPs) to correct the study's processes. The quick work of requesting participants proved resourceful when I completed the pilot test and identified that no adjustments were needed to the main study. With no changes needed, I began recruiting research participants to complete the study promptly. The criterion for participants of both the pilot study and research study inclusion was advertised with the flyer to request for participants:

- Participants must be over the age of 18 years old.
- Participants must self-identify as having MS.
- Participants must read and sign a consent form to be considered for the study.
- Participants must disclose their insurance provider (i. e., Medicaid, Medicare, Private Insurance) and state if they were of low SES.
- Participants must be willing to be interviewed via video conferencing, telephone, or face-to-face.

During the participation and data collection phase, my primary responsibility was to ensure confidentiality with each participant and ensure that their trust was at the forefront of the study. Each participant was reminded that their information remained confidential, and no identifying information was written within the findings of the results. Each participant was provided an informed consent notification before they agreed to participate in the study. The informed consent described the study and its purpose. It also was stressed to participants that participated in this study was completely voluntary and that their input could help provide experiences between individuals of low SES with MS and their health care provider.

Participants were also reminded that a transcript with the information discussed during the data collection phase would be provided. The transcript would not be used in the study until the participants approved the interview, and if the participant had revisions, those were made at that time. During the study, no follow-up meetings were needed, as all participants agreed to the transcript provided to them. The participants felt confident in my ability to show the workings of the interview properly and completely.

Pilot Study

A pilot study was conducted with five participants to evaluate the IQs' effectiveness in capturing the information to answer the research question. The main purpose of performing a pilot study was to evaluate the processes associated with the main study (Leon et al., 2011). These processes included how the interview guide was effectively deployed to participants, the proper ways to ask participant IQs, and how applying the theoretical framework answered the study's research question. The pilot study identified potential issues with recruitment, correct assessment procedures, methodology, and data collection challenges (Leon et al., 2011). The pilot study process allowed for testing IQs to ensure the questions aligned with the information sought from participants and identify research bias present within the questions. I was attentive to details involved within the interview processes. Open communication was practiced between myself and the participant, but my role of the was to listen and provide follow-up questions if needed. The participants understood the questions, and no bias was noted; therefore, no modifications were needed.

The inclusion criteria for the pilot study were identical to those in the research study. The inclusion criteria required that participants self-identified as being diagnosed with MS, over 18 years old, and located throughout the United States. The study used sample questions and provided an opportunity to prepare for the main study with 12 participants. A Walden IRB consent approval was prepared to perform the pilot study. Data from the pilot study was collected using the same methods outlined for the main study to test the instrumentation plan's reliability. The pilot study helped me become familiar with the procedures executed in the main study. The initial process within the pilot study was effective, so no further corrections were made for the main study.

Data Analysis Plan

After interviewing the participant, the audio recordings were manually transcribed and verified with the assistance of Descript transcription software. Manually transcription was needed specifically for three of the interviews due to the participant's accent and the inability of Descript to recognize the participant's words. Although I had previous experience with Descript through previous graduate school courses, the software was used as a secondary source for verification purposes, and due to previous experience, there were no limitations identified with the use of the software. After the participant transcripts were reviewed for accuracy, the transcripts were sent to the participant for approval. The participant had 72 hours to review and approve the transcript. If a delay outside of the 72 hours occurred, participants were immediately notified and asked if they would like to repeat the interview to keep the information's integrity or accept the delay. Next, a thematic analysis was performed to find commonalities between the participants' interviews. Thematic analysis was the method of identifying, analyzing, and reporting patterns (themes) within data (Castleberry & Nolen, 2018, p. 808). The first step in the thematic analysis was to become familiar with the transcripts and raw data provided by the participants. The next step in the thematic analysis involved grouping phrases or sentences within the transcript text into groupings identified as "codes." Codes were placed into a concept map, allowing easy recognition of key phrases, words, or themes throughout the interview. The coding process allowed me to ask specific questions about the data I was examining. Some of these questions include:

1. What was happening within the text of the transcript?
2. Was there evidence of preceding events, during events, relative events? (Castleberry & Nolen, 2018)

After the coding process was complete, the next step was to generate subcategories or subthemes based on the phrases or sentences within the transcripts. For example, a reoccurring phrase or sentence related to the participant being "unheard in the conversation" or "ignored when they spoke"; this phrase was related to the identified theme of "disregarded" The subcategories were reviewed for accuracy, and if they represented the data correctly, they were categorized into main themes. According to Merriam and Tisdell (2015), the overall interpretation was solely based on the researchers' understanding of the participants' understanding of the phenomenon of interest (Merriam & Tisdell, 2015, p. 25). Based on the RCC theory's theoretical framework, I used thematic synthesis to identify common themes amongst the participants. The use of common themes facilitated greater transparency when reporting descriptive and analytical themes (Thomas & Harden, 2008). With the assistance of NVivo software, I was able to verify that the findings from the manual review were in line. There were no limitations with the thematic analysis due to a familiarity with executing a manual thematic review and knowledge of how to concur the data within a secondary source such as NVivo. Data saturation was reached, and the study was ended when no new themes were identified with incoming data. Upon data saturation, the codes and subcategories related to that code were reassembled and remapped for a comprehensive thematic analysis. These themes were mapped into hierarchies to allow for a greater visual tool for each theme related to one another. Once the thematic analysis had been completed, the findings were used to answer the research questions presented.

Issues of Trustworthiness

Semi-structured data gathering methods had their limitations and challenges within the research study. A limitation that needed to be considered within this research was bias based on personal experiences with an individual of low SES diagnosed with MS. The reality of the study was to expose the experiences of individuals of low SES who had MS and acknowledge that there was a potential for bias within the study. Personal experiences were identified during the onset and duration of the research as a limitation within the study. A journal of the interaction that I had with the participants was kept, and notes were reviewed to address any issues of bias that were recorded. Each participant transcription was reviewed in conjunction with the research interview journals to recognize if I went off-topic or included bias in the interview setting. By noting emotional responses in a journal, I was able to identify if there was any indication that I was leading the participant answers based on the tone of my voice when I expressed understanding or if the participant expressed emotional responses, such as crying or distress during the interview.

Avoiding reflexivity was another issue of trustworthiness. Reflexivity was the idea that a researcher’s preconceptions and biases could influence decisions and actions throughout qualitative research activities, which were critical during the entire research process (Johnson et al., 2019). According to Merriam and Tisdell (2015), conducting a field test of the interview guide questions prior to the main study enabled me to identify potential flaws with the design and adjust accordingly to reduce the bias that may be introduced. Overcoming these limitations, challenges, and barriers involved carefully considering all participants and allowing them to drive the study and represent their experiences credibly without any influence from the researcher.

Credibility

Addressing credibility, also known as validity, within the study was essential to creating formative research (Patton, 1999). There were many opinions throughout various research studies regarding how credibility needed to be expressed through research, but the overwhelming agreement, according to Merriam and Grenier (2019), was that qualitative researchers needed to respond to concerns of those reading with an outline of how that researcher addressed credibility within their specific study. In this study, I asked participants to provide experiences with their health care providers. I maintained credibility, ensuring that there was internal validity within the study. Internal validity involved how the research findings match reality and how congruent they were with reality (Merriam & Tisdell, 2015). Wolcott (2005, p. 160) suggests that increasing credibility means to increase the correspondence between the researcher and the real world. I kept reflective journals for the interviewing process. These journals reflected observations during the interview, such as the tone or expressions used by the participants. Keeping a journal of the accounts allowed me to record any bias experienced during the interaction with participants.

Dependability

Dependability requires that the researcher fully outline and document all protocols taken within the research (Merriam & Tisdell, 2015). Through these carefully documented descriptions of research operations, others may replicate the study with the same results. Dependability also promoted the notion of extrapolating rather than generalizing (Merriam & Tisdell, 2015, p. 255). The study used triangulation methods, which was seen as a strategy for obtaining congruent realistic data as understood by the participants (Merriam & Tisdell, 2015). The study's audit trails were necessary to describe how data was collected and how themes and categories were established throughout the research process. Maintaining an audit trail related to this research required me to keep a journal that provided a running record of the data as engagement occurred with participants (Merriam & Tisdell, 2015) and provided a detailed account of how the study was performed.

Ethical Procedures

All data collections were implemented once I received IRB approval and the IRB expiration date was set. Proper procedures were taken to ensure the protection of all participants involved. The following was implemented to ensure the confidentiality of each participant:

1. Participants were over 18 years of age at the time of the study.
2. The participants understood that the study was voluntary.
3. Risks associated with the study were explained.
4. No monetary benefits were provided for participation.

5. No coercion methods were used.
6. Participants could end the interview at any time.
7. All participants were fully informed of these protection methods before signing the informed consent.
8. Transcripts are stored for a maximum of two years since the study's conclusion and are also stored on a password-protected cloud device dedicated strictly to this study and data was only accessible by me.

Informed consent forms required a signature from the participant, and a portion of the informed consent focused on the participants' complete understanding of the items discussed. Participants were provided the option of performing their interview via telephone, in person, or video conferencing sessions (such as Skype and FaceTime). Participants' time constraints were respected and noted. Each participant was informed that they would receive a transcript of the interview within 72 hours of the conclusion.

All IRB guidelines were adhered to, and participant information was securely always kept through password protection during this study. It was important to note that I was a graduate assistant who worked with the IRB, but there was no influence on my IRB approval process because I was strictly a ghostwriter for the IRB and had minimal involvement with those who reviewed the IRB application.

Summary

In conclusion, the purpose of this study was to understand the relationship between an individual of low SES with MS and their health care provider. The pilot study discussed in Chapter 3 tested the study's procedures prior to the start of the main study.

The results of the pilot student rendered the results that no changes needed to be made to the interview guide or the participant selection methods. Participants were asked to volunteer for the study through a flyer posted on multiple social media groups. Participants were selected for the pilot study and the main study using the purposeful sampling method. The participants considered for this study were located throughout the United States, were of low SES, and had self-identified as having MS. The socioeconomic question in the participant survey determined the SES status of each participant. Specific questions and the order in which they were presented were determined ahead of time to maintain the interview's structured format. The participants were allowed to elaborate on each question with antonymy.

Chapter 3 outlined the research rationale, design, and methodology used within the research study. The researcher's role within the study and the selection of the participants was introduced within Chapter 3, along with the instrumentation and data analysis plan for deciphering the codes and themes within the research. The research's trustworthiness issues included the credibility and dependability of the pilot and main study data. Chapter 3 concluded with the pilot study processes, the pilot study's results, and how those results affected the main study's procedures.

Chapter 4: Results

The purpose of this basic qualitative study was to understand the lived experiences of individuals diagnosed with MS of low SES and their perspectives of developing and sustaining an authentic relationship with their health care provider. The research question was “What were the lived experiences of low SES individuals diagnosed with MS in developing authentic relationships with their health care providers?” This chapter describes the research setting, participant demographics, data collection and analysis, evidence of trustworthiness, and the study results. The analysis for this study includes demographic information on the participants, the data collection and data analysis methods used for the research, and the processes used to ensure trustworthiness and credibility within the study. This chapter ends with the results and interpretations of the interviews and a summary that comprises an overview of Chapter 5.

Setting

The interviews with participants were via Zoom video and audio conferencing. Participants were provided a meeting link that they could use to access the interview room. Once the participant entered the virtual interview room, the participant was reminded that the interview would be recorded. The participant could opt out of performing the interview if they wished. Interviews were recorded through the Zoom conferencing system, and all interviews were transcribed using Descript software and manual transcription methods.

Interviews with participants were conducted at a time of the participants choosing. All participants who volunteered for the study were able to keep their scheduled dates and times, creating minimal disruption in the scheduling processes, therefore finishing the interviews promptly. Allowing participants to make their appointments helped reduce the need for rescheduling and cancellations. For continuity in the study to remain present, all appointment requests were maintained within a password-protected file containing calendar data. The calendar data included interview dates, times, and participant contact information. During the interview request, participants were assured that their information would be kept confidential.

Demographics

The pilot and main SPs' inclusion criteria included individuals who self-identified as being diagnosed with MS, over 18 years old, and located throughout the United States. Twelve participants met the inclusion criteria for this study. Family income levels ranged from $12,000–$45,000. Seven of the 12 participants were unemployed, four worked part time, and one was employed full time (Appendix A). All participants were of low income based on their family income. Each participant had different experiences regarding authentic relationships with their health care providers. The demographics of the 12 participants that participated in this study included current yearly family income, current insurance coverage, employment status.

Description of the Participants

TP-01

The first participant was a single male diagnosed with MS who stated he worked part time but could not keep his previous job due to his condition. He became aware of the study through the Facebook post requesting participants. This participant reported Medicaid coverage.

TP-02

The second participant in this study previously worked at a bank. She was diagnosed with MS five years before 2021 and had to quit working due to the doctor appointments and health issues related to her MS diagnosis. Her husband was the only one working in the household, and their annual family income was $45,000. They could not afford insurance because of financial hardship; therefore, this participant presented as uninsured and low income.

TP-03

The third participant classified themselves as unemployed and diagnosed with MS. She was laid off due to the COVID-19 pandemic and continued to receive unemployment benefits. Before being laid off, she made approximately $35,000 per year with minimal expenses. When asked how much she earned now on unemployment, her response was “significantly less.” This participant had applied for government-funded insurance but had yet to receive benefits.

TP-04

Participant four was an unemployed female diagnosed with MS who was on disability. She reported receiving alimony, and since 2016, she had consistently earned about $32,000 per year. The participant stated she had Medicare as her insurance provider and was the sole person in her family unit.

TP-05

Participant five was an unemployed female diagnosed with MS who was currently on disability. This participant held Medicaid as her insurance provider and made approximately $1,000 per month from disability. The participant mentioned that she had been receiving disability for five years, and the amount had increased over the years, starting at $800 per month. This amount placed her annual household income at $12,000.

SP-06

Participant six was an unemployed male participant. This participant stated that he could not work due to his MS. He had been on disability for 12 years, and his earnings were approximately $30,000 per year. He also stated that there had been an increase in his disability payments over the last 12 years. He first began receiving $22,000 per year, and it gradually increased throughout time. The participant did not make mention how much the increase was each year. This participant held Medicaid as his current insurance.

SP-07

Participant seven was an unemployed male participant. This individual lost his job in March 2020 and was currently still unemployed. He currently did not hold any insurance due to his limited income and was trying to find insurance to purchase or possibly apply for government assistance. His annual household income was $30,000, and he collected $42,000 in annual wages before losing his job.

SP-08

Participant eight was a female participant diagnosed with MS who worked part time in a gas station. She reported consistently earning approximately $20,000 annually.

This participant had been a Medicaid recipient for the last ten years and had continuously worked part-time during the same period.

SP-09

Participant nine was a female participant diagnosed with MS who worked part time as a substitute teacher. Her husband recently lost his job, which caused her family to lose their private insurance benefits. Because of her current part-time status, the family could not afford to purchase insurance, and she was trying to file for health care assistance. Before losing his job, the family purchased private insurance, but the participant stated that the “copays were high, and the insurance was not easy to use.” There was no set timeframe for how long a participant needed to be considered low SES, so the participant qualified for the study.

SP-10

Participant 10 was an employed male participant. He worked as an auto mechanic and had been at the same company for approximately 15 years. He previously worked directly on the vehicles, but due to his MS symptoms, he had been forced to work inside the establishment. The participant earned an annual household income of $38,000 per year and was on private insurance through his employer. The participant made approximately $42,000 per year before transferring to perform his duties inside the workplace.

SP-11

The eleventh participant was employed as a waitress and worked 20-35 hours per week. Her current employer considered 38 hours full time, so she was classified as a part-time employee. The participant's husband worked, and the household income was valued at $40,000–$42,000 a year. The consideration for a range was given due to the nature of her employment as a waitress. The participant explained that there were some weeks that she did not bring home as many tips, which affected their income. The participant did pay for private insurance through her husband's employer but faced financial struggles due to medical bill obligations and copays.

SP-12

Participant 12 had been a homemaker for the last 12 years. Her household income was approximately $41,000, and the family did pay for private insurance through her husband's employer. Because the family had private insurance, they experienced financial hardship with her medical bills and copays. Her husband recently experienced a pay cut in February 2020 that decreased his annual salary from $45,000 annually to $41,000. Despite the decrease in pay, the family could still maintain their current insurance.

Data Collection

Interviews

All data were collected from the 12 participants of low SES with MS by me using the videoconferencing platform Zoom. The Zoom interviews between myself and the participants included a welcome message and an introduction before asking the IQs. The study's purpose was described to the participant, the consent form was reviewed to ensure that the participant understood their role, and I expressed gratitude and thanks for the participant's volunteering role within the study. Consent for the interview was obtained via email when the participant was initially emailed the consent form. To ensure that full consent was understood, the consent form was reviewed in the recorded interview, and the participant was asked to vocalize if they agreed or disagreed with the interview consent. The participant was instructed again on the interview procedures, including the questions asked throughout the interview. The interview length of 30–60 minutes was mentioned to the participant, and the participant was reminded that the interview was audio recorded. Lastly, the participant was told that a transcript would be provided within 24 hours for their approval. All participants expressed their approval of the transcript 24–48 hours after receiving correspondence from me.

All interviews were recorded using Zoom audio conferencing. My dissertation committee members and a pilot study authenticated the interview guide for proper scope and alignment to the research questions and study’s purpose. Though I did know the participants’ names, the participants remained anonymous within the study under participant identification numbers 1–12. Immediately after each interview, recordings were transcribed into PDFs using Descript transcription software. In these transcriptions, I was noted as “Jennifer,” and the participants’ identifier was an identifier that consisted of their place in the study, such as TP or SP, followed by a numerical identifier to protect their identities (e.g., TP-01, SP-01). Neither the participants nor I requested follow-up interviews. All transcripts for this study were organized using NVivo 1.4.1 software.

Data Analysis

After the participant approved the transcribed interviews, the transcribed qualitative data was used for analysis to create themes based on the participants’ responses. Themes were created to identify trends within the participant responses to IQs. Thematic saturation was reached by the 12th participant and was deemed finalized after this interview. The data analysis plan for this study followed five different processes to synthesize and make sense of the data (Wong, 2008). The following steps were used:

1. Broad codes were determined by becoming familiar with the data produced within the transcripts.
2. Each transcript line was analyzed, and codes were identified on a line-by-line basis.
3. After the review, codes were separated into categories.
4. Categorizing the codes into subcategories created apparent themes.
5. Themes that presented to be most prevent among the participant interviews became the focus for the study.

The five steps allowed me to synthesize the data by:

1. The data allowed for the exploration of the relationships between thematic categories.
2. The data exposed patterns and relationships between the categories.
3. Mapping the interpretations of the patterns between the categories gave insight to themes within the participant transcripts.

   (Wong, 2008).

After the interview transcripts were verified, they were stored in the NVivo 1.4.1 platform. Using NVivo and manual coding techniques that followed the qualitative processes aligned the participants' experiences related to the authenticity they felt they had with their provider. The NVivo 1.4.1 software allowed for a broader investigation of the uploaded raw data. After the initial review of themes, the raw data was uploaded into NVivo 1.4.1 for greater integrity of the findings and support of the themes presented. After processing the interviews through the NVivo 1.4.1 software, I manually reviewed each interview to determine if the program missed common themes within the data. It was also important to understand that themes were based on the interview context, not just what the software discovered. The themes were organized, without incongruity, within the NVivo 1.4.1 software (Appendix B).

Evidence of Trustworthiness

Credibility

Credibility was sustained within this study by being objective through journaling the participant's experiences. Journaling was done through writing the instances of emotional inflection of the participants' voices, such as excitement or anger, during the video conferencing session. All participants and the data collection processes aligned well with the basic qualitative data analysis steps. To enhance objectivity and the conformity of the process, NVivo 1.4.1 was used to allow for proper data management, processing data on an analytical level, and reliability of the data through recurring and duplicative processes that the NVivo platform provided.

Transferability

Transferability was how well the research results were transferred into other research settings. The data collection process and analysis provided robust data and descriptive participant experiences on their relationship with their health care providers in alignment with the RCC theory. Transferability of the research was sustained by collecting and diving into the data to the magnitude that the findings could influence researchers to explore more individuals of low SES who were diagnosed with MS and their experiences with their health care providers. Individuals who volunteered participated in Zoom audioconferencing, semi-structured interviews with open-ended questions. This study accentuated findings in current research regarding the qualitative aspects of low SES individuals diagnosed with MS and their relationship with their health care provider.

Dependability

The study's dependability was ensured through the continuity of the processes performed with each participant. The concept of repeatability was allowable through the basic qualitative data collection processes reinforced with the qualitative analysis procedures for qualitative descriptive analysis and further reinforced with NVivo 1.4.1 for security and stability. Audit trails for the study were assured through recording each session with the participant, performing a thorough overview of the session by replaying the recording to ensure data accuracy, noting any emotional effects the participant expressed, performing manual coding and thematic analysis, and allowing NVivo 1.4.1 to perform an automated analysis of the transcribed data.

Confirmability

Participant narratives were the driving force behind this research. The participants' experiences were used to identify confirmability within the research and reduce potential researcher bias. The qualitative data analysis methods approved by the

IRB application were strictly applied to the interview processes to ensure that confirmability was met. Confirmability helped create research based on the participant experiences rather than the researchers’ influence.

Results

The study’s results were organized based on the alignment of the original research question based on the RCC theory elements, the interpersonal understanding of the research question, and the themes that presented themselves throughout the data concerning the authenticity of the relationship with their health care provider. Most participants who volunteered for this research were on Medicaid, some reported having no health insurance, and very few had private insurance through their employer. Most of the participants were unemployed due to their MS disability, others reported working a part-time job or unemployment. Very few participants reported having full-time employment. The following represents the questions to support the research question and their appropriate IQ acronym concerning the research (Appendix C). The IQ revealed that many of the participants’ common themes regarding the “authenticity of the relationship” were built upon genuine approachability and communication. Understanding, respect, truth, encouragement, engagement, empathy, openness, and honesty emerged as common phrases when participants were asked how their definition of authenticity fits in line with their current provider (IQ 5). Emerged phrases regarding the overall relationship with their provider (IQ 7) include annoyed, demanding, disrespectful, demeaning, condescending, fantastic, open, and caring. Regarding how the participants respond when asked questions, negative phrases such as unfriendly, annoyed, and disregarding emerged but positive aspects included open, communicative, and responsive were noted (IQ 8). When participants were asked how their experiences with their provider made them feel, common negative phrases appeared such as helpless, ignored, uncomfortable, offended, hurt, distrustful of their provider, hopeless, and ignored. Those with positive experiences related to the question felt as though their providers made them feel welcomed and that the provider was willing to assist and listen (IQ 9).

Research Question

Four IQs (IQ 5, IQ 7, IQ 8, IQ 9) examined the lived experiences of participants of low SES who were diagnosed with MS. These questions investigated how participants viewed authenticity in the relationship with their provider, their relationship with their provider, how the provider responded to the participant's questions, and how the participant felt when their provider responded to their questions. Observations of the participants while asking this question were mixed. Those who had positive experiences spoke with ease and openness about their experience, but those with negative experiences paused and reflected. Emotional effects were noted through the participants' tone while answering the interview question. For example, participants with a positive experience were more apt to divulge their experience quickly, with a very excited, upward inflection of their voice, but those of a negative experience hesitated to answer the question or sounded upset or angry.

Theme 1: Authentic Approachability

In the fifth IQ, the participants' definition of authenticity was examined. The following were major themes that resulted from those definitions (see Appendix D):

- Participants feel that an authentic relationship should be open, genuine, and honest between the two parties.
- Participants felt authentic approachability should include courtesy and truthfulness.

When participants were asked how they would define authenticity, participant TP-02 responded, “I would say authentic to me was someone who was going to listen to what I have to say and really being invested.” This belief was like participant TP-04, that stated, “It was the development of a relationship throughout time built on trust.” In continuing with the theme, TP-01 stated, “It was easier for me to speak to my doctor that way they could just accept what I am talking about. Just being open with me and honest was ideal”. TP-03 stated, “If I had to give a definition of authentic, it would be genuine, and I guess if we were talking about the relationship that I have with my provider my definition would be someone who was genuine, somebody who was going to listen to what I have to say.”

In IQ 7, the overall picture of the relationship between the participant and their provider was examined. The top three themes for this question were as follows:

- Participants felt that the ability to approach their provider was daunting and intimidating.
- Participants felt they could approach their provider with new concepts related to their care.

When participants were asked to provide an overall picture of the relationship with their provider, SP-09 replied, “She listened to what I had to say regarding my symptoms and ordered an MRI to help me get a diagnosis." In contrast, SP-09 responded that "there was a transition time to get to know one another and there was a hesitation to bring new information in not knowing how the provider will respond."

IQ 8 explored how the provider responded to the participant when questions were asked:

- Participants felt their provider was annoyed when they approached their physician with questions about their care or MS.
- Participants felt disregarded and disrespected when they asked questions about research or treatment related to their MS.

Participants were asked to evaluate how their providers responded to them and provide examples of their reasoning. SP-06 responded that "Initially I felt that he didn't care, and that I could tell him things about my symptoms, and he was strictly by the book. Now I feel as though I could come to him with my issues, but that took time."

IQ 9 furthered IQ 8 in expanding how the participants felt when their provider responded to the questions asked:

- Due to the unauthentic approachability in the relationship noted in IQ 8, participants felt helpless, ignored, or uncomfortable.

Regarding approachability, participants were asked how the providers respond in a specific manner that makes them feel. SP-08 replied, "because I didn't trust her and because I got to a certain mindset of not trusting her, I just stopped asking questions. I just stopped bringing things to her."

Theme 2: Communication

In IQ 5, the participants' definition of authenticity was examined. The following were two major themes that resulted from those definitions (see Appendix D)

- Participants feel an authentic relationship should consist of communication that includes encouragement, engagement, empathy, and active listening.

In response to IQ 5, SP-08 replied, "with me with relationships, and authenticity means that we were true with one another and that we were listening to one another." TP-03 felt the same sentiments by answering the question with "somebody who was going to listen to what I have to say." SP-12 responded that in an authentic relationship, communication "would be one that was very open and very honest. And one that communication was between two people. To have a relationship, you must have open communication, and it must be communication that was true. One person can't lie to the other person because we lose that level of authenticity between the two people."

In IQ 7, the overall picture of the relationship between the participant and their provider was examined. The top three subcategories for this question were as follows:

- Participants felt that communication with their providers was awkward and uncomfortable and that the authentic communication with their provider felt rushed.

SP-12's response concerning communication was that "I will go through my list of symptoms, and I'll go through my list of new occurrences, and it's okay next kind of thing."

IQ 8 explored how the provider responded to the participant when questions were asked:

- Participants felt that their provider's level of authentic communication was unfriendly.
- Participants felt that there was an open line of communication but that it had to be built up along with the relationship.

Participants' believing that they had experienced unfriendly communication when they ask questions to their provider, SP-10 responded that "when I ask questions, he was pretty dismissive. I cannot necessarily say that he listens to everything that I have to say or all of my questions." SP-09 had a different experience in that it was noted: "When I ask her questions, she was very patient and she listened to each one of my questions, and she does take the time to explain it." IQ 9 furthered IQ 8 in expanding how the participants felt when their provider responded to the questions asked:

- Unauthentic communication led participants to feel hurt, offended, and worthless.
- Unauthentic communication made participants feel belittled by their health care provider.
- Participants felt welcomed by their provider to ask questions and were encouraged to.

Much like previous questions, there was some contrast in experiences. SP-09 stated that "I am very blessed that I have such open communication and relationship with my provider," whereas TP-04 responded, "I don't tell her anything because there's no reason.

She’s not going to do anything about it. So, I don’t tell her anything because I don’t feel like she cares. Medicare doesn’t pay enough for her to listen to me about my condition.”

Relationship-Centered Care Model

Participants in this study reported that approachability was linked to the personhood characteristics within the RCC theory. *Personhood* was defined as the provider’s mannerisms while interacting with the participant. Key findings related to the RCC theory elements presented that participants’ felt that approachability and personhood needed to create an authentic relationship with their provider IQ 5, IQ 6, and IQ 8 were used to address how approachability and personhood applied to the research question, and subthemes such as open and authenticity in the approachability were consistent in the participant answers.

Participants in this study reported courtesy and truthfulness regarding fostering the relationship with their providers. When participants did not experience these, the participant felt awkward, uncomfortable, disregarded, offended, hurt, and worthless. The RCC theory was aligned with themes developed regarding the RCC theory that relationships between participants and health care providers did not occur in isolation (IQ 8). How participants see their definition of authenticity aligns with fostering healthy authentic relationships with their providers (IQ 5 and IQ 6).

Participants in the study reported encouragement, engagement, listening, and empathy regarding essential items for building a relationship and maintaining an authentic relationship with their health care provider. Key findings related to the RCC theory elements and the frequency values amongst the 12 participants were presented.

The RCC theory was aligned with themes developed regarding the fostering of the relationship with their provider (IQ 8), how participants see if their definition of authenticity aligned in the maintaining of healthy authentic relationships with their provider (IQ 5 and IQ 6), and regarding how the provider made the participant feel.

Summary

The purpose of this basic qualitative study was to examine the experiences of participants of low SES who had been diagnosed with MS and their health care providers. From the research question presented, multiple themes emerged. The research question's purpose was to evaluate the experiences of low SES participants who had been diagnosed with MS regarding the authenticity in the relationship with their health care provider. The overwhelming results from this study were that providers failed to provide good experiences for the participants (Appendix E). Many participants did not trust their providers based on their experiences, and many felt helpless in their current relationship with their health care providers.

Chapter 4 included the setting for the study and the demographics and descriptions of the participants within the study. The chapter provided a detailed account of the participant's employment status, yearly income, and insurance provider. Chapter 4 described the data collection processes used after the interview and evaluated the evidence of trustworthiness related to the data's credibility, transferability, dependability, and confirmability. Chapter 4 concluded with the themes identified within the research results and how those results applied to the research question. Chapter 5 will focus on the discussions, conclusions, and recommendations for future research. The interpretations of the findings related to the development of authentic approachability and communication within the participant and health care provider relationships are evaluated, along with the barriers to building authentic relationships.

Chapter 5: Discussions, Conclusions, and Recommendations

Barriers leading to health care disparities have become a focus for health care delivery. Of those barriers, establishing an authentic relationship between a health care provider and the patient should not be overlooked. Many factors, such as affordability, access, and diversity in the health care system, influence care and outcomes, creating challenges that make the task of eliminating health disparities and achieving health equity daunting and elusive (Williams et al., 2016). Evaluating the challenges individuals diagnosed with MS who were of low SES face when interacting with health care providers is essential to creating a collaborative, authentic relationship, and better communication (Golla et al., 2014; Suchman, 2011).

The purpose of this basic qualitative study was to explore the lived experiences related to the authenticity of the relationship between individuals diagnosed with MS who were of low SES and their providers. Participants in this study noted a disconnect with health care providers based on their belief that their SES directly affected how health care providers interacted in the relationship (see Cadden et al., 2018). Health care providers can build this authentic relationship with their patients through building a rapport focused on (a) providing assurances, (b) telling patients it is okay to ask questions, (c) showing patients their lab results and explaining what they mean, (d) avoid language and behaviors that were judgmental of patients, and (e) asking patients what they want in the relationship (Dang et al., 2017).

Interpretation of the Findings

The relationship between the patient in the provider should include trust, respect, and communication (Arpey et al., 2017). Authentic approachability and communication in this study were expressed through the participants' interpretation of their experiences with their providers (Appendix F). Participants reported that courtesy, truthfulness, encouragement, engagement, listening, and empathy were key in fostering an open and transparent relationship between them and their providers. The provision of truthful information to patients was one way to enable them to make correct decisions that benefit their overall health. Without this knowledge, it is uncertain whether patients can make informed decisions (Zolkefli, 2018).

The participants expressed negative and positive feedback that helped explain how their experiences affected their health outcomes. There were two realistic outcomes among participants: (a) the expectations versus experiences of the patients and health care provider interactions and (b) the factors that influenced the authentic communication and approachability (see Soundy et al., 2016). When participants did not experience courtesy and truthfulness, the participant felt awkward, uncomfortable, disregarded, offended, hurt, and worthless. Those who experienced negative situations were more inclined to find new providers, whereas those with positive experiences had no desire to change to another provider. If the relationship is challenged or failing, physicians should be able to recognize the causes for the disruption in the relationship and implement solutions to improve care (Chipidza et al., 2015). Patients who present positive experiences hold a sustainable relationship with their provider and can make cohesive plans with their provider on their plan of care (Harbishettar et al., 2019). In contrast, participants who expressed negative experiences with their provider were dissatisfied with their care, prompting them to search for another provider. This change in health care providers can lead to longer wait times to be seen by a new provider, creating a risk in their health outcomes (Adler & Newman, 2002).

Approachability in Development of Authentic Relationships

The relationship between the patient and their health care provider is critical in delivering proper health care (Harbishettar et al., 2019), which includes providing information, resources, and an accurate diagnosis. The relationship between a patient and a health care provider is founded on trust and open communication between the patient and the health care provider. Patients feel they can trust their provider if they have a provider who exhibits affect and emotional interest while interacting with them (Council of Accountable Physician Practices Focus Group, 2017). Trust and understanding established through positive connections allow the patient to feel comfortable in their health treatment plans. However, changes in the delivery of health care services, such as the emphasis on cost controls and the almost complete conversion to managed care for the delivery of services under Medicaid, may be problematic for lower SES populations regarding patient experiences (Institute of Medicine on Assuring the Health of the Public in the 21st Century, 2002).

Approachability in health care includes the ability for a patient to discuss treatment options with their provider openly (Harbishettar et al., 2019). Components of approachability include providing clear information on care essential to the patients’ health outcomes. Each participant’s experience varied in response regarding their ability to approach their provider (Appendix G). The participants’ reflections on how they should be regarded in the relationship support previous research that stated that patients can establish a trusting relationship if their health care provider is forthright in the relationship (Soundy et al., 2016). Participants consistently responded that approachability must be highly regarded in the relationship between the health care provider and the participant.

When patients experience unanswered questions or distrust of their medical provider, they are likely to mistrust their provider and not disclose new symptoms (Soundy et al., 2016). Patients need to feel that they can approach their provider with questions and concerns regarding their health without distrust. But many health care providers put the treatment protocol first rather than concentrating on the relationship with their patients (Soundy et al., 2016). The findings in this research exposed that nine of the 12 participants expressed that the relationship with their provider felt unauthentic due to their inability to approach their provider. They stated that they could not approach their provider with treatment plans, though the other three participants stated they felt comfortable adding input and fully communicating their health care needs (Appendix G). The three participants who reported positive experiences in the approachability also reported that they were more likely to communicate their health challenges to their providers. The feeling of comfort from a patient allows a provider to learn more about the patient, creating a positive experience in the health care approachability (Harbishettar et al., 2019). In contrast, those who had negative experiences with approachability suffer from a delay in diagnosis due to the patient not feeling comfortable enough to share pertinent health information with their provider.

Despite the findings related to approachability, the impact of the research participants' low SES and their experiences regarding approachability in the relationship with their health care provider was unclear. Although lower-income patients are likely to express greater dissatisfaction with their health care provider (Becker & Newman, 2003), only nine of the 12 participants interviewed in this research referred to their health care provider as unapproachable regarding new treatments, symptoms, or questions regarding the participants' care. No conclusive evidence was produced that could directly link a decline in approachability with their provider due to the participants' low SES. However, there was a consistent finding that the participant did not provide information about their symptoms or feelings if there were no open approachability. The lack of approachability in the relationship caused a strain between the patient and provider (Becker & Newsom, 2003). Lastly, although income levels directly affected the ability for participants to approach their provider regarding their health care plans (Adler & Newman, 2002), there was not enough evidence from the participant experiences to conclusively solve the assumption that lower SES affected authenticity in approachability.

Further, although there was no conclusive evidence regarding approachability, the concept was related to the personhood characteristics of the RCC theory. IQ 8 asked for participants to provide their definition of authenticity. The participant responses aligned with how the provider made them feel, which supported the RCC theory that approachability could affect emotional connections.

Communication in the Development of Authentic Relationships

Communication was the foundation for the patient- health care provider relationships to become authentic. Without proper communication, misunderstandings or misinterpretations of the relationship manifested between a patient and their health care provider. Understanding authentic communication was best accomplished by hearing patients' experiences regarding their health care providers. Physician communication led to favorable recommendations, and the patient's perceived satisfaction played an important role in this process. The physician should display empathy and compassion while communicating with patients, which helps build a favorable perception of the physician (Mehra & Mishra, 2021). Communication was a key element in developing and sustaining a relationship between patients and health care providers (Becker & Newsom, 2003). The nonverbal and verbal interaction between the participant and their health care provider deciphered how well the two individuals relayed and received information. Poor communication between a patient and a health care provider was a primary source of dissatisfaction amongst patients. Patients dissatisfied with their provider had a higher rate of changing physicians to seek out better communication with a health care provider (Becker & Newsom, 2003). Positive and negative participant experiences within this research proved that communication directly affected the authenticity of the relationship**.**

Barriers to Authentic Communication

In this study, participants divulged their experiences regarding how authentic they felt their provider was in communicating with them. Those with negative experiences felt their providers were demeaning and were often spoken down to in their responses. This negative response was like Van Ryn and Burke's (2000) finding that providers' perceptions of their patients affected their assessment of their patient's intelligence. Patients in low SES groups often experience lower communication levels with their provider leading to unsatisfactory ratings and an assumption of their education level (Haviland et al., 2005), but the connection between low SES and communication authenticity was inconclusive in this research.

The RCC theory was aligned with the interview content supporting the idea that relationships between participants and health care providers did not occur in isolation. According to the RCC theory, if open communication was not present from the provider, the relationship could be jeopardized, leaving the patient helpless in the relationship.

Positive Experiences

For those that expressed positive experiences, each of Soklaridis' et al. four RCC theory principles applied as follows:

1. Participants felt that their provider was authentic in making them feel like their relationship mattered through communication and the ease of approachability with the provider.
2. Participants expressed that their providers were empathetic and apathetic to their problems and that by having a team-like dynamic, as mentioned by Beach et al. (2014) participants felt comfortable approaching and communicating with their providers.
3. Participants felt as though there was a partnership between them and their health care provider. They expressed that the relationship was built on open

communication, which created self-awareness of the role of the provider and the needs of the participant (Suchman, 2011)

4. The participant was felt more inclined to be engaged and stay with their current provider. Remaining with their current provider potentially led to better health outcomes.

Negative Experiences

Negative experiences provided by the participants supported why providers need to follow the four principles of the RCC theory. When the participant had a negative experience, the participant encountered the following feeling under Soklaridis' et al. (2016) four RCC theory principles:

1. The participant felt that their provider did not engage in open communication and could not approach their provider. This lack of approachability with the provider showed the participant that their personhood did not matter.
2. The participant did not feel they had an authentic relationship with their provider. Participants did not feel their provider showed empathy and apathy for their health needs.
3. The participant felt the relationship was one-sided. Their provider did not reciprocate communication that made the participant feel as though they were being heard. Many participants with negative outlooks on the relationship felt that their questions or suggestions were easily dismissed.
4. The participant did not feel they wanted to seek further help from other providers due to the lack of communication and approachability.

The RCC theory elements support an authentic relationship between the patient and the health care provider through authentic communication and approachability. If the patient or health care provider's approach, philosophy, or attitude was influenced positively or negatively, this could change the relationship. Negative experiences jeopardize the health outcomes of patients due to the lack of authentic communication and relationship between the patient and their health care provider (Beach et al., 2014). Participants who expressed positive experiences felt trust and openness with the communication and approachability authenticity, but those with negative experiences became closed off from their provider and felt their voice was not heard.

Theoretical Framework

The RCC theory created guidelines for building an authentic relationship between patients and health care providers. The RCC theory guidelines clarified that authentic approachability and communication were the foundation for creating an authentic relationship between patients and health care providers. Patients who feel respected and satisfied with the authenticity in the relationship with their health care provider will be more inclined to adhere to treatment plans, be actively engaged in the relationship, and trust their provider. Patient satisfaction plays a significant role in adherence to treatment and contributes to a positive working patient-physician therapeutic relationship (Walsh et al., 2019). If the patient had a negative experience with their provider, the participant changed physicians frequently, which led to diminished health outcomes.

Limitations of the Study

Within this basic qualitative study, there were some limitations. Limitations were specific to time constrictions, participant sample sizes, and maintaining reflexivity. The sample size of 12 individuals diagnosed with MS who were of low SES was important to the study’s limitations because it shows a narrow sampling compared to a larger study concerning MS perceptions of all SES. However, the study was still reliable and transferable despite the sampling size. Even with a smaller sampling size, the study could still impact social change. There were no limitations related to recruitment, as the social media form used had a large population of followers to volunteer.

I remained mindful of how any personal bias affected how data was collected within the study and how that bias could directly affect the outcomes. It was critical to remain constantly aware throughout the study of any personal bias and remain consistent with the information presented within the scope of the study. It was important to note that many participants presented negative experiences regarding the questions asked. Because of this, a level of bias could be perceived within the study results, but fortunately, the results unfolded due to the three positives versus the nine negative experiences.

Recommendations

The research into the lived experiences of individuals diagnosed with MS who were of low SES contains informed criteria that allowed future research regarding experiences with the participant’s primary care provider as a separate phenomenon. Recommendations for future studies suggest an investigation into the authentic relationship between the participant’s primary care provider versus their specialist providers. Further research could isolate differences in authenticity between the participants' primary health care provider and the participant's specialist. It was recommended that the experiences of individuals diagnosed with MS who were of low SES and their primary care provider be expanded.

Implications

The study's findings may contribute to positive social change by helping in understanding the experiences of individuals diagnosed with MS who were of low SES and their relationship with their health care providers. A renewed understanding of the participants' viewpoints may contribute to developing more authentic relationships with their health care providers without undue influence. Based on the gap in the literature on the experiences of individuals diagnosed with MS who were of low SES and their health care provider, it was critical to perform this research and bring the experiences of these participants to the front. Through this research, there was an opportunity to create social change for these participants by creating a powerful understanding of possible bias factors surrounding the participant and the health care provider's authenticity in relationships. There was also the ability to bring awareness to health care administrators to use this research to enhance the patient-provider relationship and improve the delivery and quality of health care rendered.

Methodological, Theoretical, and Empirical Implications

Implications regarding methodological, theoretical, or empirical processes were non-existent in this study. The participants were randomly selected, and all fell within the criteria regulated by the study. The individuals diagnosed with MS who were of low SES were an appropriate and meaningful population to investigate the gap in the literature described in Chapter 1. The gap in the literature described in Chapter 1 encourages the exploration of the level of authenticity participants experience with their health care providers.

Recommendations for Practice

Recommendations regarding this basic qualitative research study may aid in providing further understanding of the experiences of individuals diagnosed with MS who were of low SES. This study noted that most participants had a healthy open relationship with their primary care providers but failed to experience the same relationship with their MS specialists. Recommendations for health care providers involved in the care of their MS patients is that there needed to be consistent open communication with their patients and establish that their patients could always approach them with information. By practicing these recommendations, providers could establish an authentic relationship with their patients and improve the health outcomes for these individuals.

Conclusion

This research provided an opportunity to create social change by providing an open forum for participants to express their experiences with their health care providers. The exposure of these experiences created a powerful understanding of possible bias that surrounded the participant and their health care provider’s authenticity in the relationship. The participants’ expressions of their experiences supplied an opportunity for health care administrators to use this research to improve health care with more focus on the relationships between the provider and patients at their health care facility. The participant’s experiences would also enhance health care professionals’ knowledge of how these participants view their appointments with their health care provider. Further, the health care providers could use this information to strengthen the relationship, leading to better health outcomes for the participant.

The research findings represent the experiences that individuals diagnosed with MS who were of low SES had with their health care provider. This research was important to undertake due to its importance in understanding what participants of low SES experience when seeing a provider for a specific issue such as MS. The experiences provided by the participants in this research helped in understanding the importance of an authentic relationship between a patient and a health care provider. Increased awareness of these experiences may allow health care professionals to be more cognizant amongst participants of the same criteria as those who participated in this study.

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Appendix A: Characteristics of Participants

Participant	Household Income	Insurance	Employment
1	$14,000	Medicaid	Part-time
2	$45,000	None	Unemployed
3	$35,000	None	Unemployed
4	$32,000	Medicaid	Unemployed
5	$12,000	Medicaid	Unemployed
6	$30,000	Medicaid	Unemployed
7	$30,000	None	Part-time
8	$20,000	Medicaid	Part-time
9	$38,000	None	Part-time
10	$38,000	Private	Full-time
11	$42,000	Private	Part-time
12	$41,000	Private	Unemployed

Appendix B: Participant Statements, Codes, and Themes

Participant	Excerpts	Codes	Categories	Themes
SP-10	"It was daunting to go to these appointments"	Intimidation to bring new information to the providers attention	Helpless, ignored,	Authentic Approachability
SP-11	"He gets annoyed with me. I have asked questions before, and he acted like he" didn't hear me"	Provider evading participants questions	Dismissive, disregarded, ignored	Authentic Approachability
SP-10	"When I ask questions, he was pretty dismissive of what I am saying to him"	Unconcerned, Nonchalant attitude from the provider	Worthless, hopeless, hurt	Authentic Communication
SP-06	"The ability to trust my provider to know that what they're saying was true and thoughtful"	Distrust of providers opinion	Ignored, demeaned	Authentic Communication
SP-05	"It gets a little awkward and frustrating to talk to him"	Distrust of providers answers	Apprehensive, belittled	Authentic Communication
SP-11	"It was very awkward. It was almost like he was in a hurry"	Uncertainty on the interaction with their provider	Offended, alone	Authentic Communication
TP-04	"I do not trust my provider. She didn't spend more than 10 minutes with me in the room"	Distrust of providers ability to fully explain procedures	Truthfulness, unfriendly,	Authentic Communication
TP-02	"I had one specialist who was flat out disrespectful in the way that he spoke to me"	Providers poor communication with participant	Demeaning, condescending, offensive	Authentic Communication
TP-02	"When I finally was able to go to the doctor, she was super cold and unfriendly to me"	Unfriendly approaches from provider	Uncomfortable, helpless, worthless	Authentic Approachability
SP-08	"I would go in there and she was just cold and unfriendly to me, she had no empathy for the situation that I was going through"	Ignored by provider	Unempathetic, dismissive	Authentic Communication
TP-01	"I did everything they asked me to, but I still did not know what was going on. I still wasn't getting the explanation"	Uncertainty of outcomes	Hopelessness, uneasiness	Authentic communication

(table continues)

Participant	Excerpts	Codes	Categories	Themes
TP-01	“When I ask doctors about it, they immediately were apprehensive and would say: Don’t confuse your internet search with my degree”	Dismissed by providers; Opinion on diagnosis was does not addressed	Hurt, ignored, furious	Authentic Approachability
SP-07	“When I go to my provider with my opinions, I feel like I am not being listened to, I have asked for other testing, and didn’t get a response”	Dismissed by providers opinions of potential treatment or test	Furious, alone, unheard	Authentic Approachability
SP-07	“It made me feel terrible in the sense of I’m not being listened to”	Uncertainty regarding how well the provider was listening to participants concerns	Hopelessness, dismissed	Authentic Communication
SP-07	“When he response to me in this manner, it does to make me feel a little bit like he was not listening to me”	Distrust of provider’s attention	Ignored, dismissed, worthless	Authentic Communication
SP-09	“When I ask questions or bring forward information, she listens to each one of my questions, and she does take the time to explain it”	Appreciative of provider’s time invested in participant	Caring, comfortable	Authentic approachability
SP-09	“I asked her about this, and she didn’t hesitate to say, if you would like to do these tests, we can”	Provider listened and responded to the participants concerns and issues	Open, genuine, empathetic	Authentic Communication
SP-09	“I feel like I am well taken care of. I could bring things to her to talk about and she listens”	Close relationship with the provider	Engaged, encouraging, courteous	Authentic approachability

Appendix C: Interview Questions

Question identifier	Interview question
IQ 5	How would you define authenticity in a relationship?
IQ 7	Can you provide to me an overall picture of your relationship with your provider(s)?
IQ 8	How did you feel your provider responds to you when you ask questions?
IQ 9	How does it make you feel when the provider responds to you in this manner?

Appendix D: Concept Maps

Figure D1

Approachability Concept Map

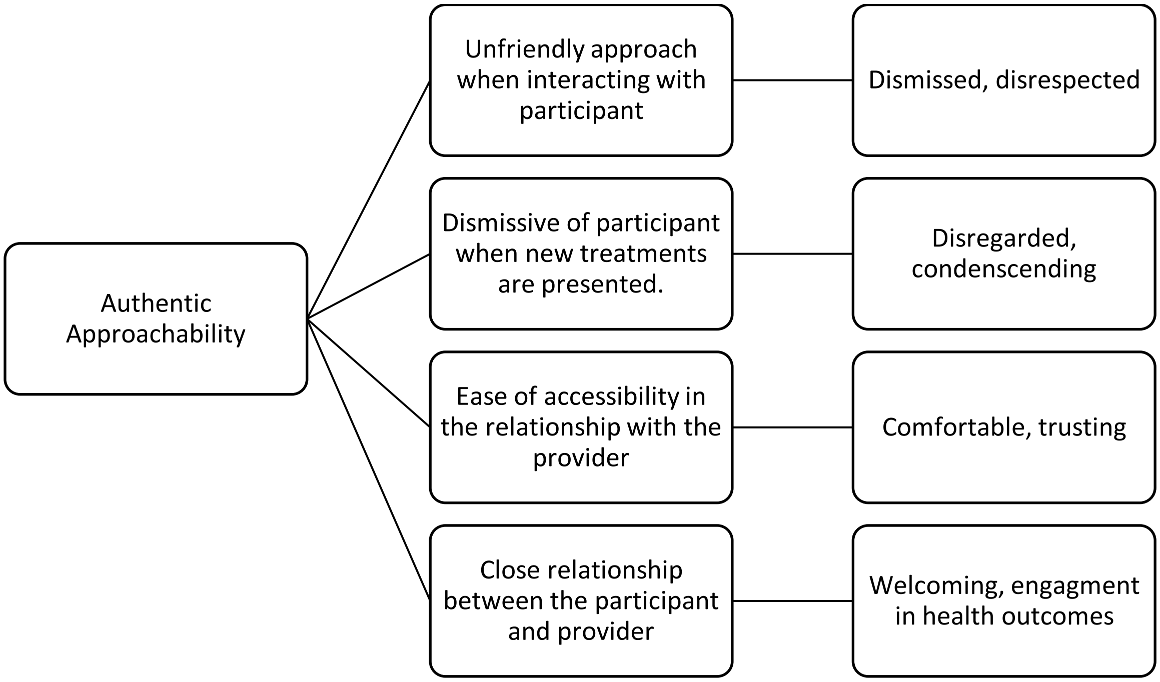
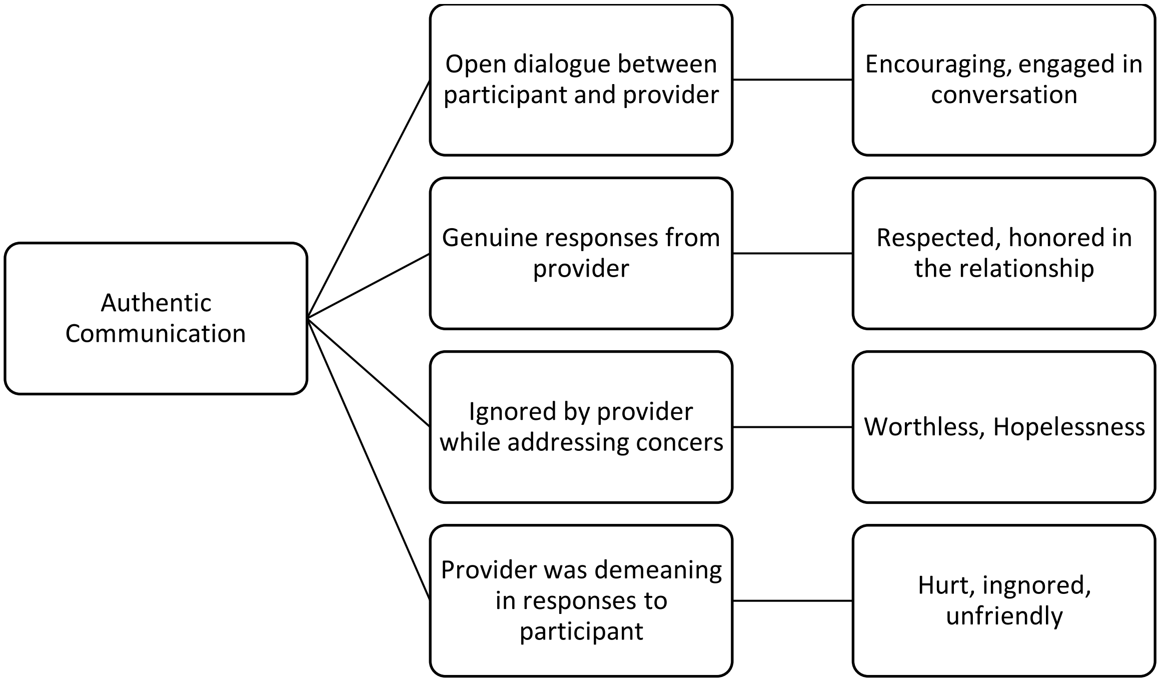


Figure D2

Communication Concept Map



Appendix E: Results from Themes

Interview Question	Approachability Theme	Communication Theme
IQ5	Open, genuine, and honest relationship between individuals	Encouragement and engagement between parties
IQ7	Unable to approach due to feeling intimidated. Ability to bring new ideas to their provider regarding treatments or potential therapies	Ability to speak to provider about concepts related to care
IQ8	Uncertainty in how provider will respond to questions	Provider was dismissive of questions asked by the participant; provider was open to hearing what the participant said and communicated answers or addressed concerns.
IQ9	Helpless, ignored	Unheard in the relationship
IQ9	Open, communicative	Participants felt that their provider listened to what they said and were empathetic

Appendix F: Study Findings

Theoretical Foundation	Research Question	Key findings
RCC	What are the experiences of low socioeconomic status individuals diagnosed with multiple sclerosis involving their healthcare provider?	Individuals of low socioeconomic status who had been diagnosed with multiple sclerosis experienced a lack of authenticity in the relationship with their providers due to lack of approachability and communication. This lack of authenticity led the participants to have a negative experience such as with their care. Due to experiences of low authenticity, many of the participants did not trust their provider to care for them. It was important to note that there were positive experiences regarding the interaction with their provider. Participants who had a positive experience, with open communication and approachability spoke of trusting their provider and felt an open relationship and authentic approachability.

Note. The acronym RCC relates to the relationship centered care theory.

Appendix G: Findings Related to RCC Theory

Figure G1

Personhood and Approachability

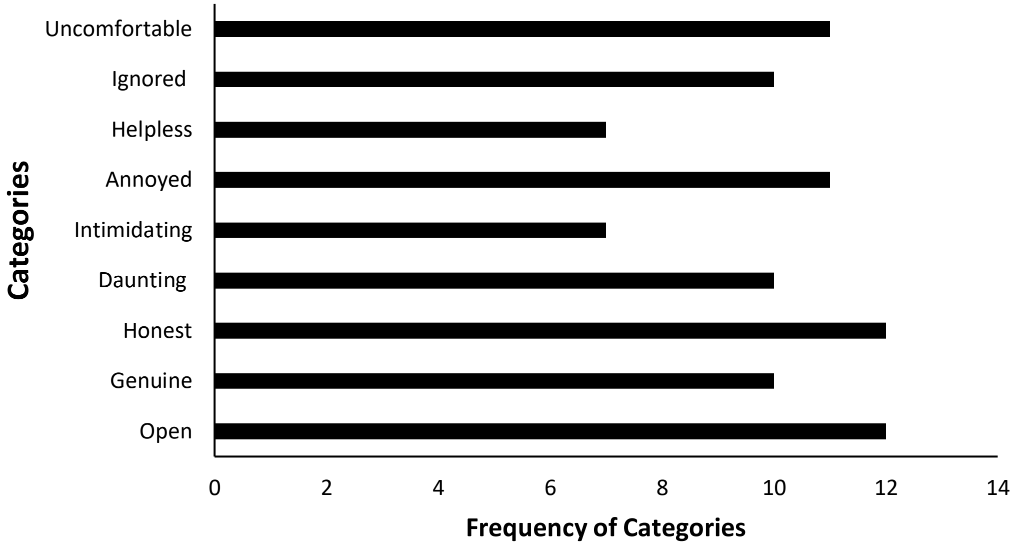


Figure G2

Respect and Fostering an Authentic Relationship

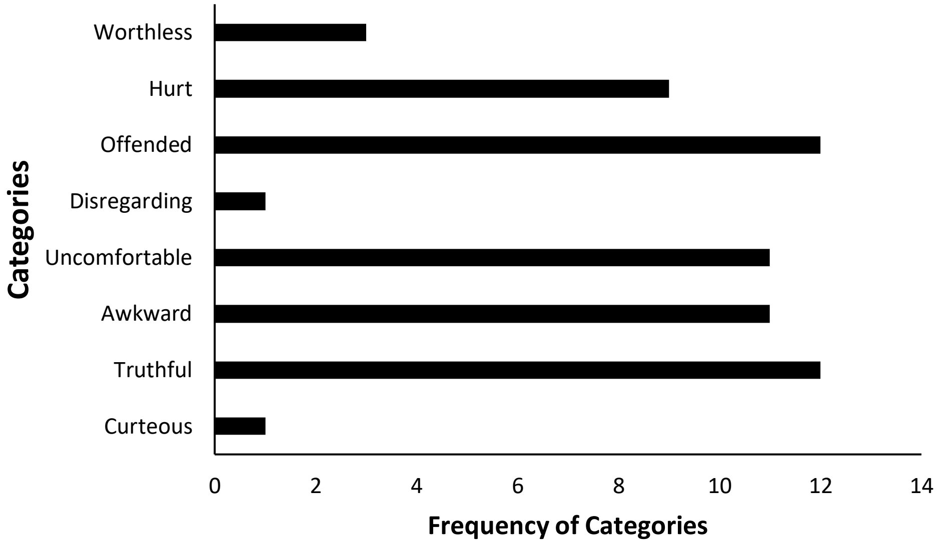


Figure G3

Authentic Communication Between Participants and Their Health Care Provider