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Walden University

College of Health Sciences and Public Policy

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Santiago Rivera

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2023

Abstract

Understanding Patient-Centered Care: Perception of Hispanic Physicians in Teaching Hospitals of the United States

by

Santiago Rivera

MHA, University of Phoenix, 2015

BS, Interamerican University of Puerto Rico, 1989

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services – Public Health Policy

Walden University

November 2023

Abstract

The aim of this qualitative phenomenological inquiry was to understand Hispanic physicians' perceptions of patient-centered care (PCC) as an integrated priority to improve healthcare quality, safety, accessibility, and affordability. The problem involves lack of research that includes Hispanic physician perspectives in PCC; such perspective can affect healthcare quality. Self-determination theory (SDT) served as the conceptual framework. A sample of 10 purposely selected Hispanic physicians who worked for U.S. teaching hospitals and had been in their position for at least 2 years took part in semistructured interviews to answer the research questions, which addressed what challenges Hispanic physicians face in practicing PCC in U.S. teaching hospitals and what the perceptions of Hispanic physicians are regarding the care quality, safety, accessibility, and affordability of PCC during the COVID-19 pandemic in U.S. teaching hospitals. Braun and Clark's six-step thematic analysis process was used to analyze the data. Results showed that fostering patient empowerment, providing patient inclusion in shared decision-making, prioritizing patient values and preferences, overcoming linguistic and cultural barriers, promoting a patient-centered communication framework, building cultural competency through educational and training programs, ensuring accessibility and affordability of healthcare, and developing policies that ensure transparency are essential for the implementation of the PCC model in U.S. teaching hospitals. Implications for positive social change include understanding of the PCC from Hispanic physicians; such understranding can result in improved healthcare services as an integrated priority of the PCC, leading to improved quality, safety, accessibility, and affordability in healthcare.

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Dedication

I dedicate this dissertation to myself, who made sacrifices from the beginning of my doctoral journey to its completion. To my partner, Louis Dominguez-Lira, my most excellent dedication and praise for believing in me and providing the never-ending encouragement and support to persevere.

Finally, to all my participants, thank you for your unwavering support in helping me complete this project; you Hispanic physicians allowed the story to be told.

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First and foremost, I want to thank God for his encouragement and for keeping me anchored in finishing this dissertation; without Him, I would not have overcome all the obstacles and challenges I faced. My committee members, Dr. Joshua Bass, Dr. Eboni Green, and Dr. Nicole Dhanraj, thank you for your support and contribution throughout this journey. I have been a handful sometimes, but I appreciate all your input and recommendations throughout this dissertation's completion. Finally, words are not enough to express how indebted I am to my mother, who has always guided me from heaven and has always been in my heart. With all of my heart, I always appreciated my partner Louis Dominguez-Lira's constant support in finishing my dissertation.

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Chapter 1: Introduction to the Study

Effective doctor–patient communication is essential in building a health-related value in delivering high-quality healthcare and helping to regulate patients' emotions, facilitate comprehension of medical information, better identify patients' needs and perceptions, and improve PCC results (Shiraly et al., 2021). Patients may visit multiple clinicians in various clinics or systems due to changes to the idea of a care visit and the proliferation of care delivery arrangements. This fragmentation of medical care and coverage in the United States has been detrimental to patient-centeredness and continues to present challenges to making care more patient centered (Boissy, 2020). The COVID-19 pandemic has emphasized the importance of PCC and the value of patient satisfaction and health-related outcomes (Jones et al., 2021).

PCC is an essential element of quality healthcare worldwide (Lateef & Mhlongo, 2022). PCC is a medical strategy in which doctors customize interventions to maintain the respect and responsiveness of their patients (Kwame & Petrucka, 2021). To improve patient satisfaction, enhance the reputation of providers, increase morale and productivity among clinicians, and improve resource allocation, PCC ensures that all clinical judgments involving assessment, diagnosis, planning, implementation, and evaluation are influenced by the fundamental principles of the patients (Bonner et al., 2021). Presently, there is limited research on the perception of Hispanic physicians as an integrated priority of PCC, which can impact patient satisfaction with care and foster greater job satisfaction among healthcare professionals, increased quality and safety of care, and greater quality of life and well-being of patients (Schuttner et al., 2022).

The COVID-19 pandemic has affected PCC’s quality, safety, and accessibility components, impacting patient relationship outcomes such as trust and satisfaction with treatment regimens (Morgan et al., 2023). In 2019, the COVID-19 pandemic posed an unprecedented threat to the world’s healthcare systems (Chandratre & Soman, 2020; Razu et al., 2021). The pandemic had affected about 107 million Americans as of May 31, 2023 (Worldmeters, 2023). Many healthcare services turned to online environments as face-to-face interactions between doctors and patients were not recommended. This shift jeopardized the crucial aspects of PCC: effective patient–doctor communication and standards of care (Spagnoletti et al., 2020). More important than the value of the patient interaction is the doctor's understanding of the patient's symptoms through the doctor’s subjective experience and health-related values to provide appropriate therapy and a successful connection between healthcare providers (Neutze et al., 2021; Palmer Kelly et al., 2021).

During the COVID-19 pandemic, the work of healthcare professionals in the United States has been more challenging than usual, resulting in the better alignment of the doctor as a central moderator in the provision of PCC (Doherty et al., 2019; Ward, 2018). Researchers have found certain practices—such as respect for patients’ values, preferences, and expressed needs; coordination and integration of care; information and education; and emotional support and alleviation of fear and anxiety—conducive to a positive patient experience (O’Neil, 2022). Findings have indicated that Picker's eight principles of PCC were directly affected during the COVID-19 pandemic (O'Neill, 2022). The U.S. Department of Health and Human Services (2022) emphasized the importance of the PCC model as hospitals in the United States reported that continuing fluctuations in the number of patients with COVID-19 made it challenging to establish a better care plan and directly affected the PCC model. U.S. hospitals reported that the pandemic led to delayed care, and professionals feared that erosion of trust in hospital safety would continue to keep patients from seeking needed care. Also, hospitals reported that lack of care and reduced hospital use significantly impacted patients during the COVID-19 pandemic (Grimm, 2021).

During the COVID-19 pandemic, the U.S. Department of Health and Human Services encountered a differential in mobility and mortality as the main multifactorial determinants, which are social determinants (i.e., the combination of genetic and environmental factors) that contribute to the development of a trait or disease and play a principal role in PCC (Andraska et al., 2021). Additionally, the availability of healthcare professionals from minority groups who can serve patients with diverse cultural, social, and linguistic backgrounds is crucial for achieving a higher level of PCC (Golden et al., 2021). Healthcare providers must establish rapport with patients to improve clinical practice and delivery (Campinha-Bacote, 2019).

PCC has received increased attention in recent years and is now considered an essential aspiration of high-quality healthcare systems. However, limited research has specifically addressed Hispanic physicians' perceptions as an integrated priority of PCC to improve the quality, safety, accessibility, and affordability of healthcare (Jones et al., 2021; Schroeder et al., 2020; Schuttner et al., 2022). There is a need to better understand PCC from the perspective of Hispanic physicians for several reasons, including gaps in the literature concerning how physicians and patients define PCC differently. The purpose of this study was to understand the perspectives of Hispanic physicians as an integrated priority of PCC to improve quality, safety, accessibility, and affordability in healthcare.

Background of the Study

Jones et al. (2021) and Schroeder et al. (2020) studied the issue of Hispanic physicians regarding empowering patients to make decisions about their healthcare. Hispanic physicians' view of PCC is an area deserving further investigation because of the impact of inadequate healthcare coverage, time-limited medical visits, and implicit racial bias in medical encounters for underrepresented patients. The lack of PCC by health providers is crucial in perpetuating disparities in healthcare outcomes and experiences (Mitchell, & Perry, 2020). Patient individuality, effective doctor–patient communication, and a supportive emotional and social environment that values patients are crucial elements of PCC (Freytag & Street, 2021). PCC is being implemented in healthcare systems worldwide to improve the quality of care (Edgman-Levitan & Schoenbaum, 2021; Kuipers et al., 2019). There are implementation challenges with the United States' fragmented health system (e.g., the exclusion of certain groups and exclusion of staff's parenthood) which might diminish the value of the staff as autonomous persons. The diminishing value of the staff might result in poor working conditions and high turnover rates, unfairness due to lack of empathy, and risk for compassion fatigue, that need to improve to increase PCC (Summer Meranius et al., 2020).

Transitioning to virtual healthcare services due to the potential danger of COVID-19 spreading impacted the PCC model (Parveen, 2020; Tan et al., 2020). U.S. policymakers have been pushing patients to take a proactive part in assuring creative techniques to increase the quality, safety, and accessibility of PCC. It has been determined that attitudes toward affordability among Hispanic physicians as an integral component of PCC may impact outcomes such as trust and satisfaction with treatment regimens. In the patient-centered concept, perspectives from Hispanic physicians may add another lens to evaluate intricate systems and procedures.

Problem Statement

This study focused on understanding Hispanic physicians' perspectives as an integrated priority of PCC to improve quality, safety, accessibility, and affordability in healthcare. First, U.S. policymakers have been pushing patients to proactively ensure creative engagement techniques to increase the quality, safety, and accessibility of PCC. Second, attitudes toward the awareness of the exclusion of certain groups (e.g., Hispanic physicians) that are integral components of PCC may impact outcomes such as trust and satisfaction with treatment regimens. Finally, in the patient-centered concept, perspectives from Hispanic physicians may add another lens to evaluate the intricate systems and procedures that can reduce unfairness due to lack of empathy and risk for compassion fatigue that need to improve to increase PCC (Summer Meranius et al., 2020).

Purpose of the Study

Through this qualitative study, I aimed to understand Hispanic physicians' perceptions as an integrated priority of PCC to improve the quality, safety, accessibility, and affordability of healthcare. The specific research design included essential qualitative inquiry, or interpretative description, to address the research questions in this qualitative study, providing the platform to answer straightforward questions without framing the inquiry.

Research Questions

RQ1: What challenges do Hispanic physicians face in practicing PCC in U.S. teaching hospitals?

RQ2: What were the perceptions of Hispanic physicians regarding the care quality, safety, accessibility, and affordability of PCC during the COVID-19 pandemic in U.S. teaching hospitals?

Theoretical Foundation

Self-determination theory (SDT; Podlog & Brown, 2016) was used to explain the study results. In 1977, psychologists Richard Ryan and Edward Deci developed the SDT of motivation. Self-determination is an important concept that refers to people's ability to make choices and manage their own lives. This ability plays a vital role in the PCC model because it creates an awareness of how vital competence, relatedness, and autonomy are to Hispanic physicians' motivation and performance (Cherry, 2019).

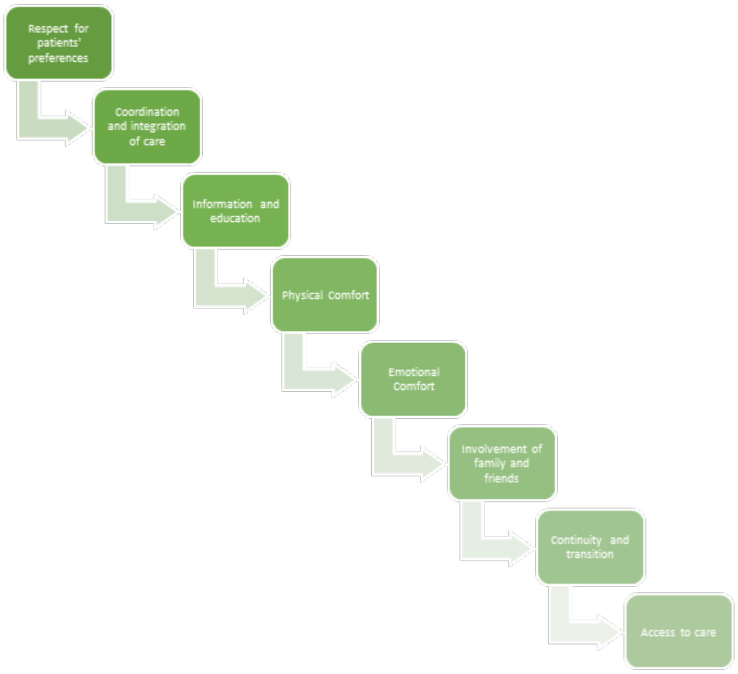
SDT is a motivational theory that highlights the value of evaluating autonomy in decision-making within the patient relationship. Autonomy, competence, and relatedness are the three essential psychosocial components in an individual that, when fulfilled, improve task performance and, when suppressed, produce a deleterious impact on the optimal well-being of an individual (Podlog & Brown, 2016). The reality of a patient's well-being is markedly dependent on their environment. According to Doherty et al. (2019), physician–patient communication directly impacts an individual's well-being, and as evidenced by studies, has been the most affected since the COVID-19 pandemic began. Therefore, it is essential to understand Hispanic physicians' perceptions as an integrated priority of PCC to improve quality, safety, accessibility, and affordability in healthcare (Doherty et al., 2019).

Conceptual Framework

The conceptual framework for this study stemmed from the eight dimensions of PCC presented by the Picker Institute (O’Neill, 2022).

Figure 1

Framework of the Eight Dimensions of Patient-Centered Care



Note. From *The Eight Principles of Patient-Centered Care* by N. O’Neill (2022), One View Healthcare (https://www.oneviewhealthcare.com/blog/the-eight-principles-of-patient-centered-care/).

Although healthcare interventions that represent all eight dimensions of PCC shown by the Picker Institute are essential to ensure quality healthcare (O’Neill, 2022), not all the dimensions are equally crucial for implementing PCC from the perspective of physicians (Sinaiko et al., 2019). Patient preferences, information, education, and coordination of care are the four most important dimensions that need to be addressed according to physicians' perceptions to implement quality healthcare (Sinaiko et al., 2019). Providing the patient with the necessary information and educating the patient regarding the dynamics of the disease they are suffering from empower the patient to make decisions regarding their healthcare and opt for approaches that are safe, accessible, and affordable as well as innovative (World Health Organization, 2018). Not all the dimensions are equally crucial for implementing PCC, according to the physician’s perspective (Sinaiko et al., 2019). Providing the patient with the necessary information and educating the patient regarding the dynamics of the disease they are suffering from are essential aspects for the patient to make decisions regarding their healthcare and opt for approaches that are safe, accessible, and affordable as well as innovative in terms of patient care, which was the primary aim of this study.

Patient preferences, expressed needs and values, education, information, communication, integration, and coordination of healthcare services are the key elements that lead to PCC directly and nurture the remaining five dimensions of PCC described by Picker (i.e., physical and emotional support, accessibility of healthcare, shared care with family and friends, continuity, and transition), which indirectly influence PCC.

Additionally, autonomy, freedom, and strength are the three fundamental pillars that link SDT to this study. Bodegård et al. (2022) stated that shared decision-making through improved communication between the physician and the patient leads to increased patient satisfaction and better biomedical outcomes. The process decreases the anxiety index of patients, creating a sense of autonomy and freedom of decision-making in patients and strengthening patients' compliance with the treatment (Deniz et al., 2021).

Definitions

Accessibility: The ability to get medical care and services when needed. Accessibility of healthcare refers to the ease with which an individual can obtain needed medical assistance. Accessibility depends on the patient's social, cultural, economic, and geographic factors that influence healthcare access worldwide; the effects of changes in access; and the relationship between access and health for specific U.S. populations—including racial and ethnic minorities, people with limited English proficiency, the uninsured, the elderly, children, and veterans (Marks, 2022).

Affordability: A function of income, spending, and judgments about the value of goods and services for their price. The affordability is an economic concept, a healthcare services budget issue for individuals and families, and a current policy threshold. It reviews measures that capture the cost burden for individuals and families with different forms of coverage, in various financial circumstances, and with different health concerns (United States of Care, 2022).

Comfort: This term refers to a personalized perceived condition of strengthening across inseparable environmental, psychological, social, physiological, and cultural domains (Dos Santos Souza et al., 2021).

Comfort care: The application of personalized interventions designed artistically to fulfill patients' needs and provide relief and transcendence to patients' needs across environmental, psychological, social, physiological, and cultural realms (Dos Santos Souza et al., 2021).

Cultural diversity: Cultural diversity, sometimes referred to as *multiculturalism*, is a quality of diversity in many cultures. Cultural diversity is a system that recognizes and respects the existence and presence of diverse groups of people within a society. The design values people's sociocultural differences and encourages everyone to celebrate them. A diverse cultural environment also inspires everyone to make a significant contribution to empowering their cultural identity and the cultural identities of others (Man, 2021).

Culture: The behavioral patterns and customs observed by a group of people or, in other words, the way of life of social groups linked by language, religion, cuisine, social habits, music, and arts (Pappas & McKelvie, 2021).

Healthcare: Healthcare is a fundamental human good because it affects people's opportunity to pursue life goals, reduces pain and suffering, helps prevent premature loss of life, and provides information needed to plan for individuals' lives. Healthcare is defined as preventing and treating diseases through professional medical services. An example of healthcare is medication prescription for conditions (American Medical Association [AMA], 2022a).

Healthcare technology: Healthcare technology, also known as *healthcare tech*, refers to any information technology (IT) tools or software designed to improve hospital and organizational productivity, give new insights into medicines and treatments, or improve the overall quality of care provided (Foresee Medical, 2022).

Hispanic physicians: Physicians who live and practice in the United States but are not native Americans and come from a Spanish-speaking minority cultural background (Osseo-Asare et al., 2018).

Modern teaching hospitals: Very complex in their organizational structure due to their multiple tasks, such as teaching, research, and healthcare (Howell, 2020). According to the American Hospital Association (AHA, 2020), teaching hospitals serve as centers for training future healthcare professionals while supporting an environment in which biomedical and clinical researchers can flourish, offering specialized services and providing patient care. In addition to training physicians in hands-on clinical patient care, faculty in teaching hospitals prepare physicians for the new demands of a changing healthcare environment, such as using health information technology, caring for patients in outpatient clinics, and delivering team-based care. The Accreditation Council for Graduate Medical Education (ACGME) is a certification body that plays a vital role in the checks and balances on the standards of teaching hospitals. Teaching hospitals receive two types of payments to maintain standards: direct graduate medical education (DGME) and indirect medical education (IME) payments. DGME costs account for infrastructure, stipends, benefits, and faculty required to train doctors, while IME payments are used for patient care (Howell, 2020). Teaching hospitals are now providing exceptional services to the residents of the United States. According to the AHA, 82% of Level 1 trauma centers, 78% of burn centers, 74% of advanced stroke centers, 68% of pediatric intensive care units (ICUs), and 50% of surgical transplant services are provided by teaching hospitals.

Patient-centered care (PCC): A type of healthcare whereby providers consider patient values, needs, and preferences while ensuring that patient values guide all clinical decisions (Zizzo et al., 2017).

Patient empowerment: Patient empowerment is “a process through which people gain greater control over decisions and actions affecting their health” (Jenkins, 2019, para. 4). Providers can increase their patients' involvement in many ways, such as sharing patient education materials and ensuring that they have a say in their treatment plans. Regardless of methods, patient empowerment in healthcare has the same result: improving consumer health outcomes across the board (Jenkins, 2019).

Perception: A form of subjective interpretation and conclusion that someone makes using two interconnected systems in their mind (Sargent, 2019).

Physicians: A physician (also known as a *medical doctor*, *medical practitioner*, or simply a *doctor*) is a professional who is trained and licensed to practice medicine. There are many different types of physicians; some opt to specialize in fields such as pediatrics, gynecology, or surgery. Those who assume the responsibility of providing continuous, comprehensive care to individuals or families are *primary care providers* (Clements, 2020). Physicians use their knowledge and skills to manage patients presenting various symptoms. A physician can be trained in medical education to pursue a clinical career as per their own choice in the United States (Statista, 2021).

Public healthcare policy: Public health policy is defined as the laws, regulations, actions, and decisions implemented to promote wellness and ensure that specific health goals are met (Columbia University Mailman School of Public Health, 2022).

Quality of care: Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes. It is based on evidence-based professional knowledge and is critical for universal health coverage. Quality healthcare can be defined in many ways, but there is growing acknowledgement that quality health services should be effective, safe, people-centered, timely, equitable, and integrated (World Health Organization, 2022).

Resident: Graduated medical student who continues training in a specialized field of medicine. A medical residency can last 2 to 7 years for a surgeon and other subspecialties. Residents provide direct care under the supervision of an attending physician or senior resident (Whitlock, 2021).

U.S. teaching hospitals: Healthcare organizations that provide state-of-the-art healthcare services under complex conditions and are committed to the highest level of medical education (Association of American Medical Colleges [AAMC], 2022). They foster an environment of research in various clinical programs and the latest advances in medicine (AAMC, 2022).

Assumptions

According to Carrillo-Durán (2017), assumptions are tentative affirmations or denials of a research problem. They can be conjectures about possible characteristics, causes, specific problems, or statements about the phenomenon to be studied. This study included several assumptions. The first assumption was that participants would be honest about their healthcare affiliation. The second assumption was that Hispanic physicians who participated had worked in a U.S. teaching hospital and had experience with the PCC process within the United States. Third, I assumed that participants would respond to the interview questions honestly to support accuracy and credibility.

Scope and Delimitations

The scope of the study revolved around understanding the challenges that Hispanic physicians face in practicing PCC in U.S. teaching hospitals and the perceptions that Hispanic physicians have as an integrated priority of PCC to improve the quality, safety, accessibility, and affordability of healthcare. The study focused on understanding Hispanic physicians’ perspectives as an integrated priority of the PCC to improve quality, safety, accessibility, and affordability in healthcare, which has been discussed in the literature (Serafini et al., 2020). Ross and Bibler Zaidi (2019) described delimitations as a researcher's restrictions on the scope of a study to highlight the boundaries to which the study is restricted. I included between 10 and 15 Hispanic physicians working in a U.S. teaching hospital in Miami, Florida, via purposive sampling according to my perception of reaching data saturation by 10–15 participants. Teaching hospitals bring together medical education, research, and patient care in a unique environment that fosters discovery and the latest advances in medicine (AHA, 2020).

Limitations

This study had several limitations. One of the limitations was the small sample size. The study also yielded fruitful, relevant, and reliable results while implementing an appropriate recruiting process for the participants. Another limitation was the research findings reported could have resulted from misinterpreting what participants' words were intended to mean. The limitation was overcome by adequately recording and analyzing the participants’ answers to the research questions. Additionally, the participants may not have answered the questions openly and honestly, which may have generated inaccurate information. A researcher's bias toward a study is a very common limitation in research, which I overcame by creating a thorough research plan, asking general questions, placing topics into separate categories, showing the participants the results, and sharing analytical duties with my chair. The research methodology was another critical limitation of the research, which I overcame by selecting and implementing the most appropriate methodology for the study with my committee chair's approval. Further, I sought to avoid including irrelevant details, keeping the methodology section straightforward and thorough. Basic procedures should only be explained if they are unconventional and unfamiliar to readers.

Significance of the Study

Through this qualitative study, I aimed to understand Hispanic physicians' perceptions as an integrated priority of the PCC to improve quality, safety, accessibility, and affordability in healthcare. The specific research design included essential qualitative inquiry, or interpretative description, to address the research questions in this qualitative study, providing the platform to answer straightforward questions without framing the inquiry. The study findings are significant to the healthcare industry to support future improvement for including Hispanic physicians while improving care quality, safety, accessibility, and affordability as part of PCC.

Importance in Practice

The study results identify Hispanic physicians’ perceptions as an integrated priority of PCC to improve quality, safety, accessibility, and affordability in healthcare while practicing PCC at U.S. teaching hospitals. The results may help healthcare industry leadership and the U.S. government identify and provide an understanding of the challenges that Hispanic physicians in U.S. teaching hospitals face and the impact of limited opportunities for improving PCC. With the results, promotion practices can be further analyzed, and suggestions provided to assist Hispanic physicians in improving the PCC model.

Theory's Importance

The importance of SDT in this research was the awareness that it provided of how vital competence, relatedness, and autonomy are to Hispanic physicians’ motivation and performance. The healthcare industry can take steps to understand the challenges that Hispanic physicians in U.S. teaching hospitals face and the impact of limited opportunities for improving PCC.

The Importance to Social Change

The understanding of the PCC from Hispanic physicians creates an improvement of healthcare services as an integrated priority of the PCC, leading to improved quality, safety, accessibility, and affordability in healthcare faced while practicing PCC at U.S. teaching hospitals, creating a sense of improvement in the PCC.

Summary and Transition

Chapter 1 addressed the primary literature on the PCC model that formed the essential background of the study. In addition, I presented the study’s problem statement and the significance of the study findings. The importance of SDT in this research was outlined in relation to the awareness of how vital competence, relatedness, and autonomy are to Hispanic physicians' motivation and performance. The healthcare industry can take steps to understand the challenges that Hispanic physicians in U.S. teaching hospitals face and the impact of limited opportunities for improving PCC.

The qualitative nature of the study was described, and basic assumptions, limitations, scope, and delimitations of the study were disclosed. Terms used repeatedly in the study, such as *physicians*, *Hispanic physicians*, *perceptions*, *PCC*, *comfort*, *comfort* *care*, and *culture*, were operationalized. I stated the critical significance of the findings to theory, society, and healthcare practice.

In Chapter 2, I present an understanding of PCC model in the context of existing published literature. I begin with the historical elements of the PCC model and address the essential elements of PCC during this pandemic era, along with the model's cultural implications. I end the literature review by highlighting the emerging role of technology in delivering PCC.

Chapter 2: Literature Review

The PCC model provides a framework for developing a quality-based healthcare system where high patient satisfaction rates are the norm. Limited research has specifically looked at the perceptions of Hispanic physicians as an integrated priority of the PCC to improve the quality, safety, accessibility, and affordability of healthcare (Jones et al., 2021; Schroeder et al., 2020; Schuttner et al., 2022). Thus, researchers seek to better understand PCC from the perspective of Hispanic physicians for several reasons, including gaps in the literature that show how physicians and patients define it differently. The purpose of the study was to understand the perspectives of Hispanic physicians as an integrated priority of the PCC to improve quality, safety, accessibility, and affordability in healthcare. The purpose of Chapter 2 is to provide a thorough review of the literature regarding Hispanic physicians' views of PCC.

This chapter is divided into sections addressing (a) the historical context of the PCC model, (b) the elements of an effective PCC model, (c) issues relating to accessibility, (d) affordability, (e) patient empowerment, and (f) patient diversity. The literature review also includes an exploration of the PCC model during the COVID-19 pandemic and cultural issues and implications relating to the PCC model.

Literature Search Strategy

I used the Walden University Library to conduct a review of the literature related to Hispanic doctors, PCC, accessibility, affordability, patient empowerment, quality care, quality healthcare, financial and economic effect, physicians' perceptions, government regulation, healthcare policy, and cultural diversity. MEDLINE with Full Text/PubMed, CINAHL, PsycINFO, SocINDEX, ScienceDirect, Academic Search Complete, Gale, and

Academic OneFile Select databases were searched. Sources of information included books, peer-reviewed journals, government statistics, dissertations, and theses. A total of 146 sources with pertinent information, with publication dates ranging from 2019 to the present, were identified. Four years' worth of detailed data were collected. Older material has been supplied to provide the reader with a perspective on the topic's beginnings and history. RefWorks was used to assist in organizing the content into categories. A subset of the retrieved sources was chosen as having the most relevance to this topic, which formed the basis for the literature evaluation.

Theoretical Foundation

SDT and the PCC model were used as the framework for this research study. SDT (Podlog & Brown, 2016) and the PCC model will be used to explain the study results. Self-determination is an important concept that refers to people's ability to make choices and manage their own lives. This ability plays a vital role in the PCC model because it creates an awareness of how vital competence, relatedness, and autonomy are to Hispanic physicians' motivation and performance (Cherry, 2019).

Self-Determination Theory

SDT is a motivational theory that initially had a limited focus on inner motivation but later broadened to also consider extrinsic incentive (Ryan & Deci, 2019). According to SDT, intrinsic and extrinsic motivation are the two fundamental forms of motivation that lead to changes in an individual's health habits, with autonomy serving as the foundation. Extrinsic motivation refers to the external control of a person's actions through reward or punishment, whereas intrinsic motivation is the capacity of an individual to enjoy an activity in which they are participating. Because intrinsic motivation is a type of autonomous motivation, the behavioral changes are thought to be long-lasting. The concept of autonomy is the ability to live independently or feel free to make decisions. Other tenets of the theory include competence and relatedness. The capacity to engage with one's surroundings efficiently and take advantage of chances to hone or display one's talents is referred to as competence, and a sense of belonging (Maslow, 1943) or a feeling of ongoing support from or toward others is an example of relatedness. These three factors are connected to a person's psychological health (Cai et al., 2020).

In recent years, there has been a noticeable growth in the use of SDT as the theoretical framework for studies (Cai et al., 2020; Day et al., 2022; Gwadz et al., 2022). Its ubiquitous applicability has led to a rise in its use as the theoretical foundation for many investigations (Cai et al., 2020). SDT has been used as a theoretical framework by multiple researchers working in such different fields as sports (Standage & Ryan, 2020), education (Bunce et al., 2021), virtual learning (Huang et al., 2019), leadership (Kanat-Maymon et al., 2020), and health coaching (Denneson et al., 2020). In the healthcare field, the autonomy, competence, and relatedness of an individual have all been considered by SDT in the past to design and enhance healthcare treatments (Ryan & Deci, 2019). However, PCC is also influenced by physicians' autonomy, competence, and relatedness. Therefore, by considering and promoting the autonomy, competence, and relatedness of physicians, SDT may also aid in maintaining high-quality healthcare results. Physicians must be independently motivated for the healthcare system to change from a traditional healthcare system to the PCC model.

Patient-Centered Care Model

Economic prosperity and development depend heavily on a nation's health. To attain such a level of prosperity, constant improvements are needed to provide state-of-the-art healthcare and to develop policies that ensure that healthcare is adequate, accessible, and affordable for everyone (Warner et al., 2020). Affordability and accessibility are critical elements of the PCC model. They are implemented in the United States under the Patient Protection and Affordable Care Act (Park et al., 2020). On March 23, 2010, under the government of President Obama, the United States enacted its first law relating to health affordability, named the Patient Protection and Affordable Care Act (Jaqua & Jaqua, 2019). This act aimed to improve the healthcare system by enhancing the quality, efficiency, affordability, and accessibility of healthcare facilities (Jaqua & Jaqua, 2019).

The Patient Protection and Affordable Care Act introduced financial policies to allow the government of the United States to make its healthcare system affordable for all U.S. citizens and to pave the way for implementing the PCC model (Park et al., 2020). Affordability and accessibility are interlinked, as when things are affordable, they are accessible, and vice versa. The PCC model requires easy access to the healthcare system, whether this involves primary care or specialist and other health services. The model means that patients should have easy access to the health facilities at any particular location. When a hospital implements the PCC model, irrespective of its geographical location, it means that patients within that location must have easy access to the healthcare facility. The model even addresses issues relating to the local transport system

(Araki, 2019). When implementing the PCC model, these two elements must be considered.

Conceptual Framework

The Picker principles of PCC were used to create the conceptual foundation for the study (Davis et al., 2019). The Picker/Commonwealth Program for PCC was launched in 1987 to investigate patient wants or problems regarding healthcare. Eight PCC principles were developed as a result, covering the following topics: patients' needs and preferences, education and communication, healthcare accessibility, emotional comfort, physical comfort or ease, involvement of family and friends, healthcare coordination, and continuity and transition (Carthon et al., 2020; Saha et al., 2008). These guidelines have been applied in several research studies to create PCC models (Cramm & Nieboer, 2019).

The first PCC concept, patient preferences or values, emphasizes the value of honoring patients' values, preferences, and requirements while providing them with care for the illness they are experiencing. It encourages the doctor to view the patient as a unique person with unique emotional, physical, psychological, and spiritual needs (Araki, 2019). The information, education, and communication dimension of PCC emphasizes the significance of effective doctor–patient interactions and the need to establish communications in which the patient's health-related information is delivered in an understandable manner, enabling them to take part in shared decision-making (Araki, 2019). The PCC model was further developed using the information, education, and communication domains to encourage PCC through effective communication (Kwame & Petrucka, 2021). The information and education principle refers to informing patients about their clinical condition's status, how their disease is likely to progress in the future, and how things are likely to turn out in general (Kwame & Petrucka, 2021).

The availability and simplicity of access to healthcare services are discussed in the third Picker principle, accessibility of care. This is about ensuring the patient's physical access to healthcare services and the healthcare setting (Araki, 2019; Jasser, 2020). The fourth of the Picker principles is emotional support, which is a process for enabling patients to relieve any fear or anxiety regarding their disease and treatment (Spector & Starmer, 2019). It also involves helping patients cope with the fear of the impact of their illness on them, their family members and friends, or their financial status or job (Araki, 2019). Physical comfort is the fifth of the principles proposed by the Picker Institute. This highlights to healthcare workers the importance of effective pain management for patients. It is about motivating physicians to help patients perform their daily activities while staying in a healthcare setting in a supportive environment (Araki, 2019).

The sixth principle in the model, involvement of family and friends, has to do with respecting the role of the family and friends of patients in the provision of their healthcare services and motivating patients to involve such people in their healthcare decision-making out of their own choice (Araki, 2019). The seventh principle of Picker's model, coordination of care, is about enabling physicians to work together for the benefit of the patient (Araki, 2019). This supports the idea of the multidisciplinary care of a patient and the pursuit for their benefit of integrated disease management (Kuipers et al., 2021; Will et al., 2019).

The eighth and last of these principles is continuity and transition of care. This relates to the healthcare services provided to patients by physicians when they are leaving the hospital or getting discharged from an inpatient setting (Araki, 2019). It highlights that the transition of healthcare services from inpatient to outpatient settings should be smooth enough to ensure continuity of healthcare services without any break in the patient's healthcare. It motivates physicians to provide sufficient healthcare information to patients for them to understand their medications and to be aware of any social support programs they may require (Araki, 2019).

Applying all these principles to the healthcare setting provides a way to practice PCC (Araki, 2019; Jasser, 2020). The framework of the PCC model provided by the Picker Institute has become a central part of healthcare research and policymaking globally (Davis et al., 2019). It has been promoted by the World Health Organization, the Institute of Medicine, and the Health Minister of Australia (Davis et al., 2019). While implementing PCC, all these concepts should be kept in mind. Patient preferences, information and education, and integrated treatment are for doctors the three most crucial components of PCC (Berghout et al., 2015; Davis et al., 2019). The Picker principles of physical comfort, emotional support, accessibility of healthcare, involvement of family and friends, and continuity and transition are nourished by the patient's expressed preferences in relation to their own needs and values, education and communication, and integration and coordination of healthcare services (Davis et al., 2019).

The Picker principles of knowledge, education, and communication result in a sense of autonomy and confidence in shared decision-making. The SDT of motivation describes this as an extension of the social and cultural context in either facilitating or thwarting people’s basic psychological needs, perceived sense of self-direction, performance, and well-being (Caspar et al., 2019). It has been suggested that people would be more capable of making decisions about their healthcare if given the required knowledge and education about the dynamics of the condition they are experiencing. Through this qualitative study, I aimed to understand Hispanic physicians' perceptions as an integrated priority of the PCC to improve quality, safety, accessibility, and affordability in healthcare. It can involve integrated priorities with these concepts being used in patient care, which can enable Hispanic physicians to promote patient autonomy through the provision of choice in rehabilitation exercises, providing rationales, giving individuals the opportunity to voice their thoughts and opinions, providing information for informed decision-making, and encouraging family members to be autonomy-supportive in their interactions with patients to improve PCC (Podlog & Brown, 2016).

Literature Review

The Historical Context of the Patient-Centered Care Model

Although the idea of PCC was introduced in 1969, there is not a single, widely recognized definition (Webair, 2021). However, a patient’s preferences, experiences, life stories, and understanding of their ailment are all considered when making decisions under the PCC paradigm of healthcare (Kwame & Petrucka, 2021). Through collaborative decision-making, the PCC model seeks to respect patients’ beliefs, dignity, compassion and respect, coordination, and personalization (Kwame & Petrucka, 2021).

Issues Leading to the Patient-Centered Care Model

This study focuses on understanding Hispanic physicians' perspectives as an integrated priority of the PCC to improve quality, safety, accessibility, and affordability in healthcare. First, U.S. policymakers have been pushing patients to proactively ensure creative engagement techniques to increase quality, safety, and accessibility in PCC. Second, attitudes toward the awareness of the exclusion of certain groups, such as Hispanic physicians, that are integral components of PCC may impact outcomes such as trust and satisfaction with treatment regimens. Finally, in the patient-centered concept, perspectives from Hispanic physicians may add another lens to evaluate the intricate systems and procedures that can reduce the unfairness due to empathy and risk for compassion fatigue that need to improve to increase PCC.

In the past, power dynamics in healthcare institutions tended to be unbalanced, leaving patients with little knowledge of their overall state of health (David et al., 2019). Further, between 1970 and 1980, there were relevant issues with the healthcare facility's organization, such as the deficiency in the value of patient information and communication from the decision-making view, the destabilization of the efficiency of patient-centeredness, and the misaligning of the power between physicians and the patient (Siouta & Olsson, 2020). This design created problems concerning collaboration and the transmission of information between different categories of healthcare providers and between healthcare providers and patients. Thus, it restricted the patients' influence on their care situation (Siouta & Olsson, 2020). Placing the patient at the center has been more cost-effective and improves the patient care experience (Siouta & Olsson, 2020). Patient-centeredness reduces recovery time and minimizes medical complications, automatically enhancing the quality of life as well as the self-confidence of the patients (Siouta & Olsson, 2020).

The Patient-Centered Care Model and Its Importance

Physicians using the PCC model can help address multimorbidity because of the model's focus on the overall needs and well-being of the patient (Kuipers et al., 2019). PCC offers a thorough picture of the patient's health and aids in creating the circumstances necessary to meet the patient's health improvement objectives. The patient is the major character in the PCC model, and they should have a voice in all communications with the healthcare system. To provide PCC, the patient and their family must actively participate in decision-making alongside the doctor. This model acknowledges the patient's history, including their family, as well as their cultural, societal, and economic beliefs.

Today, one of the six essential components of a high-quality healthcare system is PCC (Ghane & Esmaeili, 2019). PCC was given a platform for attaining health fairness and eliminating health inequalities (Sinaiko et al., 2019). The government has been elevating the voice of patients and moving away from a paternalistic paradigm. Experts perform actions on individuals because it is acknowledged that PCC may improve people's health and reduce the burden, they impose on healthcare systems (Kuipers et al., 2019).

The Principles and Attributes of the Patient-Centered Care Model

The eight guiding principles of the PCC model are respect for patients, coordination and integration of care, information and education, physical comfort, emotional support and reduction of fear and anxiety, involvement of family and friends, continuity and transition, and access to care (O'Neill, 2022). Patients are treated with respect, decency, and consideration for their cultural values when receiving PCC. Patients feel that they are being treated as an individual and are involved in decision-making. By integrating and synchronizing clinical and patient care, patients' emotions of vulnerability and dread are lessened. PCC keeps the patient up to date on their clinical condition, prognosis, progress, overall treatment process, and any other information that may improve their capacity to self-manage and promote their own health (Sinaiko et al., 2019). The patients receive emotional support, which enables them to experience less dread about their health condition, anxiety about how their sickness will affect their personal lives, and financial stress related to paying for their care. PCC involves recognizing their needs, considering their contributions, making accommodations for them, and including them in decision-making (O'Neill, 2022).

Disadvantages of the Patient-Centered Care Model

The PCC model is accepted by Hispanic physicians because of its increased effectiveness in terms of PCC. For this reason, the negative aspects of the PCC model have not been studied in-depth. Researchers such as Summer Meranius et al. (2020) have discussed how PCC is responsible for repetitive falls, such as increased personal and financial costs; exclusion of certain groups; exclusion of staff's personhood; risk for compassion fatigue; and unfairness due to empathy especially in patients with cognitive impairment, which have led to increased personal costs due to fractures or injuries, and hospital expenditures for rehabilitation have also been increased.

The results of falls are the "costs" generated by injuries, fractures, and pain. These costs not only include suffering on the patient's part and risks to patient safety but are also felt in economic terms through increased expenses for hospital care and rehabilitation, which directly impact the PCC. Also, in the exclusion of certain groups, the PCC was portrayed as a hotel-like service. The patients were seen as consumers with a right to autonomy and choice. This might be unsuitable for those older people with a limited capacity to make informed decisions. Many older persons become dependent on others due to age-related illnesses and/or impaired cognitive functions. This way of conceptualizing PCC does not account for the complexities involved in decision-making for such older persons. Another disadvantage is empathy, which is a powerful source of motivation that often makes people direct their attention toward one individual while forgetting others. Before making this decision, some participants were induced to feel empathy for one of the other people. Patients who were not induced to feel empathy acted fairly, while those who were induced to feel empathy acted in a partial way to benefit the person for whom they felt empathy. Second, people tend to feel more empathy for people who are like themselves. Third, people tend to feel more empathy for people they like. These results can be applied to the context of healthcare; there seems to be a risk that PCC, due to its empathic nature, tends to unfairly favor patients who happen to be within the health provider's span of attention and are like the health provider and whom the health provider likes (Summer Meranius et al., 2020). Uittenbroek et al. (2018) also reported an increased cost of PCC with no improvement in healthcare outcomes in a randomized controlled trial of 1,456 elderly patients in the Netherland with an increase in quality-adjusted life year per day able-to-age risk profile improvement. There is also ambiguity regarding operationalizing PCCM in certain groups (Fogg et al., 2018). Metzelthin et al. (2015), in their study on 346 older patients with PCC, increased healthcare cost and utilization without being beneficial in terms of healthcare outcomes. However, the intervention under study led to an increase in healthcare utilization and related costs without providing any beneficial effects. This study adds to the scarce amount of evidence of the cost-effectiveness of proactive primary care in community-dwelling frail older people to identify the drawbacks of PCC.

Other research has indicated that the PCC model is centralized toward the patient, meaning the rights of healthcare providers are controlled. This behavior deprives healthcare providers of their right to be autonomous as healthcare professionals because the PCC establishes four clinical ethical principles, that is, beneficence, nonmaleficence, autonomy, and justice. Informed consent, truth-telling, and confidentiality spring from the principle of autonomy and each is discussed. In inpatient care situations, not infrequently, there are conflicts between ethical principles, especially between beneficence and autonomy. A 4-pronged systematic approach to ethical problem-solving and several illustrative cases of conflicts are presented. Comments following the cases highlight the ethical principles involved and clarify the resolution of these conflicts (Summer Meranius et al., 2020; Varkey, 2021).

AMA and the Patient-Centered Care Model

Despite potential disadvantages, the AMA has been promoting PCC to produce good quality healthcare outcomes in the United States (AMA, 2022b). The American Medical Association has endorsed the importance of the practical communication element of the PCC model by providing a checklist for practicing the PCC model (AMA, 2022b). The main components of this checklist include (a) equity of healthcare services among different racial groups in the United States (Manchanda, 2021); (b) sharing their clinical notes with the patients (Miralles, 2021); (c) development of the Patient Experience Program Formation Advisory council for the patient and their family; (d) ensuring adherence of patients with medications; (e) identifying social determinants of health; (f) supporting empathy in the physician-patient relationship; (g) practicing value-based care (AMA, 2022b); (h) effective management of the transition of care; (i) creating plans and their implementation in end-of-life care; (j) integration of behavioral health in PCC; and (k) ensuring a sufficient number of physicians to provide patient-centered healthcare services in the United States (AMA, 2022b).

The Consequences of Accessibility and Affordability

The consequences of the accessibility and affordability of anything in society are variable and highly dependent on the nature of the beneficiary. The same rule applies to healthcare services. Hence, there are both positive and negative consequences of accessible and affordable access to healthcare services. Because the variables of availability and affordability are highly dependent on the nature of the patient in the access to care process. It is a direct relationship between the two variables. Affordability is determined by how the healthcare provider's charges relate to the patient's ability and willingness to pay for services. The availability measures the extent to which the provider has the requisite resources, such as personnel and technology, to meet the client's needs. In the digitalization age, the interaction between physicians and patients is changing all the time (Harbishettar et al., 2019). Through the help of technology, patients now have access to information regarding any disease and its treatments. If used correctly, this digitalization can benefit both the patient and the physician.

The integration of digitalization into primary care includes a variety of electronic methods that are used to provide accessibility to healthcare providers and patients to manage healthcare information. In primary care, examples of health IT include (a) computerized disease registries, (b) computerized provider order entry, (c) consumer health IT applications, (d) the electronic medical record systems (i.e., EMRs, EHRs, and PHRs), (e) electronic prescribing, and (f) telehealth services (Agency for Healthcare Research and Quality, 2019). This easy availability of information to the patient may lead them to question their physician's knowledge, resulting in a conflict between them. This can create uncertainty regarding the patient’s attitude in the physician's mind. The second possibility regarding easy access and affordability is that it can lead to patients choosing to change their physician. This can hinder the building of an emotional affiliation between the patient and their physician, which is itself one of the essential elements of the PCC model (Harbishettar et al., 2019). The third consequence can be a positive one, depending on the quality of the care provided. The accessibility and affordability of healthcare will only be beneficial to the patient when the care provided is of good quality. Otherwise, healthcare services will be affordable and easy to access, but due to the poor quality of these services, the recovery time of the patient may be prolonged, increasing the overall health cost. The system overall would not remain cost-effective (Shelly et al., 2020). Hospitals designed according to the PCC model need to ensure that accessibility and affordability are aligned with the overall quality of care in the healthcare services provided to their patients.

Empowering Patients

The PCC model has a high degree of complexity and involves various actors at different healthcare institutional levels and in different care contexts. It empowers patients because of its multidimensional consideration of influencing healthcare factors to recognize their point of view, includes them in decision-making, and share any information regarding the patient's health conditions (Sinaiko et al., 2019).

The PCC has paved the way for involving patients in the entire treatment process. Physicians must give equal importance and respect to their patients' choices in their treatment decision-making process (Donnelly, 2019). The "Knowledge and Information" element of the PCC model places a responsibility on the healthcare system to inform and educate patients about their diseases and treatment (Donnelly, 2019; Sinaiko et al., 2019). Meetings between the physician and the patient should be based on a schedule where the physician has time to listen to the patient's insights and understand them emotionally. This enables the physician to connect with the patient and offer them emotional support (National Health Services, 2020). According to the NHS Long-Term Plan (NHSLTP, 2019), the use of technology in the healthcare system will also empower patients; electronic recording of health data, use of mobile applications, and wearable technology will all work to support the "Knowledge and Information" element of the PCC model. One study has shown that approximately 20 million women can digitally access their maternity records in 2023–24, proving that technology will strengthen the application of the "Knowledge and Information" dimension of the PCC model (Donnelly, 2019). The true empowerment of the patient has been one of the main aims of the PCC model, and its implementation in hospitals will help the healthcare system achieve this objective (Donnelly, 2019).

Although studies have shown that the PCC model empowers patients by providing them freedom for decision-making and helping them reach their therapeutic goals smoothly, various ethical conflicts need to be considered as these ethical conflicts affect the patient and affect healthcare outcomes badly (Sinaiko et al., 2019). The holism of PCC puts the patient in a state of confusion about how much personal information should be disclosed to the physician. In this state of confusion, they might unknowingly reveal some of their personal life stories, not relevant to the current health conditions. This is especially important when a patient cannot assess which sensitive information is to be shared by the doctor and to what extent it should be shared. Prompting the patient to over explain their personal stories, which can be detrimental to their health as the patient feel distressed, creating difficulties for the physician in achieving their therapeutic goals (Hansson & Fröding, 2020).

Patient Diversity and the Patient-Centered Care Model

The term "diversity" relates to variation; patient diversity relates to the variations in patients that arise from age, sex, color, or race. According to the 2020 U.S. Census, non-Hispanic White Americans made up 57.8% of the total population, Hispanics 18.7%, and Black or African Americans 12.1% (Jensen et al., 2021).

Patient diversity and the PCC are needed to improve healthcare quality. To deliver individualized PCC, a healthcare provider must consider patients' diversity of lifestyles, experiences, and perspectives to collaborate in joint decision-making. PCC can enhance equity in healthcare delivery; cultural sensitivity enhances PCC. Indicators of culturally sensitive healthcare identified in focus groups of low-income African American, Latino-American, and European American primary care patients included interpersonal skills, individualized treatment, effective communication, and technical competence. The U.S. Office of Minority Health has set national standards for culturally and linguistically appropriate healthcare services. The principal standard is that healthcare must provide adequate, equitable, understandable, and respectful quality care and services responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs (Stubbe, 2020).

Quality Provisions in Healthcare

Patient Quality Care

Patient quality care is how healthcare services for individuals and populations improve their desired health outcomes. It is based on evidence-based healthcare provider knowledge and should be effective, safe, patient-centered, timely, equitable, integrated, and efficient (World Health Organization, 2022a). The concept of quality care has been defined in several different ways since 1980, from the work of Avedis Donabedian to the recent definition provided by the World Health Organization in 2018 (Busse et al., 2019). The Institute of Medicine of the United States has also described patient-centeredness as one of the core dimensions of good quality healthcare, alongside effectiveness and equitability (Delaney, 2019). A report presented by the Institute of Medicine described the four basic levels of patient quality care and the role of the PCC model in each. The levels of quality care affected by the PCC model are the clinical, microsystems, organizational, and environmental groups (Delaney, 2019). Principles from the PCC model, specifically "patient and family involvement" and "shared decision-making," are relevant for maintaining all four levels of quality care. This reinforces the role of the PCC model in providing good quality healthcare in the United States (Delaney, 2019).

The Doors Opened by Empowering Patients

Applying the PCC model has allowed patients to make their voices heard, enabling them to interact with healthcare providers efficiently and giving them a sense of empowerment (Bodolica & Spraggon, 2019). Patient empowerment has been one of the core elements highlighted globally by national governments' efforts to implement the PCC model (Bodolica & Spraggon, 2019). Many authors have described patient empowerment as providing the patient with the power to effectively achieve their healthcare goals (Bailo et al., 2019; Bodolica & Spraggon, 2019; Theys, 2021). It may also be defined as the ability of patients to manage themselves during their illness to maintain the required levels of self-care and personal motivation (Bailo et al., 2019). Empowerment of patients in the health-seeking process has encouraged them to participate in self-care, supporting the "continuity and transition of care" dimension of the PCC model (Bodolica & Spraggon, 2019). It has increased patients' adherence to their medications and indirectly stabilized the emotional and physical health of the patient (Bodolica & Spraggon, 2019). As a result, it has helped physicians implement and fulfill the eight principles of the PCC model, all required for maintaining a system of effective PCC (Bodolica & Spraggon, 2019).

Understanding Quality Measures

Quality measures are standards of practice for measuring the performance of healthcare providers in caring for patients and populations (Centers for Medicare and Medicaid Services [CMMS], 2019). Quality measures can focus on essential aspects of care such as health outcomes, clinical processes, patient safety, efficient use of healthcare resources, care coordination, patient engagement in their care, patient perception of their care, and population and public health (CMMS, 2019). They have been utilized by the Centers for Medicare & Medicaid Services (CMMS, 2022) to ensure better healthcare outcomes. Given the disruptions in the physician-patient relationship caused by technological advancements and the increased screen time required from physicians, CMMS came up with a framework for quality measures concerning PCC under the "Meaningful Measures Framework, 2017" (Lorange, 2021). For the United States, this framework brought together all the quality measures of the PCC model under a single list of priorities. The goal of aligning all the quality measures according to their order of importance was to facilitate clinical decision-making by physicians and patients and to support all the novel approaches required to make the PCC model accessible (Lorange, 2021). These meaningful measures of quality helped improve the PCC model by focusing on eight areas of healthcare, including chronic disease management, preventive care, maintaining the mental health of patients, prevention and treatment of drug abuse, hospital admissions, and discharges, and transferability of healthcare information (Lorange, 2021).

U.S. Teaching Hospitals

U.S. Teaching Hospitals and the Patient-Centered Care Model

As presented, most hospitals in the United States currently offer their healthcare services to patients, and on average, these hospitals deal with hundreds of thousands of patients daily (Statista, 2021). Teaching hospitals are essential to better understand Hispanic physicians' perceptions as an integrated priority of the PCC to improve quality, safety, accessibility, and affordability in healthcare throughout the highest level of medical education, research, and patient care in a unique environment where the next generation of healthcare providers are trained. The U.S. teaching hospitals foster an environment of discovery and the latest medical advances. In addition, teaching hospitals are distinguished by their clinical programs, where scientists and physicians work together to bring new treatments safely and quickly from the research bench to the bedside safely and quickly (AHA, 2020).

The PCC model contrasts strongly with the previously prevailed biomedical and paternalistic healthcare models. The term "patient" refers to "someone who suffers". The patient can be a person receiving medical, surgical, or other forms of treatment for a disorder or illness. The PCC approach to healthcare takes account of a person's history, family, and individual strengths and weaknesses. It also involves a change from treating the patient as a passive recipient of a facility's healthcare services to a model where the patient is treated as having an active role in their healthcare (Sinaiko et al., 2019).

PCC in the United States health system will provide patients with a better quality of treatment and help improve health equity. However, aligning the U.S. health system with the PCC Model is still in progress. The first efforts to introduce PCC to the U.S. care system began in the 1960s (Sinaiko et al., 2019). In May 2019, to boost efforts to move the U.S. healthcare system toward the PCC model, Academy Health collaborated with the Robert Wood Johnson Foundation to host a new conference pursuing this agenda. Committed advocates (i.e., patients and policymakers), researchers, health system representatives, and other concerned parties all came together to discuss the different strategies and models of PCC.

U.S. Teaching Hospitals and Quality Patient Outcomes

Quality patient outcomes is a measure that reflects the impact of healthcare services on the health status of patients. During the COVID-19 pandemic, the United States experienced a disproportion between the PCC and the quality of patient outcomes in U.S. teaching hospitals. Decision-making fatigue had a disproportionately negative impact, given severe isolation restrictions and drastic changes in everyday routines during the pandemic. Patients were struggling with the decision-making process divided by vaccination status, acute COVID-19 condition, and varying chronic health conditions that may exist. The ongoing uncertainty and changes compound patients' daily struggles during the pandemic and create challenges for Hispanic physicians in practicing PCC (American Psychological Association, 2023).

Hispanic Physicians

Hispanic Physicians in Teaching Hospitals in the United States

This qualitative study aims to understand Hispanic physicians' perceptions as an integrated priority of the PCC to improve the quality, safety, accessibility, and affordability of healthcare. Hispanic physicians are Spanish-speaking minority physicians living and working in the United States. Many of them also belong to what is known as the limited English proficiency (LEP) community. Recent statistics show that Hispanic physicians constitute 18% of United States physicians, of which 8% work as family physicians (Statista, 2020).

A lack of patient-centered communication (PCC) with health providers is essential in perpetuating disparities in healthcare outcomes (Mitchell & Perry, 2020). Presently, there is limited research on the perception of Hispanic physicians as an integrated priority of PCC, which can impact the patient quality, safety, accessibility, and affordability of their healthcare. The Hispanic physicians are an essential healthcare provider group to understand the perceptions as an integrated priority of the PCC to improve the quality, safety, accessibility, and affordability of healthcare. Hispanic physicians are Spanish-speaking minority physicians living and working in the United States.

Linguistic proficiency and cultural competency are essential factors in determining healthcare quality. The ethno-racial concordance also affects the accessibility of healthcare services and provides patients with a better level of interpersonal care, as is reflected in patient-reported outcomes (UCLA, 2020). Developing a concordant physician-patient relationship helps create a sense of mutual respect, belief, trust, and satisfaction between the physician and the patient, paving the way to good quality healthcare and improved patient satisfaction (UCLA, 2020). According to the U.S. Census Bureau, about 25 million people in the United States belong to the limited English proficient (LEP) population, most of whom come from the Hispanic population (Zong, 2020). Most LEPs (28%) are found in California (UCLA, 2020). Around 44% of the people in California speak Spanish in their homes, and unfortunately, Hispanic physicians are particularly underrepresented in the California workforce. There are only 62 Hispanic physicians per 100,000 Hispanics (UCLA, 2020). Studies have shown that, when treated by a Hispanic physician, Hispanic patients displayed better glycemic control, reported greater satisfaction and trust, and experienced no communication gaps as opposed to when treated by White American physicians (UCLA, 2020).

Education and Training. The growing shortage of Hispanic physicians in the United States results in low admissions and graduation rates for Hispanic medical students. It has been estimated that at current rates, it would take California almost 500 more years to train enough Hispanic physicians to cater to its rapidly increasing Hispanic population (Martinez et al., 2020). Even at the residency level, the representation of Hispanic resident physicians is far less than that of White American physicians (Martinez et al., 2020). Better understanding the education and training of Hispanic physicians in the United States helps us to understand better the perceptions of Hispanic physicians in the process of empowering patients to make decisions about their healthcare and supporting innovative approaches to improve quality, safety, accessibility, and affordability as an integrated priority of PCC during a pandemic. The U.S. Census Bureau presented a summary report of statistics for Hispanic resident physicians in 2021, which showed the relatively low numbers of Hispanic resident physicians in four states of the United States, namely California, New York, Texas, and Florida, in relation to their overall Hispanic populations of almost 15 million, 3 million, 11 million, and 5 million, respectively (U.S. Census Bureau, 2021b).

Geographical Location. Although the population of Hispanics is expected to increase to 111 million by 2060, this increase will not be uniform in terms of geographical distribution across the United States. Previous reports show that California's Hispanic population now makes up the single largest ethnic group in the state (UCLA, 2020). Due to this unusual situation, California is more vulnerable to the negative impact of a physician shortage than other states in the United States. According to one report, there are only 50 Hispanic physicians per 100,000 of the Hispanic population in California (UCLA, 2020). Zhang et al. (2020) have also identified California, Texas, and Florida as suffering the most from a shortage of physicians. The main reasons for excessive physician shortages in these areas are increasing demand due to an aging population and the growing retirement rate among existing physicians (Zhang et al., 2020). According to one study, the older adults of California will increase to 14% of the state's overall population by 2030, while 30.3% of the physicians in California will retire in the coming 5 years (Zhang et al., 2020). The people of Florida and Texas are expected to increase by 33% and 22%, respectively, by 2030, whereas their aging population is expected to increase by 73% and 55%, respectively. Approximately 34% of physicians in Florida and 27% in Texas are nearing retirement age (Zhang et al., 2020).

Cultural Competency Training. Owing to the increasing Hispanic population in the United States and the shortage of Hispanic physicians, the country needs to initiate a cultural competency training program for physicians in its medical schools (Kaihlanen et al., 2019). Cultural competency training involves developing physicians' knowledge and skills to enhance their respect for cultural diversity and develop their understanding of the prevalence and importance of cultural issues in the United States (Young & Guo, 2020). The scope of cultural competency training ranges from simply identifying the facts of a patient's cultural values to acquiring knowledge of complex intercultural communication skills; identifying the cultural barriers experienced by minority patients when seeking healthcare for their illness; and instituting policies that accord with the needs of minority cultural patients (Handtke et al., 2019). According to the U.S. Department of Health and Human Services (2022), roughly 32 states in the United States are currently implementing cultural competency training programs and following the National Culturally and Linguistically Appropriate Services (CLAS) Standards. A program named "Think Cultural Health" has been launched in the United States to provide free cultural competency training for healthcare professionals (U.S. Department of Health & Human Services, 2020). Medical schools in America also require their students to achieve accreditation in cultural competency education. The Association of American Medical Colleges, along with many other organizations in the United States, has been working hard to create a culturally inclusive environment in the country's teaching hospitals and thereby ensure the quality of healthcare suitable for the multicultural society of the United States (Association of American Medical Colleges, 2019).

Physician Ethnicity, Race, and Language. Implementing cultural competency training in the United States is essential for ethno-racial concordance between physicians and patients (Takeshita et al., 2020). Studies have shown that racial concordance between the physician and patient provides clinical benefits through improved physician-patient communication, a higher quality of patient care, and improved patient-reported outcomes (Garcia et al., 2019). Garcia et al. (2019) studied data collected from 149,775 patient satisfaction surveys; Asian physicians received lower patient satisfaction scores than non-Hispanic White physicians. This population-based survey study used data from Press Ganey Outpatient Medical Practice Surveys collected from December 1, 2010, to November 30, 2014, including 149,775 patient survey responses for 962 physicians. Five patients per physician were randomly selected to complete a satisfaction survey after an outpatient visit every month. Asian physicians served a more significant proportion of Asian patients, who were more likely to give lower satisfaction scores than nonAsian patients. The association between the Asian race/ethnicity of the physician and receiving the most favorable LTR score remained nonsignificant (OR, 0.93; 95% CI, 0.86-1.02; P=.11). Asian patients were less likely to give the most favorable LTR score compared with white patients (OR, 0.56; 95% CI, 0.54-0.58; $P < .001$; Garcia et al., 2019).

Researchers using patient satisfaction scores for physician compensation and promotion should consider statistical adjustments for patient race and ethnicity. The study suggested that Asian physicians may be more likely to receive lower patient satisfaction scores because they serve more Asian patients. Patient satisfaction scores should be adjusted for patient race and ethnicity (Garcia et al., 2019).

Garcia et al. (2019) stated their research had multiple limitations. The analysis used data on patients and physicians not paired with quality or clinical outcomes data, making it difficult to determine whether Asian physicians provided comparable quality care to their White counterparts. Also, too few Black, African American, and Hispanic physicians were included in the concordance analysis.

Cultural competency training will help reduce any bias among physicians toward their patients. Ethno-racial concordance between patients and physicians is essential for ensuring effective communication and interaction with the patient, one of the principles of the PCC model (Takeshita et al., 2020). A concordant relationship between physician and patient in terms of ethnicity, culture, and language would make it easier to involve patients in clinical decision-making, enhance their physical and emotional comfort, and aid and encourage continuity and transition in patient care, all of which would contribute in turn to promoting quality healthcare by supporting the principles of the PCC model (Takeshita et al., 2020).

The Patient-Centered Care Model and the COVID-19 Pandemic

The Impact of COVID-19 on Patient-Centered Care

PCC provides a model of care based on the patient's values and preferences (Casu et al., 2019). It ensures patient satisfaction and well-being by respecting patients' viewpoints and promoting shared clinical decision-making (Pinho et al., 2021). The integrated model of care supports self-development, active patient involvement, and joint planning for better results, giving importance to the patient experience to such an extent that it can be used to revise methods and procedures at an organizational level (Sinaiko et al., 2019).

The COVID-19 pandemic has changed the entire working structure of the healthcare system (Plagg et al., 2021). In the past, whenever there was a crisis, according to the professional point of view, the patient experience could be overlooked to maintain clinical effectiveness (Yeheskel & Rawal, 2019). PCC introduced a scenario where human interactions were severely reduced, resulting in a deterioration in the quality and effectiveness of PCC due to the limitations placed on implementing its principles (Miralles, 2021). The changes in the framework of the patient healthcare system enforced under COVID-19 have required the development of new processes to ensure that attempts to execute PCC should not stop. The pandemic has placed restrictions on patients' personal care, specifically in dealing with chronic patients. The reduction of contact to phone calls only directly affected the interaction between doctor and patient, the core element of the PCC model (Miralles, 2021). Efforts to reduce the chances of infection during the COVID-19 pandemic have interrupted and restricted the care and follow-up treatment of chronically ill patients, including in relation to pre-planned diagnostic tests. The effects of the COVID-19 era have led to the realization that the current structure of the healthcare system and previous advancements in medical care still have flaws in them and that more practical guidance is required to implement PCC in such a way that all the principles of the PCC model can be maintained even during the era of a pandemic. It is pivotal to preserve PCC, respond to patients' experiences when procedures are restructured, and carry out their role as expressing opinions about different treatment methods, which includes sharing information, feelings and signs and accepting health team instructions, which align with the decision-making process (Miralles, 2021).

Increases in the Demand for Patient Centric Care

The COVID-19 pandemic has redefined the patient-provider experience in the PCC model. Patients across the country now struggle in solitude to deal with the mental and physical ramifications of COVID-19. At the same time, overworked healthcare providers and under-resourced and exhausted care providers deliver treatment at a distance to minimize the risk of viral transmission. With over 30 million cases and over 500,000 deaths due to COVID-19 in the United States alone, the fear and anxiety experienced by patients and healthcare providers are understandable. What further impacts and complicates an already difficult situation during the COVID-19 pandemic is the forced and necessary isolation to limit the spread of disease. Physical distancing has shifted COVID-19 from a difficult illness to a tragedy, causing a direct impact on delivering the highest level of patient care in the PCC, especially for patients who cannot connect with loved ones virtually (Gupta et al., 2021).

The COVID-19 pandemic has threatened to cause critical disruption to health services because of barriers relating to both supply and demand. As a result, maternal and infant mortality could increase significantly in the aftermath of the pandemic. COVID-19 has impacted current health service dynamics, usage, and the behavior of healthcare workers (Tossou, 2021).

Reduced Physician Commitment

The COVID-19 pandemic has been associated with loss of revenue, reduced work hours, and reduced earnings for physicians in the United States (AMC, 2022). The percentage of full-time doctors has fallen to 80.7% during the pandemic from 84.2% before COVID-19. According to the AMC (2022), there are 818,000 physicians involved in direct patient care in the United States. The rise in doctor exits would translate to the nation losing an estimated 3,272 direct-care physicians between January 2019 and October 2021. Unemployment among physicians fell, but labor force exits rose during January–October 2021.

While physicians may have the means to step away from the labor force more than other, lower-paid healthcare workers—the years of investment in medical education make walking away from their job a difficult decision. There may also be a cohort of physicians, particularly women, including women of color, who may have needed to step out of the workforce due to continued instability in childcare (AMC, 2022).

According to Kelly et al. (2022), themes emerged from the data that mapped onto the Job Demands-Control-Social Support model. Physicians' commitments reported that every aspect of primary care service delivery needed to be adapted for COVID-19, significantly increasing their job demands. Several also described pride in developing new skills, which increase their workload and are more likely to indicate signs of burnout.

The Experiences of Hispanic Physicians During the COVID-19 Pandemic

The COVID-19 pandemic has exposed problems in the healthcare systems of many developed countries, including the United States (Daley et al., 2021). Though the healthcare system of the United States provides all the essentials of healthcare to White Americans, it has failed to provide equal care to the minority cultures of the United States, affecting the process of empowering patients to make decisions about their healthcare and supporting innovative approaches to improve quality, safety, accessibility, and affordability as an integrated priority of PCC during a pandemic (Daley et al., 2021). Although the cause of high COVID-19 morbidity and mortality in the United States has exposed problems in the PCC, the purpose of this study is to understand Hispanic physicians' perceptions as an integrated priority of the PCC to improve quality, safety, accessibility, and affordability in healthcare.

The Impact of the COVID-19 Pandemic on the Patient-Centered Care Model

COVID-19 carved its effects into every segment of daily life, from social gatherings to official meetings, sports education, and business to health. All sectors were deeply affected by the pandemic. Sports were shifted to online gaming, business to the cloud, and education to virtual (Rawat et al., 2021). Every sector eventually found an alternative way of working. Still, the health sector could not achieve absolute stability because it was at the center of the storm worldwide.

The pandemic of 2020 has highlighted the importance of the PCC model and the function of general physicians in the health sector. Because the core element of the model is to involve and interact with the patient in their care, COVID-19 has increased the challenges in implementing the PCC model in hospitals. Due to the excessive morbidity of COVID-19, it was difficult for physicians to interact with patients in the context of PCC. During the pandemic, physicians could not fulfill all eight principles of the PCC model, as healthcare staff was unable to interact physically with patients (Ohta et al., 2021). The excessive patient load in healthcare centers created a sense of fear among patients, as the number of critical patients was much higher than usual. Access to medical facilities was reduced because fewer physicians were available than required. The main burden of the interactions between healthcare staff and patients had to be carried virtually (Ohta et al., 2021).

Cultural Issues Relating to the Patient-Centered Care Model

The Role of Hispanic Physicians in the Patient-Centered Care Model

Hispanic physicians have played an essential role in implementing the PCC model in the United States. It is evident from the literature that minority patients prefer to receive healthcare services from minority physicians (Jetty et al., 2021). Effective physician-patient interaction is essential for improving interpersonal care practices. Cultural concordance between physician and patient leads to an improved understanding of patient preferences and values, fulfilling the first principle of the PCC model (Jetty et al., 2021). Effective communication between physician and patient is facilitated by the lack of linguistic barriers and enables the implementation of the information, education, and communication aspect of the model (Jetty et al., 2021).

Moreover, Hispanic patients experience more comfort with Hispanic physicians than White physicians, irrespective of their behavior, as they trust Hispanic physicians more than White American physicians. This fulfills the “emotional comfort” and “physical comfort” elements of the PCC model (Jetty et al., 2021). It is evident from the literature that most Hispanic physicians practice in underserved areas of the United States, and most Hispanics are residents of these underserved areas (Daley et al., 2021).

Healthcare Market Forces

Demand Versus Supply

According to the most current statistics of total population of the United States as of Wednesday, November 2, 2022, the population of the United States is almost 335 million people (Worldometer, 2022). When it comes to easy access to care, enhanced healthcare quality, and maintaining continuity in healthcare, the costs depend on the size of the available healthcare workforce. The proportion of older adults in the population is increasing daily, and the availability of doctors to the public has become one of the top hurdles faced in the United States (Zhang et al., 2020). According to a prediction from the Bureau of Labor Statistics (2021), almost 90,000 new jobs will be required to address the increasing demand nationwide, or physicians can be expected to face an increase in their workload of around 13%. These statistics set out a predicted shortage of physicians over the following decades because the demand for physicians in the United States is increasing faster than the supply rate. In 2020, the United States faced a shortage of approximately 45,000 primary care doctors and 46,000 healthcare specialists (Zhang et al., 2020). According to the AAMC, the projected shortage of physicians in the United States will be about 121,300 by 2034 (Zhang et al., 2020). This continual shortage of doctors will damage the implementation of the PCC model, adversely affect healthcare organizations, and lead to poor patient outcomes.

The demand for physicians refers to the number of physician jobs required to meet the healthcare needs of the population. In contrast, the shortage of physicians has been defined as the difference between the available supply of physicians and the demand for them (Zhang et al., 2020). At the national level, the shortage of physicians will continue to increase up to 2030, and the estimated shortage will be approximately 139,000, impacting every region of the United States, affecting the implementation of the PCC model, and the continuity and transition of care (Zhang et al., 2020).

The United States has the most diverse population in the world, and its population is aging at an accelerated rate (Vespa et al., 2018). The number of people ages 65 and older in the United States has increased steadily during the past century, and growth has accelerated since 2011, when baby boomers first started to turn 65. Between 2020 and 2060, the number of older adults is projected to increase by 69%, from 56.0 million to 94.7 million. Although much smaller in total size, the number of people ages 85 and older is projected to nearly triple from 6.7 million in 2020 to 19.0 million by 2060 (Mather & Kilduff, 2020). Moreover, the U.S. Department of Health and Human Services (HHS) released a new report that shows 31 million Americans have health coverage through the Affordable Care Act. The data shows those individuals currently enrolled in health coverage through the Health Insurance Marketplaces and Medicaid expansion under the ACA, including 11.3 million people enrolled in the ACA Marketplace plans as of February 2021 and 14.8 million newly eligible people enrolled in Medicaid through the ACA's expansion of eligibility to adults as of December 2020 (U.S. Department of Health and Human Services, 2021). In a study conducted by Zhang et al. (2020) based on estimated changes in the number of the population and age, the author concluded that the United States would face a physician shortage and that would affect the delivery of healthcare facilities. According to this study, the United States will face an estimated shortage of 1.4 million physicians within 12 years (AMA, 2022a). This shortage will directly affect PCC as there will not be enough doctors per patient to give them special care and time (Zhang et al., 2020).

Government Regulation

Private or public entities in the United States may impose regulations on the healthcare system for implementing PCC at the federal, state, and city levels. These may provide quality healthcare, easy access, and cost-effectiveness. Major regulatory organizations are the Centers for Medicare & Medicaid Services, the Centers for Disease Control and Prevention, and the Food and Drug Administration, which perform their duties under the auspices of the U.S. Department of Health and Human Services (Center for Drug Evaluation and Research, 2021; Centers for Medicare and Medicaid Services, 2021; Office for Human Research Protections [OHRP], 2021).

Many acts and laws have been enacted in this sector in recent years. The Health and Social Care Act was introduced in 2013 to ensure that healthcare providers and physicians provide quality care to patients. It stated that it was the physician's responsibility to ensure the delivery of PCC to patients (Care Quality Commission, 2019). Congress proposed the Health Information Technology for Economic and Clinical Health (HITECH) Act in 2021 to promote the adoption of technology and electronic health records for the safety of patients and ensure quality PCC (Mercer, 2021). The act was put forward with a lack of interoperability despite having been through all the stages of meaningful use (Padula & Sculpher, 2021).

U.S. Public Health Policies

Public health policies are laws, regulations, actions, and decisions implemented within society to promote wellness and ensure that specific health goals are met

(Columbia, 2021). The domain of public health policies can vary from formal legislation to regulations affecting different aspects. The primary purpose of public health policies is to improve the overall quality of healthcare. The World Health Organization, the Center for Disease Control and Prevention, the Food and Drug Administration, and other governmental and non-governmental organizations performed systematic studies to design the public health policy for implementing PCC. Public health policies translate research into practical efforts to keep healthcare quality high (Centers for Disease Control and Prevention, 2021; Center for Drug Evaluation and Research, 2021; World Health Organization, 2019).

The American Academy of Family Physicians has urged all national, state, federal, and private sector institutions to collaborate with public health bodies to focus on developing integrated care to improve the country's health system (The American Academy of Family Physicians Foundation, 2021). Under the federal executive branch, several agencies conduct health-related activities. These bodies are concerned with health problems. The four congressional committees were most involved in healthcare dealing with most issues, while the U.S. Health and Human Services department work with the private sector to come together on decisions relating to healthcare. The United States government must ensure that the public interest is served by measures adopted (NCBI, 2021).

Empowering patients is one of the significant elements of PCCM; the U.S. Cures Act entitles U.S. citizens to get empowered regarding their healthcare. This act revolutionized the healthcare system by digitalizing it and ensuring data privacy. Under the Health Insurance and Portability and Accountability Act, patients have legal access to their healthcare data and records, ensuring transparency in cost and care and competitive medical care options. Moreover, the digitalization of clinical data provides patients with a platform to find innovation in treatments and modernization in the art of medical care (ONC's Cures Act Final Rule, 2019).

Technology

The Increasing Dependence on Technology

In recent years, healthcare practices have been changing globally. Healthcare facilities are now geared much more toward PCC, and the patient's point of view has become an increasingly important factor in the provision of healthcare services. Today, the world is changing every day, and the use of technology in every field of life is increasing, including healthcare (Downes et al., 2019). Healthcare has entered the era of digitalization, and healthcare facilities are available with a single click. Moreover, healthcare service providers are also using technology to enhance their entire system's efficiency.

Information technology has deepened its roots in the healthcare industry; data are being recorded electronically, and the use of modern software and machines is growing. By 2021, the use of technology in the healthcare system in the United States could have increased by up to 96% (Topaz et al., 2020). The use of electronic devices keeps growing and an estimated 77% of U.S. citizens use smartphones (Bauer et al., 2020). Patients are now more interested in deciding their personal health goals or having a one-click health report (Topaz et al., 2020). Telehealth, health applications, and other information and communication technology have changed the communication medium between health providers and patients.

Applications related to health monitoring have given physicians easy and cost-effective access to patients for monitoring their health goals or medical history (Downes et al., 2019). On the other hand, Topaz et al. (2020) has shown that because of technology, certain aspects of PCC (e.g., personal interaction and emotional support) are not being adequately fulfilled. The argument presented in this research is that virtual interaction is not as effective as physical interaction and results in a lack of emotional support from physicians to their patients (Topaz et al., 2020).

The Role of Technology in the Patient-Centered Care Model

Technology has played a role in advancing the PCC model (Appleman et al., 2020). Technological advancements have played a positive role in strengthening some elements and a negative one in compromising other aspects of the PCC model. The past few decades have shown many emerging surgical robotic platforms that can work in complex and confined channels of the internal human organs and improve the cognitive and physical skills of the surgeons during the operation, and much more (Rong et al., 2020; Thai et al., 2020). Artificial intelligence uses algorithms to make decisions and keep itself updated by extracting new information from medical journals or self-analysis (Rong et al., 2020). Artificial intelligence could save up to $150 billion for the U.S. health economy by 2026 (Bjerring & Busch, 2021).

Artificial intelligence (AI) has played a vital role in the field of radiology. This has made the various radiological tests more advanced and accessible to patients with limited time, and their results are now more accurate. AI can refine images and process them within a minute to present them on the radiologist’s desk. The cumulative effect will help us enhance the patient care experience in radiology (Hawk, 2020). Another advance in the health sector has been telemedicine, through which patients can access healthcare very quickly. Patients can now use this medium to communicate remotely with their physicians from anywhere in the world. The expected market value of telemedicine is estimated to be $113 billion by 2025. Telemedicine provides a platform for physicians to diagnose and treat their patients using telecommunications technology. It has played an essential role in the U.S. healthcare system, especially in allowing patients to interact with their busy and overburdened physicians (Ku, 2021). Telemedicine in the United States has improved access to healthcare for citizens living in remote areas while also making it more affordable for people who are physically disabled or live in areas with limited transportation (Downes et al., 2019).

However, certain flaws in the system work to compromise some of the principles of the PCC model. It has become difficult for physicians to find a balance between face-to-face patient interactions and using technology best (Gordon et al., 2020). Technological advances in the health sector, from storing medical records electronically to robotic surgery, are making the physician-patient relationship more virtual, less personal, and emotionally supportive (Gordon et al., 2020). This is where technology starts to harm implementing the PCC model. One of the core elements of PCC, “emotional support,” is being compromised, and this can also indirectly affect the physical comfort element of PCC (Gordon et al., 2020). So, while technology in the healthcare system has supported the “access to care” and “information, education, and communication” aspects of the PCC model by allowing patients to enjoy healthcare services at home, it has also compromised the “emotional comfort” and “physical comfort” sides of the model.

Additionally, professionals can now be so involved in dealing with technology that they may rarely have time to discuss patients' critical medical and social needs. The development of an emotional connection in the age of digitalization is getting more complicated daily (Ogilvie, 2020). Additionally, documenting patients' sensitive information using IT services to prevent loss of data from physicians' minds and prevent intermingling of sensitive details of one patient with another is essential; it creates an ethical conflict of getting this information leaked, which is against PCC. Therefore, it is recommended to document as little sensitive information as possible, considering the principles of IT security (Hansson & Fröding, 2020).

Quality and Affordability of Technology

Affordability is one of the main factors for U.S. citizens regarding healthcare. A study by Beal and Foli (2021) showed that an increase of $10 in healthcare costs would raise the level of non-adherence to medication by 7%. Following this, failure to take medication leads to a rise in overall healthcare costs and poorer outcomes. In addition, cost-related access problems cause significant psychological stress, directly affecting personal health (Beal & Foli, 2021). In recent years, technological advancement in the health sector has been beneficial and has enhanced the quality of healthcare services, but these advancements have increased the cost of health to some extent. According to one study, improvements in the health sector have raised the cost of health by approximately 50%. New technologies are still developing, so it is too early to say whether they will eventually help reduce healthcare costs and increase efficiency (Clemens, 2017).

Empowering Patients With Technology

The principle of empowering patients can be thought of in general terms as the whole process involved in helping a patient gain control over their own lives; more specifically, it assists the patient in monitoring their health parameters. The principles of patient empowerment are “access and control,” “knowledge and information,” and “shareholding” (Lau, 2019). Technology has played a vital role in empowering patients. To enhance access and control, the patient should have access to their personal medical history and be able to track their health parameters. Patients should be equipped with the tools to enhance their health literacy to strengthen their knowledge. To improve “patient shareholding,” blockchain technology can be used by patients to monitor their progress and increase their participation in their treatment (Lau, 2019).

The world is now connected with tools to store health data electronically, monitor and educate, and track behavioral changes with a single click. The digitalization of the healthcare system has empowered patients (Alam et al., 2020). Wearable technologies can be attached to shoes, eyeglasses, earrings, clothing, gloves, and watches. Mobile phone applications significantly empower patients by providing a platform to keep an eye on their health records. Important areas of data that can now be recorded include heart rate, blood pressure, body temperature, body oxygen saturation, and physical activity (Ul Hasan & Negulescu, 2020).

Disadvantages of Healthcare Technology

Technological advances in healthcare are helping our lives more than ever as technological advances continually emerge. While healthcare innovation may seem like progress, there are certainly both advantages and disadvantages for patients in this emerging healthcare technology (Galen Data, 2022). According to Galen Data (2022), the first disadvantage of technology in healthcare for patients is the cybersecurity risk of the exposure of private data or the demands for ransom that are sometimes associated with data breaches. The risks related to altered data can have serious consequences. Patients and healthcare professionals relying on data to make treatment decisions depend on having correct and accurate datasets. Deleting or changing data can lead to a wrong diagnosis, treatment plan, or other adverse effects.

The second disadvantage lies in dealing with dashboards on connected medical devices and computers, which remove the human touch from treatment, resulting in a potential lack of empathy in patient care. Especially for elderly and more vulnerable patients, relying on technology as the interface for maintenance can cause confusion and frustration. It can result in treatment plans not being appropriately understood or patient non-compliance.

The third disadvantage of technology in healthcare is poor implementation and alignment across multi-cultural settings. As technologies such as artificial intelligence and machine learning become more prevalent, care must be taken to ensure that healthcare professionals understand their limitations. For example, many machine-learning models are trained on historical data. They do not adapt well to changes over time or situations with significant mismatches between operational data and the data used for training. Similarly, their multi-cultural adaptability and understanding may lead to complacency among clinicians, potentially failing to cross-check or consider alternatives to the system's predictions. However, as this new industry matures, the disadvantages are likely to be outweighed by the advantages, presenting a new standard for care (Galen Data, 2022).

Summary and Conclusions

The literature review has described the concept of the PCC model considering the available literature, its overall history, the elements required for its successful implementation, and its underlying principles. The PCC model was reviewed considering accessibility and affordability issues. The role of PCC in maintaining quality healthcare services has been addressed. The importance of an ethno-racial concordance between the patient and their physician has been established, and the impact of the COVID-19 pandemic on the PCC model has been discussed. The chapter has also highlighted the advantages and disadvantages of using technology in the PCC model.

Further, this research has identified the issue of disequilibrium in healthcare workforce demand and supply in teaching hospitals in the United States. Although there has been plenty of literature (i.e., in the form of patient-reported outcomes) describing patients’ views of PCC, literature discussing the delivery of PCC from the physician’s perspective has been scarce. Therefore, my study has been designed to review PCC from the physician's point of view. This will help the United States teaching hospital administrators identify Hispanic physicians’ issues in practicing PCC. This paragraph summarizes Chapter 2 and is a transition to Chapter 3, describing the basic methodology used in this study, the research design, and the proposed data collection method.

Chapter 3: Research Method

Introduction

The purpose of this qualitative study was to understand Hispanic physicians' perceptions as an integrated priority of the PCC to improve quality, safety, accessibility, and affordability in healthcare. Chapter 3 provides a comprehensive review of research methodology, including a description of qualitative research methodology as well as the suitability of qualitative research design for this study. It provides an in-depth description of research methodology, including study participants, sampling techniques, recruitment procedures, development and validation of the data collection tool, the data collection procedure, along with the plan for data analysis based on pre-existing literature for qualitative research methodology. Additionally, I summarize the ethical procedure followed while conducting this study—the existing ethical concerns of this study and my expertise in overcoming those ethical challenges. In the last part of Chapter 3, I briefly explain the assumptions and limitations of his study.

Research Design and Rationale

The qualitative research methodology was used in the study to understand Hispanic physicians' perceptions as an integrated priority of the PCC to improve quality, safety, accessibility, and affordability in healthcare. The qualitative research methodology was appropriate for the study because qualitative research depicts the reality of the participants by summing up a variety of perspectives from various participants of the study and involves the researcher in research by considering the researcher as an instrument (Flick, 2022). According to Barker and Pistrang (2021), qualitative research is pragmatic as well as interpretive in nature and is based upon the lived experiences of study participants. The research questions investigated in this study were the following:

RQ1: What challenges do Hispanic physicians face in practicing PCC in U.S. teaching hospitals?

RQ2: What were the perceptions of Hispanic physicians regarding the care quality, safety, accessibility, and affordability of PCC during the COVID-19 pandemic in U.S. teaching hospitals?

There are four main qualitative study designs: ethnography, phenomenology, narrative, and case study design (Turner & Hagstrom-Schmidt, 2022). Ethnographic studies are generally used to learn about a culture, via more immersive practices. An ethnographer tries to investigate miracles through the lens of anthropology (Pink et al., 2022). Given the nature of this study, the use of an ethnographic design was not necessary, as I was not exploring the way people live or how their way of living was based upon cultural and behavioral values of their environment.

Case study design is a qualitative research design that is applied to people, assignments, time phase, procedures, and organizations using multiple data sources. It is used to develop an in-depth description of a single case or multiple cases and to evaluate interventions that do not have a clear, single set of outcomes (Hancock et al., 2021). Case study design was not appropriate for the study. I focused on understanding the perceptions of Hispanic physicians regarding empowering patients to make decisions about their healthcare and supporting innovative approaches to improve quality, safety, accessibility, and affordability, as an integrated priority of PCC during a pandemic rather than evaluating the interventions. Further results provide very little basis for scientific generalization (Hancock et al., 2021).

Narrative research design was not the best method to use in this study, as the narrative research design requires that the researcher collect data to explore skills required for solving problems like communication (Cortazzi & Jin, 2020). Narrative research is criticized by researchers as it focuses on individual context rather than social context. Renjith et al. (2021) stated that narrative design responds to the question “What happened?” The purpose of this study was to understand the perceptions of Hispanic physicians regarding empowering patients to make decisions about their healthcare and supporting innovative approaches to improve quality, safety, accessibility, and affordability as an integrated priority of PCC during a pandemic. Because of this, the narrative approach would not have been suitable.

I used a phenomenological study design because it focuses on creating a comprehensive concept of an event based on lived experiences of individuals (Renjith et al., 2021). Phenomenology refers to the strategy of studying the effect of an experience on a specific gathering of individuals (Thomas, 2021). The approach of phenomenology is accepted in studies related to healthcare as it provides fundamental knowledge of understanding lived experiences, perspectives, and perceptions of individuals participating in research (Thomas, 2021). It refers to a humanistic approach for studying a phenomenon to capture experiences of study participants through interviews (Kumatongo & Muzata, 2021). Phenomenological studies are focused on depicting lived experiences of participants and identifying the congruence of shared experiences (Kumatongo & Muzata, 2021). In this approach, the researcher explores the relationship of the participants to the setting and tries to gain insight into the motivation of the participants. Further, it focuses on data collection to identify the significance of the phenomena (Kumatongo & Muzata, 2021). Phenomenological study design includes in-depth, semistructured interviews and observations of the researcher (Kumatongo & Muzata, 2021).

Descriptive phenomenology provides suitable and valid methods to gather narrative data, which enforce a person-centered approach to develop comprehensive understanding of lived experiences (Larsen & Adu, 2021). Descriptive phenomenology, a branch of phenomenology, is a widely accepted qualitative research design in healthcare research (Larsen & Adu, 2021). Another branch of phenomenology is interpretive phenomenology, in which lived experiences of participants are interpreted rather than simple described (Smith & Nizza, 2022). I determined that descriptive phenomenology was the method of choice for this study because it aimed at understanding the perceptions of Hispanic physicians regarding empowering patients to make decisions about their healthcare and supporting innovative approaches to improve quality, safety, accessibility, and affordability, as an integrated priority of PCC.

Role of the Researcher

The role of researcher in qualitative studies is different from their role in quantitative studies. In qualitative studies, the researcher acts as an instrument in data collection, unlike in quantitative studies, where the role of the researcher is hypothetical (Becker, 2019). In quantitative studies, the study participants perform research independently without the involvement of the researcher. Similarly, in placebo-controlled randomized controlled trials, double blinding is preferred to reduce the risk of bias

(Bloomfield & Fisher, 2019). Contrastingly, in qualitative studies, data are collected via human instruments rather than machines. It is necessary that the characteristics of human instruments are clear to the consumer of the research (Becker, 2019).

In qualitative studies, researchers should describe themselves, their expectations, and their experiences to qualify themselves as researchers and reduce the risk of bias (Johnson et al., 2020). Additionally, the researcher in a qualitative study should describe their role as an emic or etic perspective. A researcher is said to play an emic role in research if they act as a participant in the whole activity and is considered to play an etic role if they play their part by being an objective viewer (Beals et al., 2020). Sometimes the researcher acts as both etic and emic alternatively (e.g., they play their role as an outsider in the beginning and as an insider at the end of research; Beals et al., 2020). Efficient researchers begin interviews by asking probing questions, listen to the answers with full concentration, ponder the responses to generate further probing questions, and direct themselves with the research into a deep conversation. They use themes and theories from a variety of sources to develop a picture of responses in their thoughts.

The role of the researcher in qualitative research is to assess the thoughts and feelings of study participants. The phenomenological design selected for this research provided an approach through which I sought to understand and describe the universal essence of a phenomenon (Delve et al., 2022). The purpose of the study was to understand Hispanic physicians' perceptions as an integrated priority of PCC to improve quality, safety, accessibility, and affordability in healthcare. Phenomenological research focuses on lived experiences for the researcher to gain deeper insights into how people understand those experiences (Delve et al., 2022).

Researchers using phenomenological research design assume that people use a universal structure or essence to make sense of their experience. The researcher interprets the participants’ feelings, perceptions, and beliefs to clarify the essence of the phenomenon under investigation. Phenomenological research design requires the researcher to bracket whatever priori assumptions they have about the experience or phenomenon (Delve et al., 2022). In simpler terms, researchers use phenomenological research designs to understand a phenomenon’s universal nature by exploring the views of those who have experienced it (Delve et al., 2022).

I played my role as an emic researcher in this study. I am a healthcare executive with over 30 years of experience and have a sharp focus on healthcare quality and service. I have leveraged strategic and operational leadership to launch complex healthcare initiatives and transform healthcare organizations, aligning the patient care model. I have also created a culture of open communication between members of the broad healthcare community to ensure the delivery of superior-quality patient care and long-term competitive advantage for organizations.

For the first research question, I was interested in identifying the challenges of Hispanic physicians regarding practicing PCC in U.S. teaching hospitals. Hence, I focused on the challenges faced by Hispanic physicians while practicing PCC in teaching hospitals in the United States along with their understanding regarding the impact of Hispanic physicians over patient decision-making while being treated by Hispanic physicians in tertiary teaching hospitals in the United States. Similarly, for the second research question, I was interested in identifying the perception of Hispanic physicians regarding the care quality, safety, accessibility, and affordability of PCC during the COVID-19 pandemic in U.S. teaching hospitals.

Research Methodology

Before the collection of data, I determined the sample population of this study (i.e., Hispanic physicians; physicians who lived and practiced in the United States but were not Native Americans and came from a Spanish-speaking minority cultural background). In qualitative research, the researcher selects the participants of a study while keeping in view the phenomena of the study. The researcher willingly opts for the study participants who will help them to answer the research questions (Hennink & Kaiser, 2021). The population of this study was Hispanic physicians working in U.S. teaching hospitals situated in Miami, Florida, during this era of the COVID-19 pandemic.

The process of selecting characteristic samples from the population is termed *sampling*. In this qualitative study, purposive sampling, a nonprobability sampling technique, was used to take out individual participants of the study from a large study population. Purposive sampling technique is based upon sampling according to a specific purpose and not according to the levels or geographic distribution of the population (Campbell at al., 2020). In purposive sampling, the individuals who have necessary information required by the researcher for the study are taken out of the population and included in the study. Therefore, the participants selected via purposive sampling are said to be handpicked, as they possess all the characteristic features required to fulfill the objectives of the study (Campbell et al., 2020).

Hennink et al. (2019) suggested that the sample size is less critical than sampling procedures, the validity of data, and the depth of investigation in a qualitative study. The selected sample size enabled the achievement of trustworthiness. Using the select sample size facilitated the development of an in-depth picture of the perceptions of Hispanic physicians regarding empowering patients to make decisions about their healthcare and supporting innovative approaches to improve quality, safety, accessibility, and affordability, as an integrated priority of PCC during a pandemic. Braun and Clarke (2021) suggested that qualitative research provides deep insight with a small sample size. Purposive sampling was used in this study for the selection of participants. It is a sampling technique in which the researcher carefully selects participants with the expectation that every participant chosen will provide the researcher with sufficient information of value for the study. This technique determines the sample size by data saturation, not power analysis.

Sample size calculation in qualitative studies is done randomly depending upon the scope of the research questions, feasibility, and objectives of the research, and availability of resources rather than statistical calculation, as in quantitative studies (Hennink & Kaiser, 2021). Moreover, most researchers collect data until data saturation is achieved and further research yields no new information (Braun & Clarke, 2021). In this study, I included between 10 Hispanic physicians working in a U.S. teaching hospital in Miami, Florida via purposive sampling according to his perception of reaching data saturation by 10 participants.

Instrumentation

Instrumentation in qualitative research is not a traditional questionnaire, but rather an interview guide used to provide a lens for data collection (Roberts, 2020). According to Roberts (2020), the researcher is the primary instrument, because the researcher selects the method and design, data collection process, and data analysis framework. The most widely used data collection processes in qualitative research are observations, interviews, and focus group discussions (Roberts, 2020). Although the use of multiple sources for data collection is encouraged to reduce the risk of mono-method errors, the research questions basically drive the method of data collection. As indicated by the research questions of the study, the observational method was not applicable to identify the perceptions of Hispanic physicians regarding patient empowerment via PCC and its affordability during the COVID-19 pandemic. In the study, semistructured interviews were used based on an interview guide I developed (see Appendix B). Semistructured interviews basically comprise a list containing guiding questions, which are added up after constant probing of the researcher's mind by responses of participants (DeJonckheere & Vaughn, 2019). According to DeJonckheere and Vaughn (2019), a semistructured interview guide should consist of open-ended questions that are clear and neutral for the study participants. Moreover, the language of a semistructured interview should be study-participant friendly, while simultaneously avoiding jargon (DeJonckheere & Vaughn, 2019). According to Kakilla et al. (2021), semistructured interviews provide the researcher with the flexibility to follow up responses of participants extensively. In this study, I designed the semistructured interview instrument after a thorough literature review. In the semistructured interviews in this study, I started with the introduction of the study, describing the aims and objectives of the study and briefing participants on the procedure of the study, which was followed by the informed consent form agreement. In the initial part of a semistructured interview, details of participants, including their affiliation with a U.S. teaching hospital and the experience of working during the COVID-19 pandemic, were collected. The semistructured interviews were conducted using an interview guide. The interview guide consisted of open-ended probing questions that I designed to motivate the study participants to share their thoughts and perceptions regarding the empowerment of patients in making decisions about their healthcare and the affordability of PCC during the COVID-19 pandemic.

I categorized the interview guide into the following categories. The first category of the interview guide consisted of questions regarding demographic information of the study participants. The second category of the interview guide dealt with the research question “What challenges do Hispanic physicians face in practicing PCC in U.S. teaching hospitals?” Similarly, the third category of the interview guide dealt with the research question “What were the perceptions of Hispanic physicians regarding the care quality, safety, accessibility, and affordability of PCC during the COVID-19 pandemic in U.S. teaching hospitals?” The content validity of the semistructured interview guide was established via its assessment by experts who pondered various aspects of the interview.

A total of eight peer-reviewed questions were asked of the participants in a preset order (Appendix B). As illustrated in Table 1, the interview guide was aligned with the research questions.

Table 1

Alignment of Interview Questions With the Research Questions

Research question	Interview question
RQ1: What challenges do Hispanic physicians face in practicing PCC in U.S. teaching hospitals?	• What patient-centered care (PCC) model challenges have you faced as a Hispanic physician practicing

Research question	Interview question
	medicine in teaching hospital organizations in the United States?
	• What are your thoughts on a Hispanic physician's impact on patients to improve the quality, safety, accessibility, and affordability of their healthcare in teaching hospital organizations in the United States? • What other positive or negative conditions have you encountered that impact the patients in making decisions towards improving PCC from the Hispanic physician practicing medicine in a teaching hospital organization in the United States? • What are your suggestions to support patients in actively participating in the PCC process regarding their health care as a Hispanic physician practicing medicine in a teaching hospital organization in the United States? • How do public health policies impact the patients' PCC process in improving the quality, safety, accessibility, and affordability of their health care from Hispanic physicians practicing medicine in teaching hospital organizations in the United States?
RQ2: What were the perceptions of Hispanic physicians regarding the care quality, safety, accessibility, and affordability of PCC during the COVID-19 pandemic in U.S. teaching hospitals?	• What is your contribution as a Hispanic physician practicing medicine in teaching hospitals in the United States towards the accessibility and affordability of PCC during the COVID-19 pandemic?

Research question	Interview question
	• How were patient quality and safety affected during the COVID-19 pandemic as part of the overall PCC in teaching hospital organizations in the United States? • How do your strengths and limitations as a Hispanic physician impact PCC during the COVID-19 pandemic in teaching hospital organizations in the United States?

Research Procedures

Hispanic physicians are essential in U.S. teaching hospitals, constituting an appropriate population for this study (New American Economy, 2020). The population for this study was Hispanic physicians between the age of 35 and 65, presently working in a U.S. teaching hospital in South Florida, including Miami-Dade County, Broward County, and Palm Beach County. The sample size was 10-15 participants, consisting of male and female participants who were Hispanic physicians working in the selected U.S. teaching hospital or had been in the position for at least 2 years. The sample selection did not exclude any populations.

The primary aim of selecting this population was to engage Hispanic physicians that work as clinical physicians in U.S. teaching hospitals in South Florida, including Miami-Dade County, Broward County, and Palm Beach County. This qualitative study aimed to understand Hispanic physicians' perceptions as an integrated priority of the PCC to improve the quality, safety, accessibility, and affordability of healthcare.

The participants were selected through purposeful sampling and representative of the broader population of Hispanic physicians who held clinical positions with a U.S. teaching hospital. To be included in this study, the potential participant must (a) self-identify as a Hispanic physician, (b) hold a clinical position, and (c) have been in the clinical position for at least 2 years. Individuals were excluded if they (a) did not self-identify as a Hispanic physician, (b) did not hold a clinical position, or (c) had been in the current position for less than 2 years.

This method is highly recommended for qualitative researchers because it permits recruiting contestants to provide in-depth and detailed information about the phenomenon under investigation. Purposive sampling better matches the sample to the aims and objectives of the research, thus improving the study's rigor and the trustworthiness of the data and results (Campbell et al., 2020). The selected purposive sample was Hispanic physicians presently working in a clinical position in the selected U.S. teaching hospitals in South Florida, including Miami-Dade County, Broward County, and Palm Beach County. The logic for limiting the sample size to 10-15 participants was to obtain accurate data and focus on a specific population that had experience with the research topic.

After approval from the IRB Committee of Walden University, with an approval number of 06-01-23-0625824 that will expires on May 31, 2024. I emailed the study invitation (Appendix A) and study consent form using the social media platforms LinkedIn, Facebook, and Instagram. I did not have an existing personal or professional relationship in the past or present with any of the participants, which minimized the risk.

Each contact participant who met the inclusion criteria then answered my invitation. The invitation instructed volunteers to schedule the day and time to complete the interview.

Once the potential participant was contacted and accepted the invitation, I reviewed their qualifications in alignment with the study inclusion criteria. The study participants sent the signed informed consent form to me, and then I set the appropriate date and time for interviews along with a place for the interview. The selected place for the interviews was isolated away from a public place in an enclosed room with closed doors and windows to minimize disturbances to the external environment. Moreover, I started the interview by building a rapport with the participants rather than directly using rote questions. Each interview lasted approximately 45 minutes. The study participants were labeled as I-HP-01, I, HP-02, I-HP-03, and so on to maintain confidentiality.

The data were gathered by using a semistructured interview guides in a language that was easily comprehendible and preferred by the study participants, including either English or Spanish. The tape recorder was checked twice before interviews to avoid technical issues during interviews. Moreover, the study participants were introduced to the recorder and the purpose of recording beforehand. The interviews were audio-recorded using a digital recorder with a built-in microphone to promote high-quality audio recording and suppress any unwanted noise. No follow-up interviews were conducted in this study; however, I contacted the interviewees by email for the member-checking step after transcription and initial coding. In the email, I offered to share her takeaways from that person's interviews via phone or email (i.e., according to the participant's preference) so the participant could confirm whether the interpretations were accurate.

All potential risks were mitigated amongst the participants and conflicts of interest by excluding the names of participants and their employers. All interviews were conducted in a private setting using Zoom's electronic platform. The data will be kept in a secure locked cabinet at home in the office.

Data Analysis Plan

In qualitative research, data analysis refers to the systematic phenomena in which interview transcript observation notes or audios/videos (non-textural material) are searched, arranged, coded, and categorized. Alternatively, qualitative data analysis is defined as the process of making sense of data collected during the study by decreasing the raw information gathered (Mihas, 2019). It is followed by the development of significant patterns which lead to the collection of meaningful information from collected data and enables the researcher to build a chain of logistical evidence (Jackson & Bazeley, 2019). Multiple types of qualitative data analysis exist in qualitative research literature, including methodological data analysis, thematic analysis, content analysis, and program evaluation (Raskind, 2019). Thematic data analysis was used in this qualitative study because it allowed the analysis of a large amount of data collected via multiple participants and synthesizes a purposeful meaning. It is not limited to a single specific epistemological position and provides a well-structured methodology for identification of key themes out of the dataset (Kiger & Varpio, 2020).

The six steps of the thematic analysis process defined by Braun and Clarke (2019) were used in the study because it provides the guidelines for collecting and familiarizing with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and writing the report. According to Linneberg and Korsgaard

(2019), coding or categorizing data in qualitative studies is essential to qualitative data analysis. The process of coding refers to categorizing the data into different categories or themes. There are two types of coding: deductive and inductive (Linneberg & Korsgaard, 2019).

The six steps prescribed by Braun and Clarke (2019) to carry out a thematic analysis were used for the two research questions and the available data. The thematic analysis consists of first, familiarizing with the data requires the researcher to be fully immersed and actively engaged in the data by transcribing the interactions and then reading (and re-reading) the transcripts and listening to the recordings. This step provides the foundation for the subsequent analysis. Second, once familiar with the data, the researcher must identify preliminary codes. These codes are more numerous and specific than themes but indicate the context of the conversation. The third step in the process is the start of the interpretive analysis of the collated codes. Relevant data extracts are sorted (combined or split) according to overarching themes. The researcher's thought process should allude to the relationship between codes, subthemes, and themes. Fourth, a deeper review of identified themes follows where the researcher needs to question whether to combine, refine, separate, or discard initial themes. Data within themes should cohere together meaningfully, while clear and identifiable distinctions between themes should exist. This step was done over two phases, where the themes need to be checked for the coded extracts (phase 1) and then for the overall data set (phase 2). A thematic map can be generated from this step. The fifth involves 'refining and defining' the themes and potential subthemes within the data. Ongoing analysis is required to enhance the identified themes further. The researcher needs to provide theme names and clear working definitions that capture the essence of each theme concisely and punchily. At this point, a unified story of the data needs to emerge from the themes. The last step is producing the report in which the researcher needs to transform the analysis into an interpretable piece of writing by using vivid and compelling extract examples that relate to the themes, research question, and literature (Braun & Clarke, 2019).

Deductive coding refers to using research questions to generate codes before touching the data collected via instrumentation, while inductive coding technique refers to the process of generating codes by using data collected during the study rather than using research questions (Linneberg & Korsgaard, 2019). Alternatively, in deductive coding, the researcher uses pre-established codes before using data, while inductive coding generates codes after data are collected with no influence of pre-existing literature (Linneberg & Korsgaard, 2019). Inductive coding will be used in this study because it is considered the best coding technique in qualitative thematic analysis (Chandra & Shang, 2019). Additionally, inductive thematic analysis allows the participants of the study to explain their personal experiences rather than seeking views on topics pre-informed by the already existing evidence.

Coding can be done manually by using colored markers to highlight, cut, or shorten the data, or the data of qualitative study can be coded by using various computer software. In our study, the data were coded by using NVivo (Version 2.0; Binji, 2019). NVivo, a computer-assisted qualitative data analysis software, was constructed by the largest qualitative research software developer, QSR International (Melbourne, Australia). The software is used for qualitative data analysis including data coding, sorting, and data retrieval along with integrating the data coding with linking, shaping, and modelling of qualitative data (Jackson & Bazeley, 2019).

After the coding of data by NVivo, I analyzed the themes generated under supervision of the committee chair to maintain the quality of data analysis in this study. According to Moon (2019), triangulation is the best method of increasing the quality of qualitative research findings. Triangulation refers to the process of increasing the credibility or validity of research findings. There are five types of triangulations, including triangulation of data, investigators, theory, environment, and methodological triangulation (ResearchArticles.com, 2020).

In this study, I employed data triangulation by using interview transcripts as well as the memos generated by the interviewer during the interviews. Additionally, to perform investigator triangulation, the data were analyzed under the committee chair supervision. Finally, I provided the copy of generated transcripts to the study participants if they wanted to add any comment or make any corrections. First, I selected the most representative citation of themes generated during data analysis. The transcripts generated will be kept in a personal computer of the researcher and will be destroyed approximately 5 years after the data analysis process.

Threats to Validity

Accuracy of qualitative research methodology is important to attain valid results. It is compulsory to maintain validity and reliability of results. By ensuring research rigor, the researcher ensures trust in the research and its findings leading to trustworthiness (Johnson et al., 2020).

Dependability

It is evident from literature that qualitative data analysis undergoes variation constantly. Alteration in context of the study, participants of the study, or change in time of the study prevents the qualitative research from being repeated. Dependability is a qualitative counterpart of reliability. It is the extent to which a study can be repeated or alterations in the study are comprehendible (Stenfors et al., 2020). According to Stenfors et al. (2020), dependability is considered to be one of the essential criteria for judging the reliability or trustworthiness of qualitative study.

Triangulation or member checking are essential aspects of dependability. In this study, the hard copy of transcribed information and analyzed data were provided to the study participants to confirm the accuracy of information they provided to the investigator during interviews or if they wanted to add any missing information to the collected data. The reliability or dependability of research in this study was maintained by using triangulation of data as well as investigators. Similarly, use of a semistructured interview guide as a secondary instrument of the study ensures the dependability of this research.

Credibility

Credibility is an essential aspect of judging the internal validity of qualitative study (Stenfors et al., 2020). This study ensured credibility by using member checking and triangulation.

Transferability

Transferability is an essential aspect of judging the external validity of qualitative study. It refers to the extent to which the findings of one study are applicable to other participants or settings. It is dependent on credibility of any qualitative study (Stenfors et al., 2020). Transferability in this study was ensured by stating clear assumptions of the study.

Confirmability

The term confirmability refers to the degree to which results of any qualitative study reflect the actual data collected during the study (i.e., the findings of research are also confirmed by other researchers; Stenfors et al., 2020). Confirmability of qualitative data collected in our study was assured by the process of multiple checking during the data collection, data arrangement, and data analysis. Additionally, the phenomena of coding generating themes also plays a part in ensuring the confirmability of qualitative data in our study.

Ethical Procedures

Accuracy of qualitative research methodology is important to attain valid results. It is compulsory to maintain validity and reliability of results. By ensuring research rigor, the researcher ensures trust in the research and its findings leading to trustworthiness (Johnson et al., 2020).

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Assumptions of the Study

The study inquired about the perception of Hispanic physicians regarding the PCC model. Perceptions are someone's schools of thought that might change over time (Smith, 2018). It may be considered a result of one's life experiences developed while facing various life circumstances. Quality healthcare facilities, including U.S. teaching hospitals, and a friendly healthcare environment may augment physicians' perceptions regarding PCC, which fosters the implementation of the PCC model. Therefore, we assume that the diversity of working environments at different teaching hospitals in the United States could impact how a physician responds to our research. Even within a single teaching hospital, the diversity of administration in various departments may alter the way Hispanic physicians perceive to be the concept of PCC.

Limitations of the Study

The study was limited to the perceptions of the Hispanic physicians, competence, and knowledge, including the small sample size. It was difficult to find significant relationships between Hispanic physicians and the patient and to be considered representative of groups to whom results were generalized or transferred. The limited hospital access in the selected location and the bias in which Hispanic physicians may give a popular answer that colleagues agree with rather than a valid opinion were a concern.

To reduce the impact of these limitations, a close look at the evaluation of the inclusion criteria of selection was necessary, as well as aligning the participant working in U.S. teaching hospitals which were essential to better understand Hispanic physicians' perceptions as an integrated priority of the PCC to improve quality, safety, accessibility, and affordability in healthcare throughout the highest level of medical education, research, and patient care in a unique environment where the next generation of healthcare providers are trained. The U.S. teaching hospitals foster an environment of discovery and the latest medical advances. In addition, teaching hospitals are distinguished by their clinical programs, where scientists and physicians work together to bring new treatments safely and quickly from the research bench to the bedside safely and quickly (AHA, 2020).

Summary

In Chapter 3, I explained my role as researcher in this study along with the use of purposive sampling technique in this study. I also explained the use of phenomenological qualitative research tradition as an appropriate research design for the study along with reasons. Then, I outlined the ethical procedures I followed before initiating data collection for my research, the use of a semistructured interview guide in data collection process of the study, along with its validity and reliability. I discussed the use of inductive coding and thematic data analysis technique for data analysis via NVivo in the study. In the end of Chapter 3, I summarized the threats to validity of my research including credibility, confirmability, dependability, and transferability. Additionally, in

Chapter 3, I provided the readers with a brief explanation of assumptions of the study followed by the limitations.

Chapter 4: Results

A qualitative, phenomenological analysis was conducted to identify the lived experiences of Hispanic physicians, an essential component of PCC model, who are directly involved in increased quality, safety, accessibility, and affordability in healthcare. A total of 10 self-guided, semistructured interviews were conducted to explore the lived experiences of Hispanic physicians working in U.S. teaching hospitals situated in Miami, Florida, during the era of the COVID-19 pandemic regarding quality, safety, accessibility, and affordability in healthcare. The purpose of this qualitative study was to understand Hispanic physicians' perceptions as an integrated priority of PCC to improve quality, safety, accessibility, and affordability in healthcare.

A phenomenological analysis methodology was used to code, organize, and categorize the data for greater insight and in-depth understanding of the participants' experiences as Hispanic physicians working in U.S. teaching hospitals. Chapter 4 includes the research questions used in the study, the data collection process, and a demographic depiction of participants. Data analysis is described, and the results are organized by each of the three lenses with quotations from the narratives used to enhance the credibility of the study. The last section of Chapter 4 presents the summary of findings of each research question while simultaneously preparing for the discussion of findings, conclusion, and limitations of the study in Chapter 5.

Research Questions

The research questions were as follows:

RQ1: What challenges do Hispanic physicians face in practicing PCC in U.S. teaching hospitals?

RQ2: What were the perceptions of Hispanic physicians regarding the care quality, safety, accessibility, and affordability of PCC during the COVID-19 pandemic in U.S. teaching hospitals?

Demographics

Apart from the lived experiences of Hispanic physicians regarding the PCC model, an additional demographic analysis was conducted to identify the demographic characteristics of study participants. The demographic features of participants included in the interview poll are described in Table 2, including their age, gender, professional degree, specialty, ethnicity, origin, city, and state in which they were living, years of experience as a Hispanic physician, and years of experience at U.S. teaching hospitals in which the study was being conducted. All the interviewees were Hispanic physicians living in Miami, Florida. All the participants had an MD degree by profession, but the sample reflects diversity in specialty qualification, with three (30%) belonging to internal medicine and the rest of the seven (70%) belonging to a variety of specialties, including pediatrics, oncology, general surgery, anesthesia, gynecology and obstetrics, family medicine, and infectious diseases. Most of the participants were male (i.e., nine male vs. one female) and aged 30 to 60 years old. This is equal to the average age of Hispanic physicians practicing in the United States (i.e., almost 50 years; Zauderer, 2023). The mean years of experience of study participants as Hispanic physicians was 27.8, whereas the mean years of experience of working as Hispanic physician at U.S. teaching hospitals was 10.9.

Table 2

Demographic Features of Participants

Partaker	City	State	Job	Specialty	Ethnicity	Origin	Sex	Age	Yrs of experience as a physician	Yrs of experience at a U.S. teaching healthcare system
I-HP-01	Miami	FL	MD	Oncology	Hispanic	Cuba	M	50–60	30	10
I-HP-02	Miami	FL	MD	Pediatric	Hispanic	PR	F	40–50	21	6
I-HP-03	Miami	FL	MD	Anesthesiology	Hispanic	Cuba	M	50–60	35	15
I-HP-04	Miami	FL	MD	Family practice	Hispanic	Cuba	M	50–60	36	13
I-HP-05	Miami	FL	MD	Internal med.	Hispanic	PR	M	40–50	22	13
I-HP-06	Miami	FL	MD	Internal med.	Hispanic	Cuba	M	30–40	15	6
I-HP-07	Miami	FL	MD	OBGYN	Hispanic	Cuba	M	40–50	28	12
I-HP-08	Miami	FL	MD	Gen. surgeon	Hispanic	Peru	M	50–60	31	12
I-HP-09	Miami	FL	MD	Internal med.	Hispanic	Cuba	M	50–60	29	10
I-HP-10	Miami	FL	MD	Infection dis.	Hispanic	Cuba	M	50-60	31	11

Further analysis of demographic data revealed that seven (70%) of the study participants had their origin in Cuba, whereas two (20%) belonged to Puerto Rico by origin. This contrasts with the latest diversity report of practicing Hispanic physicians in the United States presented by the U.S. Census Bureau (2023). According to this report, almost 6% of practicing physicians in the United States are Hispanics. Of all the practicing Hispanic physicians in the United States, 43% were born in the United States, 21% in South America, 9% in Puerto Rico, and 9% in Cuba, followed by 8% and 5% in Mexico and Central America, respectively (AAMC, n.d.).

Data Collection

A total of 10 qualitative interviews were conducted at a time and place most convenient to the participants. A self-designed semistructured interview guide was used in the study after thorough review of relevant literature. Upon approval from the IRB committee of Walden University, I shared the informed consent form and interview invitation letter with the study participants via email. The study participants replied to the email invitation with their decision to consent to the interview and then I set an appropriate date and time for interviews. I started the interview by building a rapport with the participants rather than directly using rote questions. Each interview lasted for approximately 30–45 minutes.

The study participants were labelled as I-HP-01, I-HP-02, I-HP-03, and so on to maintain confidentiality. The data were gathered by using semistructured interviews in English. The recorder tape was checked twice before interviews to avoid technical issues during interviews. Moreover, study participants were introduced to the recorder and the purpose of recording beforehand. The interviews were audio-recorded using a digital online recorder with a built-in microphone to promote high-quality audio recording and suppress any unwanted noise. Follow-up interviews were not conducted in this study. After transcription of the interviews, the interviewees were given a copy of their transcript to assess the accuracy as suggested by Johnson et al. (2020). The interviewees were asked to respond back to me regarding corrections in transcripts (if required) via email. None of the study participants requested any clarification or correction of transcripts in the study.

Data Analysis

In qualitative research, data analysis refers to the systematic phenomena in which interview transcripts, observation notes, or audios/videos (nontextured material) are searched, arranged, coded, and categorized (Williams & Moser, 2019). Several types of data analysis exist in qualitative research literature, including methodological data analysis, thematic analysis, content analysis, and program evaluation (Kuckartz, 2019). Thematic data analysis was used in this qualitative study. The recorded audio files of the interview were transcribed verbatim. The transcribed data as well as memos I created during interviews were checked for accuracy. Inductive coding was used in this study because of its effectiveness in thematic analysis (Linneberg & Korsgaard, 2019). The data were coded by using NVivo (Version 2.0; Jackson & Bazeley, 2019).

After coding of data by NVivo, the themes generated were analyzed to maintain the quality of data analysis in this study. Triangulation was used to increase the quality of research findings. In this study, I employed data triangulation by using interview transcripts as well as the personal notes I generated during the interviews. Finally, I provided a copy of generated transcripts to the study participants for the purposes of adding comments or making corrections. The first participant, I-HP-01, was selected as the most representative citation of themes generated during data analysis. The themes generated are summarized in Table 3.

Table 3

Themes Generated

Sr. no.	Main theme	Subtheme
1	Perceptions of Hispanic physicians regarding the empowerment of patients	• Cultural competence and communication • Patient education and health literacy • Shared decision-making and autonomy • Informed consent
2	Challenges of Hispanic physicians	• Racial, ethnic, and anti-immigrant prejudice, including discrimination in employment, housing, and education
3	Hispanic physician's impact on patient’s decision-making	• Socioeconomic disparities and patient empowerment • Trust and relationship building • Health access and health equity
4	Effective communication and patient engagement as support for patient	• Physician's role in empowering patients • Traditional medicine and complementary therapies • Mental health and stigma • Social awareness
5	Government policies and empowerment of patients in making decisions	• Government regulations • Government initiatives to promote access to reliable health information for patients

Results

A qualitative research method was used to identify and analyze themes within the data (Lochmiller et al., 2021). In this study, the process was initiated by defining clear research questions and objectives to guide the analysis. Data were then collected, which included interview transcripts. I familiarized myself with the data by reading and reviewing the data multiple times, making initial observations and notes. This was followed by the coding process, where initial codes were generated to label specific sections or phrases related to the research question.

Next, themes were searched for by organizing and collating similar codes, and identifying patterns and recurring ideas in the data. Themes were reviewed and refined, ensuring their accuracy and relevance to the research question. Each theme was later defined and assigned descriptive names for clarity. The data were indexed by applying the finalized themes to the entire dataset systematically. I reviewed and validated the analysis to ensure that it accurately represented participants' perspectives and experiences. The themes were later interpreted in depth, providing a coherent narrative with supporting quotes and examples from the data. Finally, I wrote a well-structured report summarizing the process, themes, and interpretations, maintaining rigor and validity throughout the analysis. Thematic analysis is an iterative process, allowing researchers to refine their understanding as they progress and draw meaningful conclusions from the data (Lochmiller et al., 2021).

Theme 1: Perceptions of Hispanic Physicians Regarding the Empowerment of Patients

Hispanic physicians often hold a strong belief in the importance of empowering their patients. With a deep understanding of their patients' cultural backgrounds and experiences, these physicians recognize that patient empowerment goes beyond merely providing medical advice. They strive to create an inclusive and collaborative healthcare environment where patients feel respected and valued as active participants in their own care. I-HP-01 described the difficulty Hispanic physicians face while communicating with non-Hispanic physicians by saying that everyone from Latin America has a unique culture and there are lots of different flavors of Hispanic, but to an extent, they can appreciate and understand an overall common culture. He added to the comments by saying, “we're all Hispanic, we all speak Spanish, we kind of understand, at least on some basic level of the background where people are coming from”.

I-HP-01 also stated,

> We can communicate with these patients, with Hispanic patients, more readily than non-Hispanic physicians. And to an extent, I always say, there's lots of different flavors of Hispanic but to an extent we can appreciate and understand an overall common culture. One, you know, everyone from Latin America has a unique culture, but overarching, we're all Hispanic, we all speak Spanish, we kind of understand, at least on some basic level of the background where people are coming from.

I-HP-02 highlighted that the development of a positive relationship between patient and doctor is important, so one should start with an idea by collaborating and communicating with the patient and stabilizing the patient rather than just relying on a staff nurse promoting indirect patient care. I-HP-03 described autonomy as the most common challenge a Hispanic physician faces while trying to empower patients. I-HP-03 stated,

> When you try to, to adapt to this, to this system, sometimes we kind of like drag our own way of thinking and the way that we were educated and, and that sometimes creates some conflict, because sometimes we want to do things.

Similarly, I-HP-07 highlighted the importance of autonomy and patient respect during medical education by labeling autonomy as the core of PCC. I-HP-07 stated,

> one of the primary tenets that I remember learning in medical school was the importance of patient autonomy, and respect for your patient and respect for your patients' decisions. And I think that really is at the core of what patient-centered care is all about.

He said that face-to-face communication and involvement of patients in decision-making with a busy schedule are challenging for Hispanic physicians. I-HP-09 discussed the importance of patient education in patient empowerment, patient safety, affordability, and accessibility of PCC. I-HP-09 stated, “Get in role of the patient and the physician as well needs to be educated to be able to impact the patient in safety, in quality and affordability, in accessibility. If the patient doesn't know”.

Based on the interviews I conducted, Hispanic physicians place emphasis on promoting health literacy and patient education, ensuring that patients have access to accurate and understandable information about their health conditions and treatment options. Similarly, interviewees shared decision-making as a fundamental aspect of patient empowerment, valuing their patients' input in developing personalized treatment plans that align with their values and preferences. By empowering patients to be active partners in their healthcare decisions, Hispanic physicians included in the study sought to enhance patient autonomy and promote better health outcomes. They believed that when patients are empowered and involved in their care, they are more likely to adhere to treatment regimens and make positive lifestyle changes. Overall, the interviewed Hispanic physicians perceived patient empowerment as a vital aspect of delivering compassionate and PCC that respects and embraces the diversity of their patients' experiences and needs.

Theme 2: Challenges of a Hispanic Physician

Hispanic physicians can face several unique challenges in their professional journey. One of the primary hurdles is navigating cultural and linguistic differences between themselves and their patients (Reopell et al., 2023). As members of the Hispanic community, Hispanic physicians can offer insight into patients' cultural beliefs and practices that may not align with every patient's background, leading to potential misunderstandings (Schowocho, 2023). Additionally, language barriers can hinder effective communication with patients who may prefer to discuss their health concerns in a language other than English (Whiteside, 2022). Only one of the Hispanic physicians, I-HP-01, stated that he never had difficulty with being Hispanic, but the challenges he faced during his life were the challenges everyone must face to strive for success in having a medical career.

The rest of the Hispanic physicians shared different responses regarding challenges they face regarding the ambiguous reaction of patients. I-HP-02 highlighted the existence of panic disorder among patients when they were exposed to any unexpected condition. Language and cultural differences were also considered big challenges according to I-HP-03. I-HP-03 stated, “mostly the languages and cultural barriers are the most important thing for Hispanic physicians in the United States….difficulties that we encounter with the language and the way of thinking that we come from a completely different system”.

While PCC was considered as the most appropriate solution to the challenges, several participants discussed the role of PCC in maintaining the quality of patient care in hospitals in the United Staes. I-HP-04, while describing the role of patient centered care, stated that he had a firm belief in PCC as an important component of quality patient care. I-HP-04 stated,

> I’m a firm believer that patient centered care has a unique role in helping patients to meet their needs. So, I'm a firm believer that this model has helped physicians, nurses or nurse practitioner and other healthcare providers to get into understanding with the patient in order to meet their needs and include them in the decision-making.

I-HP-04 further elaborated that the PCC model had helped several physicians, nurses, and nurse practitioners to understand the needs of patients and promote their inclusion in decision-making. Additionally, the language barrier was the most frequently reported challenge faced by physicians. According to I-HP-05, language barriers between doctor and patient contribute to poorer patient assessment, misdiagnosis, increased adverse events, incomplete understanding of the patient condition and prescribed treatment, and impaired confidence in services received, thus, poor quality of healthcare. I-HP-05 stated,

> One of the biggest challenges that we have is not only the language barrier, that they have most of the hospitals, especially in rural areas, where Hispanics are the minority. And other is understanding that is the treatments must be tailor made for them, in most of the hospitals teaching, don't have the tools or the knowledge on this population of this ethnicity.

The idea was further expanded by I-HP-06 who said that the two problematic points in patient care in the United States included poor leadership and attention deficit with patients and their families. I-HP-06 stated,

> The challenge has been bad. We have two points exactly that we can see some problems in the patient care in the USA that the first one is poor leadership in their attentions with patients not only with patient with family and we caregivers……just not only in the primary care providers in hospitals, we have a lot of experience in ER.

I-HP-07 described the lack of proper understanding of what PCC refers to is problematic and makes its implementation challenging for Hispanic physicians. PCC includes your right to comment, ask questions, and make complaints about your healthcare. I-HP-07 stated,

> I think one of the biggest challenges is defining what patient centered care means, what it entails. I think we all in some way, shape or form, practice this, you know, model without recognizing that this is you know, what, what we're doing.

I-HP-08 highlighted the lack of understanding the language and the existence of cultural barriers consequently results in increased inquiries by the patients leading to frustration. I-HP-08 said,

> or more complex in certain situations for them to have an answer, or too many steps to get to point A or point B or to get from this doctor to another specialist. They can have scenes; the patient manifests some frustration. And sometimes it happens the patient gets lower, and therefore the response from or in front of the doctor or the doctor's office is not the best.

Moreover, different accents are also an important barrier, according to I-HP-09, because the degree to understand what is saying is decreased if the accent is unfamiliar. I-HP-09 acknowledged that Hispanic physicians used to speak using the incorrect pronunciation of some words to help solidify doctor-patient communication. I-HP-09 stated,

> The most important thing I think, for challenging a, I believe is the language, and accent a in regarding attending patients in hospitals. He asked as Hispanic physicians, even though we speak English, but our main language is Spanish is the mean that we speak Spanish…. sometimes we don’t pronounce things correctly. And we have strong accents that for some patients are difficult to understand.

Additionally, I-HP-10 described cultural competency as the main challenge in PCC in the following words, “In my opinion, the most important is cultural competency. So that’s for me, one of the bigger challenges that I see at the time of implementation of patient-centered care itself”. This can result in incomplete medical histories and miscommunications that may impact the accuracy of diagnoses and treatment plans. Another challenge is the potential for bias or discrimination based on ethnicity or race, both from patients and colleagues.

Hispanic physicians may encounter stereotypes or face additional scrutiny, which can be emotionally taxing and undermine their professional credibility. Moreover, there may be disparities in opportunities for career advancement or access to resources, leading to limited representation of Hispanic physicians in leadership positions or research opportunities. Despite these challenges, Hispanic physicians continue to make invaluable contributions to healthcare, and efforts to promote diversity, cultural competence, and inclusion in the medical field are crucial in addressing these obstacles.

Theme 3: Hispanic Physician’s Impact on Patient’s Decision-Making

According to the interviews conducted for this study Hispanic physicians can have a significant impact on patients' decision-making processes due to their unique cultural understanding and communication skills. As members of the Hispanic community themselves, these physicians are often well-versed in the cultural nuances and beliefs of their patients, which allows them to establish a deeper connection and rapport. This cultural familiarity helps patients feel more comfortable and understood, leading to increased trust and confidence in the physician's advice (Kwame & Petrucka, 2021).

Hispanic physicians can also leverage their bilingual abilities to communicate effectively with patients who may feel more at ease to express their concerns and preferences in their native language. I-HP-02 described that to enroll patients in decision-making, they had to interact with the patient and their family, and they had to open up all information regarding patients while dealing with concerns of patients and their families.

Hispanic physicians play a significant and multifaceted role in shaping patient decision-making processes within the healthcare landscape. I-HP-02 stated,

> One of our major things that we need to face is that we need to there was a patient but also we need to, to be open and be well prepared to deal with the parents and their family members have the patience and sometimes it's just a follow up or something minor of a daily basis things with some conditions, we need to be prepared and how to adore or to deal with the parents' concerns.

According to the participants their impact extends beyond medical expertise, as they bring a unique blend of cultural understanding, language proficiency, and personal connection to their practice. I-HP-03 stated the importance of patient education in decision-making capacity by saying,

> I think we need to educate our patients and public in general about the importance of implementing a system that is going to work better for them involve getting more involvement with a more diversified society, basically that we can get them to have their own choices make their own decisions………we'll need to educate them, because they are ultimately the patient is the one that needs to make the decision.

Another emerging theme from participants is that Hispanic physicians also influence patient decision-making through effective communication. Their ability to communicate in Spanish and empathize with cultural nuances allows them to establish a deeper rapport with Spanish-speaking patients, fostering a sense of trust and comfort. Moreover, although implementation of the Affordable Care Act is also essential in promoting PCC, patient participation in decision-making is largely influenced by cultural sensitivities, according to I-HP-04.

Also, I-HP-04 stated, “So, the implementation of the Affordable Care Act has results in proof of access of healthcare services for this money, but challenge remain due to the limited cultural sensitivity, and health literacy”. Hence, according to I-HP-08, this cultural rapport between doctors and patients is crucial in discussing medical conditions, treatment options, and potential risks, as patients are more likely to openly share their concerns and better understand the information being conveyed. I-HP-08 also stated,

> To teach them on time, things to do since we're both learning. And those tools that we have in our hands can be used way before the even the patient goes to see a doctor. And therefore, information is provided. The patient might have questions.

According to I-HP-09, Hispanic physicians can bridge the gap between Western medical practices and traditional cultural beliefs, enabling patients to make informed decisions that align with their values and preferences. I-HP-09 stated,

> My suggestion for patients is to get involved to take control to speak up whatever is in the mind to speak when they have a healthcare provider in front of us is our responsibility as a healthcare provider to answer and if we don't know the answer, we need to find the answer we need to find a provider that will contribute to the wellbeing of the patient is the main. My recommendation is to get involved to get educated to add information from their primary care physician in the language which is very limited at this point. I believe that will be my recommendation.

Theme 4: Effective Communication and Patient Engagement as Support for Patient

To support patients in making healthcare decisions, Hispanic physicians can take several important steps to ensure effective communication and patient engagement. First and foremost, it is crucial for physicians to create a welcoming and culturally sensitive environment in their practices. This involves acknowledging and respecting the diverse backgrounds and beliefs of their Hispanic patients.

Building trust and a rapport with patients is key to fostering open communication and encouraging patients to actively participate in their healthcare decisions. I-HP-01 described the importance of effective communication in rapport building with the patient by saying the physicians as well as the patient should have a deep understanding of the disease, the treatment protocol, the risk and benefits of treatment, as well as the anticipated disease outcomes, especially in the field of cosmetic surgery because identifying the expectations of patients beforehand is important to produce positive healthcare outcomes. As I-HP-01 stated

> And with all patients, I think one of the most important things is to make sure that they understand what is happening, what disease, you know, what disease process is occurring, what does the treatment entail? What are the risks, what are the benefits, what are the likely outcomes? You know, in the realm of cosmetic surgery? It’s all about managing the patient's expectations. And that comes from education.

Effective communication and patient engagement are pivotal pillars of support for patients within the healthcare ecosystem. When healthcare providers establish clear and compassionate communication with patients, it cultivates a sense of trust and understanding that is essential for effective treatment.

I-HP-02 added further by saying that the education of patients plays a key role in identifying and managing their expectations. I-HP-02 stated,

> And by and managing that expectation is basically by educating the patient in an example would be, I hear what you want, I cannot give it to you. But this is because you don't have enough fat or your frame, your structure doesn't fit that or what have you. But that type of education, I think, is what enables the patient to be the active participant in their care as opposed to having things done to them.

I-HP-06 stated the importance of open dialogues between patients and doctors by saying, “They enable patients to articulate their concerns, preferences, and questions, creating a collaborative environment where decisions are made jointly”. Moreover, according to I-HP-06, Hispanic doctors are superior to non-Hispanic physicians in terms of building doctor-patient relationships. I-HP-06 stated,

> I believe that the Hispanic doctors provide more emotional support and are devoted to doctor patient relationship, these situations provide that the patient can be more open with a doctor just and centered not only in the patient that in the family of the patient is always more open when the doctor have a better relation with it with the patients. If the doctor creates a rapport with the patient and family…. I believe that the Spanish doctor provide a better relation and situation with the patient and families.

I-HP-09 assured that patient-engagement in decision-making promotes positive healthcare outcomes. According to I-HP-09,

> Patient engagement goes beyond the confines of medical consultations; it involves getting patients to get involved in their own care journey. Engaged patients are more likely to adhere to treatment plans, adopt healthier lifestyle changes, and actively participate in their recovery.

I-HP-09 stated,

> Well, also, I believe concerning this one, the most important is this diversification. So meaning, for example, inclusion of people within the community, into practice, obviously according to the qualification of every individual, and also the sensitization of the physicians…..like promoting health actions that align with the needs of the community that you're serving. I believe that will greatly improve the healthcare outcome.

On the other hand, I-HP-10 highlighted the negative impact of having a language barrier in patient-doctor communication. I-HP-10, while describing the negative impact of language barrier in patient-doctor communication, stated, "The language is something that can impact negatively the healthcare delivery itself from the patient's idea and from the provider side as well".

Hispanic physicians should try to communicate with patients in their preferred language whenever possible. Language barriers can hinder effective communication and understanding, so offering bilingual services or providing access to interpreters can significantly improve patient-provider interactions. Additionally, using clear and simple language to explain medical information and treatment options can enhance patient comprehension and empowerment in decision-making (Al Shamsi et al., 2020).

Theme 5: Government Policies and Empowerment of Patients in Making Decisions

Government policies play a crucial role in empowering patients to make informed decisions about their healthcare. By implementing supportive and patient-centered policies, governments can create an environment that fosters patient autonomy and involvement in healthcare choices. One key aspect of such policies is the promotion of health literacy through educational initiatives and resources. By enhancing patients' understanding of health information and medical concepts, they are better equipped to actively participate in decision-making processes. Additionally, policies that emphasize transparency and patient access to health data can enable individuals to make well-informed choices about their treatment options and providers. According to I-HP-01, public policies can have a positive impact over healthcare outcomes if designed according to the principles of science or else it may lead to poor standards of healthcare services. I-HP-01 stated,

> I mean, public policy, that can, that can have a lot of positive influences in that it can, as long as it's based on science, it can establish, you know, a minimum standard of care of minimum level of training of what have you. I think public policy can very negatively impact not just patient centered care, but healthcare in general.

I-HP-01 further recommended the use of proper medical guidelines and protocols while developing healthcare public policies.

> Government policies play a pivotal role in empowering patients to actively participate in their healthcare decision-making process. Enacted regulations and initiatives that prioritize patient rights, access to information, and shared decision-

making can significantly influence the dynamics between healthcare providers and patients. Policies that ensure transparency, such as the availability of comprehensive medical information and treatment options, enable patients to make informed choices aligned with their values and preferences.

I-HP-01 stated,

> So, if it's, as long as for example, public policy is dictated by proven science and public policymakers are listening to and taking the advice of VA medical societies, VA professionals, then it can be helpful. Another example is all these states that are making anti trans laws, regardless of what your position is. They're doing it not based on science, not based on what the American Academy of Psychiatry of Pediatrics of Surgery, they're not following recommendations, they're just simply passing laws out of on a whim.

I-HP-02 recommended the inclusion of the patient's point of view in policymaking. I-HP-02 stated,

> I think that if we have the patient board participating in their in their own care, the patient itself can help us to, to decide based on their diagnosis or what their treatment may entail. And then if I have a patient that I give them a sample, I have a patient that has a very, and the options are A B and C, I, B, probably I want to be bored, but even that's indication at this point in so one might be very radical, say like, you know, I just want surgery.

According to I-HP-04, policymakers should look towards areas of health information technology to shape, coordinate, and focus on national policies that support patient centered care. Moreover, initiatives that emphasize patient autonomy and the right to give or withhold consent empower for individuals should be encouraged to actively engage in discussions about their care, resulting in more personalized and patient-centered treatment plans. By fostering an environment where patients have the necessary tools and support to make well-informed decisions, government policies contribute to a healthcare landscape that respects patient agencies and enhances overall healthcare outcomes.

I-HP-04 stated,

> Policymakers need to look beyond, such as areas of health information technology, to shape and coordinate and focus on national policies to support patient centered care. This policy has policies to also have professionals to acquire and maintain a skill related to patient centered care. And it is important to encourage organization and other physicians, not only Hispanic, but also Caucasians to cultivate a culture of patient centered care. Therefore, I'm a firm believer that when we ask if physicians incorporate this model, as a unique model, we can achieve much more.

Similarly, I-HP-06 agreed that the policies are advantageous as they create policies and rules for the advantage of the patient and for a healthcare provider. I-HP-06 stated,

> The policies are an advantage because the policies create and rules and an advantage for the patient and for a healthcare provider to okay the policies create or that systems are created, how to improve protocols, how to improve patient care by for example, policies make some limitations.

I-HP-09 agreed with I-HP-06 by saying that that public health policies are essential to guide us through protocols and processes, yet he was frustrated by the regularly and repeatedly changing laws, civilizations, and cultures of the Department of Health and Human Services. I-HP-09 stated,

> For my knowledge and my understanding those public health policies are there to guide us to protocols and processes. For me, the negative side is that the Department of Health and Human Services in every weird situation. They go back and update those laws. Civilizations and cultures change drastically every 2 to 3 years.

I-HP-10 highlighted the role of government policies in the empowerment of PCC. I-HP-10 added to the theme further by saying the creation of policy aimed at patient accessibility, reimbursement rates, and the appropriate location of clinics in the case of polyclinic is primarily controlled by the government. I-HP-10 stated,

> So basically, I will tell you that about 50% of the proceeds depend upon you know, the actions of public health itself, you know, like creation of policy that will be better for patient accessibility, reimbursement rates, location of clinics in the case of polyclinic, for example, you know and so on. So, we basically can bring the care to that the patient is served with the support of the government in process.

Furthermore, governments can advocate for shared decision-making models, encouraging healthcare professionals to involve patients in treatment planning and goal setting (Marinkovic et al., 2022). This approach respects patients' values, preferences, and goals, ultimately leading to more personalized and effective care. Lastly, by ensuring affordability and accessibility of healthcare services through appropriate policies, governments can alleviate financial barriers and empower patients to seek timely and appropriate care without undue hardship. Overall, patient empowerment through government policies strengthens the doctor-patient relationship, improves healthcare outcomes, and contributes to a more patient-centered and equitable healthcare system.

Hispanic physicians have collaborated with community organizations, policymakers, and healthcare institutions to explore ways to reduce the financial burden on patients, such as offering sliding-scale fees, promoting health insurance enrollment, and advocating for policies that improve access to affordable healthcare services (Robeznieks, 2022b). By actively engaging in these efforts, Hispanic physicians are striving to uphold the principles of equitable healthcare access and lessen the disparities that have been exacerbated by the pandemic, ultimately working towards a healthier and more inclusive future for their patients and communities.

Evidence of Trustworthiness

Trustworthiness of a qualitative study refers to reliability and validity of study. It is assessed by several integral components including credibility, transferability, dependability, and confirmability (Adler, 2022).

Credibility

Credibility is the most critical aspect in determining trustworthiness in qualitative research (FitzPatrick, 2019). Credibility was established through triangulation and member checking. Triangulation in qualitative research refers to using more than one method to collect data. Member checking serves to validate accuracy by having the participants confirm the accuracy of the interview transcripts. Member checking helps to decrease the chances of misinterpreting the participants' experience while allowing the researcher to identify their own biases and possible misunderstandings. Credibility links a research study's findings with reality to demonstrate the truth of the results.

Transferability

It is an essential component to test the external validity of any qualitative research. It is observed to make sure that the findings are replicable in another study using similar methodology (Nassaji, 2021). Transferability in this study was assured by its limited small sample and invite other researchers to conduct similar research in their community. Results would likely have some variation.

Dependability

Dependability refers to an in-depth description of research design and methodology so the study could be repeated by other researchers (Stenfors et al., 2020). Dependability in our study was ensured by using rigorous data collection techniques. The interview process was similar for each study participant. Each of the eight peer-reviewed questions was asked in the same order, and the probability of data saturation was equal in each interview. A transparent research process was employed that was kept open to scrutiny which improved the dependability of our study.

Confirmability

The term confirmability refers to the evidence of the investigator’s influence (Nguyen et al., 2021). The committee chair and co-chair reviewed and evaluated the eight interview questions to ensure objectivity and reduce the potential for researcher bias while constructing research questions. A data audit was conducted prior to data analysis to ensure confirmability of study and reduce the risk of personal and researcher’s bias.

Chapter Summary

A total of five themes were generated in Chapter 4 to answer the two research questions of this qualitative study. The results of study depict that Hispanic physicians are an essential component of the PCC model as they strive to create an inclusive and collaborative healthcare environment where patients feel respected and valued as active participants in their own care. The themes generated via transcripts of research participants highlighted that Cultural Competency and Communication, Patient Education and Health Literacy and Shared Decision-Making and Autonomy are the three basic parameters that will play a positive role in patient empowerment for the PCC model, according to the perceptions of Hispanic physicians. On inquiring the perceptions of Hispanic physicians regarding affordability of PCC, I explored that during COVID-19 pandemic, Hispanic physicians have witnessed the struggles of their patients firsthand, with some patients having to for go necessary medical consultations and treatments due to financial constraints. To support their patients, Hispanic physicians have advocated for increased support and resources to ensure that PCC remains accessible and affordable. This paragraph summarizes the findings described in Chapter 4 and is a transition to Chapter 5, containing discussion on the findings, emerging themes, implications, and recommendations for future study.

Chapter 5: Discussion, Conclusions, and Recommendations

Through a qualitative, phenomenological analysis, I aimed to understand Hispanic physicians' perceptions as an integrated priority of PCC to improve quality, safety, accessibility, and affordability in healthcare by exploring their lived experiences regarding the role of the PCC model in maintaining quality healthcare. A total of 10 participants were selected through a purposive sampling technique, after which data were collected via semistructured interviews. A qualitative data analysis was conducted according to the standards of phenomenological study design.

The data analysis and themes generated via analysis were presented in Chapter 4 along with quotations of study participants to support the generated themes. In Chapter 5, I present the analytical findings of the study and compare the results of the study to the pre-existent literature. The analysis of the study is presented in the form of themes along with references to support the comparison. Moreover, I identify several limitations and provide some recommendations for leaders, shareholders, government organizations, and policymakers.

Research Questions

The research questions are as follows:

RQ1: What challenges do Hispanic physicians face in practicing PCC in U.S. teaching hospitals?

RQ2: What were the perceptions of Hispanic physicians regarding the care quality, safety, accessibility, and affordability of PCC during the COVID-19 pandemic in U.S. teaching hospitals?

Interpretation of Findings

The core themes that emerged from the qualitative analysis of research transcripts were consistent with the reviewed literature. Multiple themes were generated from participants' responses to the research questions of the study, resulting in five core themes. The five core themes of the study are described below.

After the organization and analysis of the data via NVivo 2, all the transcribed interviews were manually analyzed using the six-step framework of Braun and Clark's thematic qualitative analysis. The six-step thematic analysis framework of Braun and Clark consists of the following:

- data familiarization
- generating codes
- looking for themes
- reviewing the themes again and again
- naming and defining the themes once reviewed
- generating a final report

The coding of data was done by using different software or highlighting the text manually. The basic purpose of coding in qualitative analysis is to provide the researcher with a pattern to classify and reorganize the data into subcategories. Data in the study were coded by using words and short phrases from the interview transcripts and assigning some specific characteristics to the sentence or paragraph of interest. Codes associated with data that I found interesting were highlighted by using both manual highlighter technique as well as software programming. Codes were later organized into broader themes to respond to the research questions.

The results of the study show that Hispanic physicians play an essential role in empowerment of patients via implementation of the PCC model. They were regarded as primary tenets of the PCC model owing to their cultural competency, effective communication skills, good understanding of patients' autonomy, lack of racial and ethnic discrimination, and sense of empathy for patients of diverse cultural backgrounds. Based on the results of the study, government policymakers should play their role in empowering patients and implementing PCC via strategies identified by the lived experiences of Hispanic physicians. Consistent with the findings of a study conducted by Filler et al. (2020), Hispanic physicians face several challenges while implementing PCC in teaching hospitals in the United States.

Based on the results, Hispanic physicians described their perceptions regarding patient empowerment via the PCC model and the challenges they experience while implementing PCC in U.S. teaching hospitals, some of which were supported by reviewed literature. The results are presented by research question and the themes that supported them. The published literature is arranged in a way to support or refute the findings of the study, or it may expand the information in published literature.

Research Question 1: What Challenges Do Hispanic Physicians Face in Practicing Patient-Centered Care in U.S. Teaching Hospitals?

The purpose of this qualitative study was to understand Hispanic physicians' perceptions as an integrated priority of PCC to improve quality, safety, accessibility, and affordability in healthcare. Participants of the study shared their lived experiences regarding their understanding and perceptions of the PCC model and challenges they faced at the workplace while implementing PCC, including lack of effective knowledge of PCC, cultural and linguistic differences, lack of effective patient–doctor communication, problems with poor accent, lack of cultural competency, disparities in the way of thinking, poor leadership practices, attention deficit with patients and families, potential for bias or discrimination owing to race and ethnicity, disparities in career advancement opportunities, and lack of involvement in leadership and research opportunities. Moreover, increased frequency of inquiries by the patient due to lack of effective communication contributes to frustration. The data are explicitly presented around the themes generated from the results.

Theme 1: Perceptions of Hispanic Physicians Regarding the Empowerment of Patients

Patient empowerment is a complex subjective concept that refers to “power from within”, including multiple aspects of clinical ethics such as autonomy, self- confidence, and self-respect (Bennett et al., 2020). During the study, it was determined that Hispanic physicians hold a strong belief in the importance of empowering their patients. These physicians recognize that patient empowerment goes beyond merely providing medical advice. The perceptions of Hispanic physicians regarding patient empowerment yielded multiple concepts, including patient autonomy, patient respect, effective patient–doctor relationship and communication, inclusion of the patient in shared decision-making, promoting patient education, and ensuring accessibility and affordability of patient care. Most of the participants in the study believed that patient empowerment is an essential element of the PCC model.

Patient empowerment was referred to as “sine qua non” of PCC by Bennett et al. (2020). Nine dimensions of patient empowerment—control, participation, shared decision-making, patient support, collaboration with service providers, knowledge and understanding, psychological coping, power, and system—were identified (Bennett et al., 2020). Similarly, the results of the study described patient autonomy as a primary tenet of medical education and essential component of the PCC model. Varkey et al. (2020) described patient autonomy as one of the pillars of clinical ethics apart from beneficence, nonmaleficence, and justice.

The concept of autonomy was further elaborated by the study participants via their statements regarding the importance of shared decision-making in the PCC. Most of the study participants agreed to the idea that shared decision-making is an essential aspect of the PCC model. This is similar to the findings of a study conducted by Tonelli and Sullivan (2019), who highlighted the importance of shared decision-making in patient care. Tonelli and Sullivan (2019) described shared decision-making as a model of patient care in which clinicians provide options to the patient while the patient contributes by opting for values and preferences according to their own choice.

Varkey et al. (2021) highlighted the importance of respecting patients’ values and preferences in medical ethics and patient care. The concept of patient empowerment provided by the findings of our study was further expanded by Tew et al. (2020), who described patient reported outcome measures (PROM) as an essential element to empower patients while implementing PCC, especially in postoperative patients, and as an excellent outcome measure to improve quality of life.

Theme 2: Challenges of a Hispanic Physician

The participants in the study shared their lived experiences regarding challenges they face while implementing the PCC model in U.S. teaching hospitals. The five major challenges identified by Hispanic physicians while practicing the PCC model in the United States include linguistic barriers and problems with communication, deficient knowledge of the PCC model, lack of cultural competency leading to potential for bias due to ethno-racial disparities, poor leadership practices, and disparities in career advancement as well as research opportunities.

Physician-patient communication is primarily responsible for creating direct or indirect connections between patients and their access towards a better healthcare, encouraging self-efficacy, self-management, and shared-decision-making (Mitchell & Perry, 2020). Similarly, Seible et al. (2021) highlighted the importance of physician–patient linguistic concordance to implement the PCC model and improve patient satisfaction. One of the participants of the study stated that even if they learn and speak English with the patients rather than their native language, patients feel difficulty while understanding their accents. The accent problem was further supported by a study by Chávez (2022), who investigated the impact of three accents of healthcare providers, English, Spanish-English, and Spanish, on patient care. Spence (2022), while highlighting the importance of accent in language, stated that an accent is the first introduction when a physician meets a patient. The accent can be a positive (i.e., the patient feels comfortable) or a negative (i.e., the patient can use the accent as a means to find another physician).

Another challenge identified by Hispanic physicians in implementing the PCC model in U.S. teaching hospitals is the potential for bias due to ethno-racial disparities among patients and physicians. The existence of these ethno-racial disparities was also explained by the findings of a review by Mitchell and Perry (2020) that showed problems with patient-centered communication due to implicit racial bias. Additionally, Chu et al. (2021) discussed the existence of potential provider bias due to lack of racial concordance between physician and patients.

Patient-centered communication is an essential aspect of the PCC model and is necessary to ensure effective communication between physicians and patients. It develops a sense of similarity between physicians and their patients. According to Burgener (2020), a physician who is competent enough to engage patients with communication skills is more likely to establish a better relationship with the patient, hence, mitigating the concerns of racial differences. Patient-centered communication by the physician results in the development of a positive attitude of similarity in understanding of disease by the patient, hence positively affecting patient adherence to treatment and improvement in healthcare outcomes.

Cultural competency is a complex and dynamic subject of interest for healthcare providers to improve healthcare outcomes in the PCC model. According to Lateef and Mhlongo (2022), although there are several barriers and challenges to the PCC model, none of these is more influential than lack of cultural competency. Lack of cultural competency among healthcare providers leads to the development of negative attitudes and stereotyping behaviors towards culturally diverse populations.

Another major challenge identified by Hispanic physicians was the accessibility and affordability of the PCC model, which is parallel to a report presented by Robert Wood Johnson Foundation (2019), which emphasized that access to quality healthcare is an essential domain of the PCC model. One of the participants in the study proposed a revision of the Affordable Care Act as a solution for accessibility and affordability of PCC model. The finding is well supported by the findings of Ercia (2021), who showed that implementation of the Affordable Care Act had resulted in improvement in healthcare coverage in America, especially catering to patients who were previously uninsured. Although the Affordable Care Act was highlighted as a solution to the accessibility and affordability of the PCC model in the United States, the heavy cost of health insurance coverage is one of the most common barriers to PCC (Sinaiko et al., 2019). Contrary to this, Pirhonen et al. (2020) proved that the likelihood of PCC being cost-effective was 80% to 99% greater in comparison to usual care via Monte Carlo simulation curve.

Research Question 2: What Were the Perceptions of Hispanic Physicians Regarding the Care Quality, Safety, Accessibility, and Affordability of PCC During the COVID-19 Pandemic in U.S. Teaching Hospitals?

Theme 3: Hispanic Physician's Impact on Patient's Decision-Making

The results show that Hispanic physicians can have a significant impact on patients' decision-making processes due to their unique cultural understanding and communication skills. Stubbe (2020) highlighted the importance of similarity in the cultural context of the physician and patient to deliver individualized PCC. Physicians should understand the diversity of patients' lifestyles, perspectives, and experiences to promote patient collaboration in joint decision-making (Stubbe, 2020). This idea favors the results of the study as most of the study participants agreed that Hispanic physicians are often well-versed in the cultural nuances and beliefs of their patients, which allows them to establish a deeper connection and rapport. This cultural familiarity helps patients feel more comfortable and understanding, leading to increased trust and confidence in the physician's advice, which may encourage patients to participate in decision-making.

From the University of California, Irvine School of Social Sciences, Ashbach (2021) cited Associate Professor Glenda Flores as stating, “Latina physicians deliver culturally competent care that’s indispensable to the communities they serve, yet these skills are routinely uncompensated, tokenized, and taken for granted”. This is further supported in literature that shows that physician–patient racial concordance is essential for PCC as it improves ratings of physicians (Wang et al., 2020). Similarly, cultural competency was observed as the most important patient-centered cultural sensitivity subscale in comparison to respect and sensitivity (Roncoroni et al., 2021). Although this idea of cultural competency promoting shared decision-making is well-described by several studies in the literature, these findings were refuted by Xanthos (2021), who stated that although cultural competency is a core component of PCC, it does not address the sharing power between physician and patients and hence cannot be relied upon as a prime source of shared decision-making.

Theme 4: Effective Communication and Patient Engagement as Support for Patient

Communication is a way for people to interact with and understand each other, but the effectiveness of the communication is dependent on it exhibiting the “5 Cs” (i.e., clear, correct, complete, concise, and compassionate). All these mentioned elements are necessary to understand the essence of communication. Without the elements, the accuracy or the effectiveness of communication will be shattered. It is evident from the literature that effective communication leads to better understanding of the context, resulting in emotional connection between two peers and hence establishing trust, transparency, trustworthiness, and problem solving (Coursera, 2023). All these elements of communication hold primary importance in healthcare systems.

Based on the results of this study, 50% of the participants demanded effective communication for better outcomes of the healthcare system. Among the key players in the healthcare system are physicians and patients. Effective communication between patient and doctor is essential for the development of a positive rapport between them. The results of a study conducted by It is evident from the literature that effective communication leads to better understanding of the context, resulting in emotional connection between two peers and hence establishing trust, transparency, trustworthiness, and problem solving (Coursera, 2023). Two of the participants in the study clearly depicted that patient safety is highly dependent on effective communication, as it leads to accuracy in the process of diagnosis.

Olani et al. (2023) agreed to the findings of the study by proposing that a language barrier may have adverse effects on the patient in the form of dissatisfaction, weak relationship of trust, and low treatment adherence, hence making the treatment of the patient riskier. This resembles the output of Participant I-HP-10 as he emphasized the need for healthcare providers to communicate in the language of patient; otherwise, patient safety will be compromised. Burgener (2020) presented two important techniques of SBAR (i.e., situation, background, assessment, and recommendation) and AIDET (i.e., acknowledge, introduce, duration, explanation and thank you) to improve communication between healthcare providers and patients.

Theme 5: Government Policies and Empowerment of Patients in Making Decisions

All the participants of the study agreed to the idea that government policies play an essential role in implementation of the PCC in U.S. teaching hospitals. This is in accordance with the findings of a study by Nkrumah and Abekah-Nkrumah (2019), which emphasizes that leadership commitments are essential for implementation of the PCC model according to existing values and mission statement of PCC model. According to Nkrumah and Abekah-Nkrumah (2019), government policies play a key role in guiding hospital employees to achieve standard principles of PCC majority of the participants in our study agreed to the idea that government policies play a crucial role in empowering patients to make informed decisions about their healthcare. By implementing supportive and patient-centered policies, governments can create an environment that fosters patient autonomy and involvement in healthcare choices.

The three key public policies thought to create a positive impact over PCC and known to remove the challenges experienced by Hispanic physicians as identified by their lived experiences include promotion of educational initiatives and health literacy programs, ensuring accessibility and affordability of patients towards healthcare, and developing policies that ensure transparency (e.g., the availability of comprehensive medical information and treatment options will enable patients to make informed choices aligned with their values and preferences), hence, promoting PCC. One of the proposed public healthcare policies by the study participants (i.e., educational initiatives and training programs) is also emphasized by previously existing literature.

According to Benuto et al. (2020), cultural competency training programs for healthcare providers should be managed to ensure that they understand the importance of cultural adaptation and the time when they are required. Similarly, Roncoroni et al. (2021) stated that PCC sensitive healthcare could be promoted by targeted training programs that enable healthcare providers to empower patients and display cultural sensitivity to the patient. This idea of leadership commitment and government policies was further expanded by Nkrumah and Abekah-Nkrumah (2019), who added to the results of our study by describing the role of U.S. government in promoting PCC by managing funds for staff training, provision of adequate healthcare resources including healthcare information technology, and promoting community engagement programs along with follow-up plans for patients.

Additionally, strong, and committed leadership was labelled as key facilitator of PCC in the United States as investigated by Luxford et al. (2011). Luxford et al.'s (2011) study included chief executive officers, chief medical officers, administrative directors, and patient committee representatives of eight healthcare organizations that were known for the PCC. Additionally, Edgman-Levitan and Schoenbaum (2021) discussed the importance of development of human resource policies aimed at recruiting healthcare providers with a positive attitude of empathy and service for attainment of the PCC model in any healthcare system. Additionally, Ercia (2021) highlighted the need for policies other than Affordable Care Act to improve PCC in the United States.

Limitations of Study

Limitations of a study are a component that combines the internal and external components that affect the validity or trustworthiness of the study. Although the sample size of the study was small, the sample yielded fruitful, relevant, and reliable results. Even though the research design of our study was appropriate, the study has a few limitations. Firstly, the qualitative nature of the study makes it realistic, and the researchers find it difficult to replicate. Secondly, as the study included face-to-face interviews via Zoom, the behavior of study participants might have been affected by my presence. I noticed multiple pauses during interviews and several of the participants restated their comments even though I assured each participant regarding the confidentiality of the data.

Third, as the participants needed to be Hispanic physicians working in U.S. teaching hospital, this characteristic makes the availability for the participant more difficult due to the availability of the participant. Although the number of participants was adequate and saturation was reached, the interviews occurred during the month of July when many qualified participants were either on vacation or away from the U.S. teaching hospital. This could have affected the depth of the accessible interview pool and the variability of their stories. Another limitation of the study was the short timeline that was set according to the policy of the university to achieve the completion of the dissertation.

Recommendations for Practical Implications

The practical implications of this study are significant to bring a substantial and systematic improvement in PCC in teaching hospitals of the U.S. by overcoming the challenges Hispanic physicians experience while implementing the PCC model. At the individual level, the results of this study may help Hispanic physicians and healthcare providers by providing them with a positive energy to discuss their challenges in implementing the PCC model with the management of healthcare organizations. Moreover, the perceptions of Hispanic physicians collected via interviews and the challenges highlighted will enable them to work over prioritizing patient values and preferences, patient inclusion in decision-making, promoting patient education, building positive doctor-patient relationships, encouraging cultural competency, and overcoming linguistic barriers by promoting bilingual attitude among healthcare providers. Healthcare providers, including Hispanic physicians, should try to adopt a patient-centered communication framework comprising six core themes, including exchanging information, recognizing and responding to emotions, making decisions, enabling patient self-management, fostering healing relationships, and managing uncertainty to promoting PCC and improving the quality of healthcare in U.S. teaching hospitals.

At the organizational level, healthcare organizations may benefit from the results of this study as it clearly describes the perceptions of Hispanic physicians regarding the PCC model and the challenges they face while implementing PCC. The comments received via interview of our study emphasize that healthcare organizations should ensure equity of career and research opportunities among healthcare providers regardless of ethno-racial disparities. Additionally, they should strive to develop plans like healthcare insurance and appropriate budgeting to Improve the accessibility and affordability of the PCC model.

At the governmental level, the study findings recommend that the U.S. government should work on investing in the future of healthcare equity by addressing Hispanic physicians' barriers in U.S. teaching hospitals. Moreover, the U.S. government should make plans to ensure accessibility and affordability of patients' healthcare through cultural equity policies that ensure transparency, availability of comprehensive medical information, and treatment options that can help and enable patients to make an improvement in the decision-making process that will further improve the practical implementation of the PCC model in U.S. teaching hospitals.

The government should strive to develop a system that unburdened the physicians from excessive exhaustion to ward off the cognitive overload of Hispanic physicians, enabling them to practice the PCC model in a culturally fit environment. It should train physicians to provide culturally competent care to patients, motivating them to feel mindful and empathetic to the patient while focusing on goals of partnership, collaboration, and empathy. This study with Hispanic physicians reveals clear and well-intentioned efforts to promote diversity and alignment in applying the PCC model in U.S. teaching hospitals. We must modify past strategies, evaluate new strategies, update best practices, integrate multi-generations and multi-cultural groups, and share these with U.S. policymakers to achieve the desired changes.

U.S. policymakers, the academic and research professions, and the healthcare industry should strategize to improve healthcare to better meet the needs of patients, align Hispanic physicians as needed based on specific communities, and focus on expanding the supply of Hispanic physicians in the United States. To support the acute need for Hispanic physicians well-trained in cultural equality, we recommend a combination of evidence-informed efforts to increase the number of medical students and to support the development of measures targeted explicitly at Hispanic physicians. These efforts should consider the cumulative effect of the barriers that Hispanic physicians, as individuals with minoritized status, may promote sustained improvement in the PCC. We recommend that efforts be enacted at each stage of the education pathway to medicine.

Table 4

Recommendations for Future Implications

Theme	Recommendations
Perceptions of Hispanic physicians regarding the empowerment of patients	Prioritizing patient values and preferences Patient inclusion in decision-making Promoting patient education Positive doctor-patient relationship
Challenges of a Hispanic physician	Encouraging cultural competency Overcoming linguistic barriers by promoting bilingual attitude among healthcare providers
Hispanic physician's impact on patient's decision-making	Equity of career and research opportunities among healthcare providers regardless of ethno-racial disparities Improving accessibility and affordability of patient-centered care
Effective communication and patient engagement as support for patient	Adopting patient-centered communication framework Implementing SBAR (situation, background, assessment, and recommendation) and AIDET (acknowledge, introduce, duration, explanation, and thank you) Promoting shared decision-making
Government policies and empowerment of patients in making decisions	Initiating patient-centered educational activities and training programs for healthcare providers ensuring accessibility and affordability of patients towards healthcare by policies additional to Affordable Care Act Developing policies that ensure transparency, such as the availability of comprehensive medical information and treatment options to enable informed decision-making among patients

Recommendations for Future Research

The study examined the lived experiences of Hispanic physicians regarding PCC model in U.S. teaching hospitals. Although numerous studies regarding the PCC exist in the literature, only a few of them identified the lived experiences of Hispanic physicians regarding the PCC model. This study collected the lived experiences of Hispanic physicians regarding the PCC model as they serve as an integrated priority of the PCC to improve quality, safety, accessibility, and affordability in health care faced while practicing PCC at U.S. teaching hospitals. Researchers recommend the conduct of a multi-case study in which views of Hispanic physicians from multiple organizations are collected and compared. I recommend quantitative studies on this topic to expand the current findings. The findings of future quantitative studies may expand further the views regarding knowledge of PCC among minority physicians and challenges in implementing PCC along. Future researchers may conduct surveys to collect data regarding strategies utilized by other healthcare leaders to deal with challenges of implementing PCC. I recommend that future studies should also focus over specific demographics of patients and physicians, to see if there are similar results or outcomes. Additionally, the study focused on collecting data from hospitals of one state only, future researchers can explore data from other states of the United States to attain a better understanding of PCC.

Chapter Summary

The qualitative study was completed to explore the lived experiences of Hispanic Physicians regarding the PCC model in U.S. teaching hospitals. After analyzing the data, five themes were generated. I related each theme to the literature review to identify similarities and differences between the published literature and the findings of the study.

The recommendations generated by results and compared with the literature view were patient empowerment, patient inclusion in shared decision-making, prioritizing patient values and preferences, overcoming linguistic and cultural barriers, promoting patient-centered communication framework via application of SABR and AIDET technique, building cultural competency by educational and training programs, ensuring accessibility and affordability of patients towards healthcare and developing policies that ensure transparency, such as the availability of comprehensive medical information and treatment options to enable informed decision-making among patients.

I concluded the study by explaining that cultural competency, patient empowerment, effective communication, and shared decision are essential to implement PCC model in U.S. teaching hospitals. When healthcare workforce especially belonging to diverse cultural backgrounds is trained for cultural competency, developing bilingual behaviors, and promoting effective patient-doctor communication, patients feel respected and satisfied hence easing the path for implementation of PCC model improving the quality of healthcare. Healthcare leaders of the United States should try to become more involved with the minority physicians and focus on implementing recommendations developed by the study if they want to overcome the challenges that arise during implementation of PCC model in teaching hospitals of the United States.

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Appendix A: Recruitment Flier

Are you a Hispanic physician working in a tertiary teaching hospital in the city of Miami, Florida? If so, I would like to invite you to participate in my research study. I am a doctoral student at Walden University and am currently a candidate for a Doctor of Health Services - Public Health Policy. I am conducting a study on Understanding Patient-Centered Care: Perception of Hispanic Physicians in Teaching Hospitals of United States. The purpose of the proposed study is to understand the perspectives of Hispanic physicians as an integrated priority of the PCC to improve quality, safety, accessibility, and affordability in healthcare. Data will be collected through one-on-one interviews that will last 45 minutes. Your participation in this study is entirely voluntary, and no compensation or other benefits was offered. I sincerely hope you agree to participate in the study. If you are interested in participating, please contact Santiago Rivera at Santiago.Rivera@waldenu.edu.

Appendix B: Interview Guide

1. What Patient-Centered Care (PCC) model challenges have you faced as a Hispanic physician practicing medicine in a teaching hospital organization in the United States?
2. What are your thoughts on a Hispanic physician's impact on patients to improve the quality, safety, accessibility, and affordability of their healthcare in teaching hospital organizations in the United States?
3. What other positive or negative conditions have you encountered that impact the patients in making decisions towards improving the PCC from the Hispanic physician practicing medicine in a teaching hospital organization in the United States?
4. What are your suggestions to support patients in actively participating in the PCC process regarding their health care as a Hispanic physician practicing medicine in a teaching hospital organization in the United States?
5. How do public health policies impact the patients' PCC process in improving the quality, safety, accessibility, and affordability of their health care from Hispanic physicians practicing medicine in teaching hospital organizations in the United States?
6. What is your contribution as a Hispanic physician practicing medicine in teaching hospitals in the United States towards the accessibility and affordability of PCC during the COVID-19 pandemic?

7. How were patient quality and safety affected during the COVID-19 pandemic as part of the overall PCC in teaching hospital organizations in the United States?
8. How do your strengths and limitations as a Hispanic physician impact PCC during the COVID-19 pandemic in teaching hospital organizations in the United States?