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The Evaluation of the Relationship between Racial Health Disparities and the Patient-Provider Relationship

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Abstract

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Abstract

African Americans are adversely affected by health disparities due to the complexities of the patient-provider relationship. The behavioral model of health services was used as the theoretical framework to understand how individuals make healthcare utilization decisions. The purpose of the research was to evaluate how the patient-provider relationship influences inconsistent doctor visits by African American patients despite the prevalence of chronic conditions. 45 African Americans located in Shelby County, Tennessee were included in this study. A cross-sectional quantitative design was used to collect the data via an online survey. The 45 collected responses were analyzed by performing multiple linear regression, Pearson correlation, and Cronbach's α. Results of the analyses were statistically significant in proving that education level, income, gender of African Americans, and having health insurance affect the patient-provider relationship. It was determined by the statistically significant results that the patient-provider relationship had an effect on African American patients' decision to seek healthcare services and medication compliance and follow-up medical care. This information may guide the conversation within the Shelby County, Tennessee African American community regarding what role the patient-provider relationship has when addressing health disparities among African Americans.

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Dedication

I dedicate this research to the legacy of my uncle, Mr. Gardner Jones. In 2015, two days before he passed away, I promised him that I would make him proud and finish this degree. I cherish his memory and devote my research efforts to understanding health disparities and the importance of African Americans seeking necessary healthcare treatment. There is never any period of time that goes by that I do not think of my uncle. He meant so much to me and my family. I wish he was still here to see me accomplish what I started on March 2, 2015. I often wonder how differently things may have turned out for my uncle if he would have sought medical treatment sooner for his illness. I want my research to make a difference by helping to bridge the gap that is evident within the patient-provider relationship involving African Americans.

Acknowledgments

I would like to thank Dr. Cheryl Cullen for her unwavering support and encouragement. When I had doubts about my progress and whether I was on track, Dr. Cheryl never hesitated to offer me motivation to keep going. I often felt as if I was not meeting expectations, but she always assured me that I was doing an awesome job. I could not have completed this project without her patience and resilience.

I would like to thank my parents, my little brother, and my grandmother. They were my sounding boards when I needed to share my frustrations or celebrate milestones. Their faith in me helped me to remain focused despite the chaos that life can bring. It was my mother who encouraged me to pursue a PhD, so I am confident that she saw something in me that I doubted existed.

I want to also thank my friend of over 30 years, Lachre Brown, for her consistent friendship. She kept me encouraged throughout all of graduate school. I can never repay her for always praying for me and keeping me inspired.

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Chapter 1: Introduction to the Study

Introduction

This chapter introduces the research problem by discussing key information found within relevant literature to present the probable correlation between health disparities and the patient-provider relationship. The accessibility of quality healthcare for all citizens without regard to individual background or racial classification is a challenge and often results in health disparities among certain populations (Moy & Freeman, 2014). Populations that are affected by health disparities in the United States are often challenged with dealing with cultural stereotypes that are the result of implicit bias of the provider which only increases the prevalence of health disparities (Chapman, Kaatz, & Carnes, 2013). Health disparities that are the result of racial issues can be correlated with the structure of the healthcare system, the individual patient, the corresponding community, and the healthcare provider (Nelson, 2016).

A lack of access to healthcare can present significant challenges to vulnerable populations that have a greater likelihood of contracting life-threatening diseases (Jackson & Gracia, 2014). The possession of health insurance has been noted as a strategy to help prevent incidences of health disparities, but having health insurance does not guarantee that health services will be provided on an equal platform for all patients (Moy & Freeman, 2014). Communications that occur within the patient-provider relationship are an important component of the healthcare experience and can contribute to some of the issues such as a lack of accessibility, quality healthcare, and available healthcare providers that underprivileged populations encounter during healthcare delivery (Moy & Freeman, 2014).

The culture of a population can influence healthcare use behavior and is influenced by specific mindsets and ideals found within that population (Campbell & Long, 2014; Mott-Coles, 2014). Within the African American population, both heart disease and strokes are common conditions (Hall et al., 2015). Chronic diseases occur at a higher frequency within the African American population (Ferdinand & Puckrein, 2015). An understanding regarding the correlation between health disparities, chronic diseases, and the patient-provider relationship is needed (Thomas, 2014). Hypertension and complications from hypertension is an issue that affects African Americans (Williams, Nicholas, Vaziri, & Norris, 2014). The lack of management of chronic illnesses such as hypertension and diabetes make the African American population more vulnerable to acute onset of disease such as myocardial infarction and stroke (Ferdinand & Puckrein, 2015). African Americans run the risk of experiencing a stroke at a rate of two times compared to White Americans (Ferdinand & Puckrein, 2015).

Background of the Study

Access to healthcare is a critically important component in determining the level of efficiency and functionality of a healthcare system (Levesque, Harris, & Russell, 2013). The health of a community is dependent on its access to quality healthcare services (Tapp, White, Steuerwald, & Dulin, 2013). Appropriate and efficient access to healthcare provides the opportunity for patients to make a connection with the healthcare provider in order to obtain desired healthcare services (Levesque et al., 2013). The challenge of formulating an appropriate relationship between the provider and individual seeking care can be caused by implicit attitudes displayed by the provider, which can be difficult to govern (Hall et al., 2015). The negative attitudes and opinions that are internalized about African Americans by healthcare providers of different racial backgrounds have the possibility of promoting racial disparities in both health and healthcare since those attitudes can influence behaviors and decisions (Hall et al., 2015). Trust has been identified as the most important component of relationship building between the patient and the healthcare provider (Shan et al., 2016).

Some of the factors that create barriers in accessing healthcare for individuals include socioeconomic status as well as the location of the home residence in proximity to the healthcare provider (Levesque et al., 2013). Lack of ability to pay for incurred fees related to healthcare can also be a deterrent for seeking healthcare (Levesque et al., 2013). Lack of insurance is the most influential factor in the lack of healthcare use (Wang, Shi, Nie, & Zhu, 2013). Another barrier to accessing healthcare on a consistent basis can be attributed to how the provider interacts with the patient and whether or not the provider allows the patient to be involved in healthcare decision-making (Hall et al., 2015). Wang et al. (2013) reported that 23.63% African Americans reported being unable to secure healthcare services, which leads to delays in treatment.

Community-based participatory research (CBPR) is a practical tool that can be used by healthcare providers to determine how to positively utilize research to advance primary care practices in order to improve health equity (Tapp et al., 2013). CBPR is commonly used to evaluate vulnerable populations as it relates to the management of chronic diseases caused by access to care and health disparities (Tapp et al., 2013). Research is needed to address the healthcare needs of individuals by determining what is required to make a difference in overall health, encourage the formation of relationships, and make health concerns a reality (Tapp et al., 2013).

Problem Statement

The problem is that individuals of African American descent have a greater reported incidence of health disparities, which may be influenced by the patient-provider relationship (Cuevas, O'Brien, & Saha, 2017). Population-specific health disparities, which include barriers to access to healthcare and poor-quality health outcomes, have been commonly reported among minority populations (Dahlem, Villarruel, & Ronis, n.d.; Manadal, 2017). Health disparities among the African American population have resulted in higher incidences of poor health outcomes from certain diseases such as hypertension and diabetes, increased acute myocardial infarction, and stroke (Nelson, 2016).

Health disparities equate to poor health outcomes and health status among minority populations (Braveman, 2014). A lack of access to healthcare can present significant challenges to vulnerable populations that have a greater likelihood of contracting life-threatening diseases (Jackson & Gracia, 2014). Health disparities are a result of variations in how healthcare is obtained and accessed when various groups are compared (Rasmussen, 2014).

The level of trust within the relationship that exists between the patient and the provider can either positively or negatively influence the patient's decision to seek care

(Brennan, et al., 2013). Trust within the patient-provider relationship contributes to the views that the patient has regarding the credibility of the provider's medical expertise and professional opinion (Brennan et al., 2013).

Purpose of the Study

The purpose of this quantitative research was to evaluate how the patient-provider relationship has the potential to influence the patient's decision to access healthcare. Empirical evidence suggests that a lack of health insurance coverage creates a hindrance to securing healthcare treatment, and an evaluation of the interactions that take place between the patient and the provider to determine the level of impact on healthcare use can be used to address this issue (Tapp et al., 2013). The objective for this research project was to provide insight into how the patient-provider relationship impacts the African American's decision to seek healthcare. Based on the research, the goal was to uncover evidence to support the significance of the value that is placed on this integral relationship that exists between the provider and the patient.

The study population was located in Shelby County, Tennessee. The age of the participants ranged from 40 to 65 years old. The age of the population was determined because individuals within that age range are more likely to have chronic diseases or conditions that warrant more regular doctor's visits. The subjects were gathered through African American greek alumni fraternity and sorority organizations such as Alpha Phi Alpha, Alpha Kappa Alpha, Kappa Alpha Psi, Delta Sigma Theta, Phi Beta Sigma, Sigma Gamma Rho, and Iota Phi Theta. The leaders of the greek alumni organizations were contacted for the survey to be emailed to them to distribute to their members.

Gap in the Literature

This research provides evidence to fill a gap in the literature that suggests a need for more education to be provided to vulnerable populations regarding the importance of seeking preventative care and using available resources for healthcare. This research aimed to shed light on the variability of the frequency in which African-American patients seek healthcare based on discrimination, racial biases, and assumptions about income and education and factors such as patient involvement, effective communication, cultural norms, and cultural competency that foster compliance or non-compliance with the physician medical plan. Conducting this research may help to facilitate conversations within the African American community regarding what can be done to help individuals to understand the importance of establishing a healthy relationship and building rapport with a healthcare professional. This research may also help to provide information to healthcare providers about the significance of the patient-provider relationship and how it can affect the patient's decision to seek healthcare services.

Research Questions and Hypotheses

RQ1: Does education level, income, or gender of African Americans affect the patient-provider relationship?

H_01: There is no statistically significant relationship between education level, income, gender, and the patient-provider relationship.

H_A1: There is a statistically significant relationship between education level, income, gender, and the patient-provider relationship.

RQ2: What is the effect, if any, that the patient-provider relationship has on African American patients' decisions to seek healthcare services?

$H_0$2: There is no statistically significant relationship between the patient-provider relationship and African American patients' decisions to seek healthcare services.

H_A2: There is a statistically significant relationship between the patient-provider relationship and African American patients' decisions to seek healthcare services.

RQ3: What effect does the patient-provider relationship have on medication compliance and follow-up medical care?

$H_0$3: There is no statistically significant relationship between the patient-provider relationship and medication compliance and follow-up medical care.

H_A3: There is a statistically significant relationship between the patient-provider relationship and medication compliance and follow-up medical care.

RQ4: What effect, if any, does health insurance have on the quality of the patient-provider relationship?

$H_0$4: There is no statistically significant relationship between health insurance and the quality of the patient-provider relationship.

H_A4: There is a statistically significant relationship between health insurance and the quality of the patient-provider relationship.

Theoretical Framework

The theoretical framework that was used in this study is the behavioral model of health services use since it provides clarification on how to best understand how and why the utilization of healthcare services is determined by individuals. The behavioral model of health services use implies that an individual's usage of health services is based on the inclination to seek health services based on their perceived needs (Andersen, 1995). The behavioral model of health services use was first developed in the late 1960s and can be used to explain the use of healthcare based on personal inclinations that may encourage or discourage seeking healthcare treatment (Shepherd, Locke, Zhang, & Maihafer, 2014). The constructs of the behavioral model of health services use include predisposing, enabling, and need characteristics which substantiates the probability that individuals will need healthcare services (Butler, Kim-Godwin, & Fox, 2008). The predisposing factors involve demographics, the enabling factors involve resources, and need is based on perception (Andersen, 1995). Figure 1 shows the connection between the three constructs of the behavioral model of health services use and the variables of interest of this study.

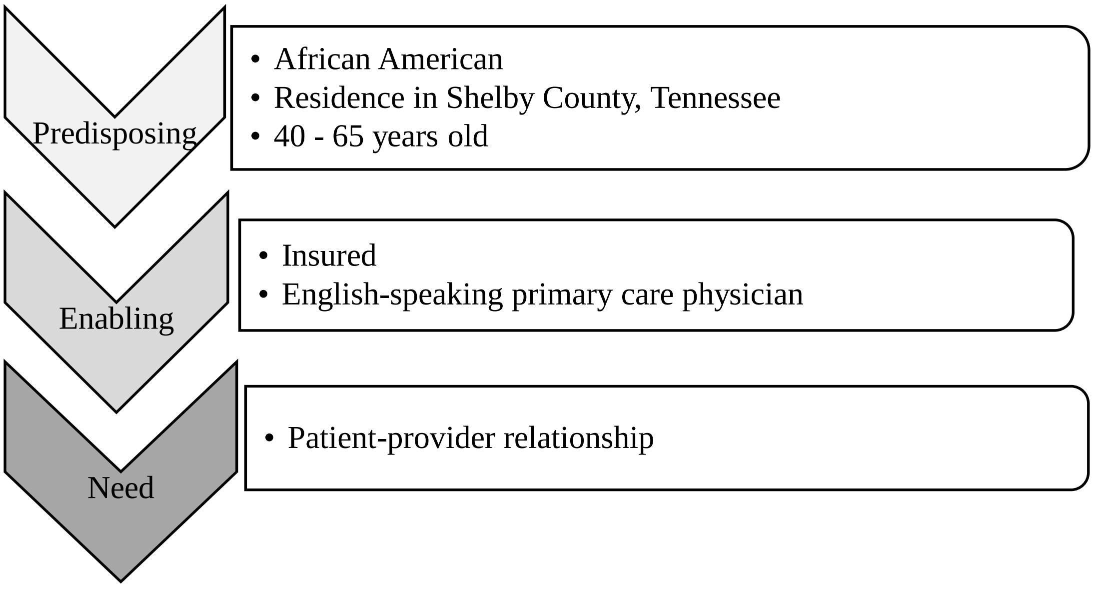

Figure 1. Correlation between behavioral model of health services use constructs and research study variables.

Nature of the Study

The nature of this study was quantitative because the objective was to examine the correlation between health disparities and the patient-provider relationship. Quantitative research allows the researcher to make predictions and show relationships between variables (Shi, 2008). Quantitative research differs from qualitative research due to the ability to reach more potential participants which would provide the opportunity to offer more findings that are more generalizable (Shi, 2008). This study incorporated a cross-sectional design through the use of an online survey. The cross-sectional design requires that the data collection only occurs once (Creswell, 2009; Shi, 2008). The data collection was obtained by analyzing the survey questionnaire with the help of SPSS Version 23. The comparison of the sample population helped to evaluate the research questions.

Operational Definitions

Acute Myocardial Infarction: Inadequate blood supply to coronary arteries that can result in the death of cardiac muscles (da Silva Santos et al., 2017).

African American: non-Hispanic individuals who choose to be identify with African as opposed to European descent (Bryc, Durand, Macphearson, Reich, & Mountain, 2015).

Chronic diseases: Conditions that cannot be transmitted from one person to another that are typically of a longer duration and progress over time (World Health Organization (WHO), 2017).

Diabetes: A disease caused by the blood sugar in the body being too high which is categorized as being either Type 1 which is managed by insulin injections or Type 2 which can be managed by diet, exercise, and oral medications (National Institute of Diabetes and Digestive and Kidney Diseases, 2016).

Health disparities: Lack of equality of access to healthcare (Braveman, 2014).

Hypertension: When blood vessels in the human body experience elevated pressure which causes the heart to pump harder; normal blood pressure in adults is defined as 120mm Hg (systolic) and 80mm Hg (diastolic;) (World Health Organization (WHO), 2015).

Patient-provider relationship: Interactions between the patient and the doctor that facilitate shared decision-making based upon mutual trust (Eliacin, Salyers, Kukla, & Matthias, 2015). In this study, the patient-provider relationship is the independent variable that will be investigated by evaluating factors such as education, income, gender, seeking healthcare, compliance with medication, and having insurance, which are the dependent variables.

Stroke: Rapid decline in nerve, spinal, cord, or brain function that impacts a particular region of the body that lasts for 24 hours or longer (Clare, 2017).

Assumptions

The assumptions of my study included that the participants completed the survey completely and honestly. Another assumption was that an adequate study population was available through African American greek alumni organizations. This study also assumed that the study population was interested in participating in the study without a financial incentive, and the participants were informed they were anonymous and were comfortable with the survey process.

Scope and Delimitations

The scope of this study was to focus on African Americans who have a primary care physician. Participant criteria was limited to African American adults who live in Shelby County, Tennessee were between the ages of 40 and 65 who had health insurance and a male or female English-speaking primary care physician. The research methodology was strictly quantitative as opposed to qualitative.

Limitations

The participants were all residents of Shelby County, Tennessee, so the results are not generalizable to the entire African American population in the United States. The participants might have been reluctant to complete the survey or disclose individual demographic information. The recruitment of the sample population was done through African American Alumni fraternities and sororities, so the participants had varying levels of education which prevents the findings from being generalizable to all African Americans in the United States.

Significance of the Study

This study was significant in order to evaluate the impact of the patient-provider relationship that exists within vulnerable populations that are more susceptible to contracting life threatening diseases and conditions. This study is also significant in order to understand why some African Americans do not go to the doctor, which can be answered by evaluating the desired population. The dynamics of the relationship between the patient and the provider must be studied to determine its correlation, if any, to health disparities within the African American community. Making health equity a priority is necessary as health disparities are a persistent issue for African Americans (Belgrave & Abrams, 2016).

The perceived level of trust that the provider has developed with the patient is considered as an important aspect of the patient-provider relationship and has the most impact on the patient's satisfaction through the interpersonal interactions that occur while medical services are provided(Chang et al., 2013). The patient and the provider must consistently engage in meaningful interactions, which will help to facilitate the process of the provider earning the trust of the patient (Peters, Benkert, Templin, & Cassidy-Bushrow, 2014). The results that are collected may help to empower identified vulnerable populations and providers about the value of forming and maintaining a beneficial and productive relationship. Patient satisfaction can be influenced by the interpersonal-based medical service encounters which affects the perception that the patient has regarding quality and the building of trust (Chang et al., 2013).

Summary

African American culture is rich with traditions and customs that can influence the behaviors of individuals within that population. In African American culture, spirituality plays a significant role for some in how health is perceived and care is obtained (Drisdom, 2013). The importance of faith for some individuals within the African American community can be viewed as a deterrent to seeking care since the spiritual mindset of much of that population is that healing comes by way of faith

(Drisdom, 2013). Health disparities are not uncommon within minority populations, but the prevalence of them is concerning. Research can be used to understand how communication between the patient and provider influences healthcare use decisions. This study evaluated the factors, if any, that determine how decisions are made to access care specifically for the African American population. Chapter 2 will provide a more in-depth explanation regarding the significance of the patient-provider relationship, a background on health disparities, and the variables that can determine a correlation between the two.

Chapter 2: Literature Review

Introduction

This chapter provides information about scholarly literature that helps to support this research by evaluating the factors that can have an impact on the patient-provider relationship and ultimately influence the prevalence of health disparities. The evaluation of the correlation between health disparities and the patient-provider relationship creates an opportunity for minority populations to be included in research efforts because the patient viewpoint is needed to add to the existing literature. There are numerous factors that can influence the patient-provider relationship which are discussed in this chapter. The provider has the responsibility to encourage individuals to feel comfortable being involved in conversations about personal healthcare concerns and initiatives (Richard et al., 2016). An identified gap within the literature is that within the African American population, there is a need to understand why and how the communication that occurs during medical visits contributes to a disconnect within the patient-provider relationship, and how ineffective communication can attribute to health disparities. Culture can influence behavior, and this research may provide evidence regarding the effect, if any, that social and cultural factors may have on how African Americans make healthcare decisions. This research will focus on a sample of the population in Shelby County, Tennessee (see Table 1).

Table 1

Shelby County, Tennessee Health Facts

Category	Reported Information
Poor or Fair Health	22%
Poor Physical Health Days	4.4
Adult Obesity	33%
Number of Primary Care Providers in Shelby County	760
Primary Care Physician Ratio	1235:1

From “Health Rankings,” by County Health & Rankings Program, 2018 (www.countyhealthrankings.org/app/tennessee/2017/rankings/shelby/county/outcomes/overall/snapshot).

The data in Table 1 are reflective of the entire population of Shelby County, Tennessee and not exclusive only to African Americans. In Shelby County, Tennessee, there are a reported 483,381 African Americans which accounts for 52% of the total population (“Suburban Stats,” n.d.). Of the total African American population, there are 223,274 men and 260,107 women (“Suburban Stats,” n.d.). Of the total population, 22.9% are men between the age of 40 and 65 and 31.4% are women between the age of 40 and 65 (Suburban Stats,” n.d.). The average median income in Shelby County, Tennessee is $47,083 (“Health Rankings.,” n.d.).

Literature Search Strategy

To evaluate the correlation between health disparities and the patient-provider relationship, the following databases were used: CINAHL & Medline, Google Scholar, and ProQuest (Health & Medical Collection database). The only articles in this peer-reviewed literature review were published between 2013 and 2018 to ensure that no out-of-date literature was included in the discussion. The following key terms were used in the searches: *acute myocardial infarction*, *African American and hypertension*, *African American patient interest in health and healthcare*, *African American and chronic diseases, definition of African American, diabetes, health disparities and African American, health disparities and physician relations*, *maintaining confidentiality in survey research*, *online survey and confidentiality*, *patient perception and physician communication*, *patient-provider relationship, health disparities and African Americans, physician relations and patient*, *physician relationship and communication, physician relationship and patient*, and *physician-patient relations and stroke*.

Definition of Health Disparities

Health disparities are defined as noted variances in how healthcare is received and provided to underserved populations (Braveman, 2014; Rasmussen, 2014). All individuals have the right to receive equal healthcare treatment, but the prevalence of health disparities means the topic remains an issue that warrants attention. The evaluation of the cause of health disparities and how to eliminate them continue to be two important challenges that threaten the status of healthcare delivery.

Health disparities create situations where disadvantaged populations are adversely impacted (Braveman, 2014; Nelson, 2016). Minorities have a greater chance of experiencing negative effects caused by health disparities because of the greater prevalence of chronic diseases within those populations (Thomas, 2014). According to Price, Khubchandani, McKinney, and Braun (2013), "racial/ethnic minorities are 1.5 to 2.0 times more likely than whites to have most of the major chronic diseases" (p. 1). Heart disease and stroke are the most prevalent conditions found among African American populations (Hall et al., 2015). Table 2 provides information regarding some of the national statistics for different racial groups in the United States. Disparities in healthcare present a significant challenge to providers tasked with meeting the objectives of providing quality care that is in alignment with predetermined quality medical care performance metrics (Chapman et al., 2013).

Table 2

Health Demographics of Racial Groups in the United States

Racial Group	Poor or Fair Health	Female Obesity (20 and older)	Male Obesity (20 and older)	Female Hypertension (20 and older)	Male Hypertension (20 and older)	No Health Insurance Coverage	Mortality
African American	13.6%	56.9%	37.6%	44.9%	40.9	11.2%	303,844
Caucasian	9.5%	36.2%	34.3%	34.5%	34.6%	7.5%	2,066,949
Hispanic	10.4%	45.0%	39.7%	23.6%	20.4%	21.1%	168,837
Mexican	9.8%	48.6%	43.5%	20.2%	20.2%	23.5%	95,795

From “National Center for Health Statistics,” by Centers for Disease Control and Prevention 2017 (https://www.cdc.gov/nchs/fastats/life-stages-and-populations.htm).

Health Insurance

Health insurance is the single most common predictor of quality of care (Nelson, 2016). The likelihood of individuals seeking healthcare services increases when there is either income or insurance to pay for the services rendered (Pullen, Perry, & Oser, 2014). There is a significant positive correlation between health insurance and positive healthcare outcomes that patients experience such as timely medical treatment and access to needed care (Green et al., 2013). Preventative care is often the mechanism that connects individuals and specialist physicians (Pullen et al., 2014). Cuevas et al. (2017) reported that patients who did not have insurance had the perception that treatment and interactions were different. Individuals without insurance have difficulty accessing care because of their inability to secure services from a provider (Tze-Fang et al., 2013; Green et al., 2013). Those who do not have insurance have the perspective that healthcare is too expensive to maintain which can prohibit a healthy lifestyle because of a lack of making regular and consistent appointments with the doctor (Watson, 2014).

Significance of the Patient-Provider Relationship

Patient care delivery is challenging if the patient-provider relationship has not been established (Murray & McCrone, 2015). The initial interaction between the patient and the provider allows both parties to become acquainted, which creates the foundation for trust to be established (Dang et al., 2017). The relationship between the patient and the provider is beneficial in helping patients to incorporate health practices that support preventative measures (Bell et al., 2013). A healthy patient-provider relationship can have a positive impact on patient adherence, whereas a negative relationship can have the opposite effect (Haywood et al., 2014). Patients want to have sustainable interactions with the providers who are responsible for overseeing healthcare (Cuevas et al., 2016).

Efforts to improve the patient-provider relationship should be a priority because a relationship perceived as healthy by the patient is a possible method to affect the prevalence of health disparities (Cuevas et al., 2016). Individual preferences of those involved in making healthcare decisions can affect the quality of the patient-provider relationship (Cuevas et al., 2017). The quality of the relationship that exists between the provider and the patient can become challenging when there are differences in both race and personal views between the provider and the patient (Cuevas et al., 2017; Lee King et al., 2015).

Patient Trust

The patient-provider relationship is cultivated and sustained by a mutual level of trust between the two parties, which should mature over time in a reciprocal manner (Hain & Sandy, 2013; Waitzman, 2014). Individuals can determine whether to trust a physician by observing actions over time (Peters, Benkert, Templin, & Cassidy-Bushrow, 2014). The level of trust between the patient and the provider will enable patients to feel comfortable sharing information with the provider and can increase the likelihood that patients will follow the medical advice given (Bell et al., 2013). The importance of establishing trust and encouraging shared decision-making with African American patients can ameliorate health outcomes and lessen the incidences of health disparities

(Peek et al., 2013). There is a correlation between medical mistrust and health disparities since both can lead to poor health outcomes (Gaston, 2013). The results from a study conducted by Gaston (2013) showed that African Americans diagnosed with HIV who trusted the provider demonstrated an increase in the level of behaviors and tendencies to be more involved in personal care.

Patient Satisfaction

Patient satisfaction is contingent upon the provider's display of emotion during the interaction that takes place when the two parties meet initially (Kafetsios, Anagnostopoulos, Lempesis, & Valindra, 2014). Satisfaction with a healthcare provider is dependent on the amount of trust that the patient has in the abilities of that provider (Dahlem, Villarruel, & Ronis, n.d.). Research shows that African American patients have the opinion that the level of dissatisfaction with the interactions that take place with healthcare providers is greater when compared to the perspectives of other patients (Hall et al., 2015). Providers that wish to improve trust with African American patients should consider utilizing a patient-centered approach (Cuevas & O'Brien, 2017). Providing patient-centered care is a significant aim for the delivery of healthcare (Raja et al., 2015). The patient-centered approach requires that the provider seeks to understand the point of view of the individual regarding the personal opinion of the ailment and the desired outcome of therapy and recommendations (Raja et al., 2015). Patient-centered care mandates that the provider engages individuals in conversations to gain understanding regarding how medical treatment is experienced (Raja et al., 2015).

Providers have the challenge of determining if a treatment is effective if the patient does not communicate satisfaction or displeasure during conversations that occur between the two individuals (Earl, 2013). The provider has to exhibit a desire to formulate relationships with each patient which will create an opportunity for rapport to be established. Nonverbal communication can have an effect on the patient-provider relationship because of the likelihood for assumptions to be made and misinterpretation to occur which will require that both parties engage in active listening (Hain & Sandy, 2013).

Relevancy of Research

To determine the issues that affect the patient-provider relationship, the perspective from the patient needs to be included within research and the current literature (Cuevas et al., 2016). The perspective from African American patients has been absent from discussions on how to best improve the relationship between the patient and the provider which could impact the disparities that exist in healthcare specifically pertaining to African American patients (Cuevas et al., 2016). The current literature does not present any information regarding how racial identity influences the healthcare experiences for African Americans (Cuevas & O'Brien, 2017). Providers that wish to improve the patient-provider relationship and interactions with African American patients will need to gather relevant details and insights from those individuals to better relations (Cuevas & O'Brien, 2017). The goal of this research project was to determine why African Americans choose to not seek medical counsel despite the prevalence of chronic diseases and conditions that commonly plague its population. Due to the history of discrimination that African Americans have been exposed to, it is not uncommon for any negative healthcare encounters to be correlated to discriminatory practices which has been shown to heighten the sensitivity for that population (Cuevas & O'Brien, 2017).

Correlation between Health Disparities and the Patient-Provider Relationship

The history of noted racism and mistreatment within medicine has exacerbated feelings of mistrust for African Americans (Belgrave & Abrams, 2016; Bhattacharya, 2013; Gaston, 2013; Green et al., 2013; Greer, Brondolo, & Brown, 2014; Nelson, 2016; Watson, 2014). Cultural differences can perpetuate feelings within individuals that the unfavorable interactions that occur are a result of racist or sexist attitudes toward minorities (Pullen et al., 2014). Blatant behavior that is laden with discriminatory tendencies is not commonly evident although refined attitudes might still influence the type of healthcare treatment options presented to the patient (Hall et al., 2015). Race can influence how patients and physicians interact which can affect the quality of the communication between the two parties (Levine & Ambady, 2013).

Organizational Culture

The behavior of the physician can reflect the organizational culture and environment that the provider works in (Al-Amin & Makarem, 2016). The organizational affiliation can influence individual perceptions (Dodek, Cahill, & Heyland, n.d.). Compassionate provider care is a significant component of patient satisfaction and is often correlated to the culture of the healthcare organization (Beardsmore & McSherry, 2017). Obtaining the patient's opinion regarding the interaction that occurred with the healthcare provider is as relevant to healthcare outcomes as the actual healthcare experience (Benjamins & Whitman, 2014).

Patient Involvement

Shared decision-making is an important component of the patient-provider relationship, and when appropriately utilized, can create necessary equilibrium in the level of power between the patient and the provider (Dierckx, Deveugele, Roosen, & Devisch, 2013; Hain & Sandy, 2013). The sharing of information should be reciprocal between the patient and the provider, which could have a significant effect on healthcare outcomes (Hain & Sandy, 2013). Shared decision-making helps to give patients the opportunity to be included in the discussions pertaining to personal health, which will also ensure that patients will be more engaged (Russell, Abidi, & Abidi, 2014).

Providers should not assume the role that excludes patients from being involved in the healthcare process (Hain & Sandy, 2013). Allowing the opportunity to be involved with decisions pertaining to personal care creates an environment based on collaboration, which will help increase involvement in the discussions on how to impact the dilemma that access to care has initiated (Richard et al., 2016). When discussions occur regarding medical decisions, the patient should be included in the discussion to determine what the concerns are and how to most appropriately address them (Dang et al., 2017; Keller, Gangnon, & Witt, 2014).

Active participation from patients and caregivers should be encouraged to facilitate communication regarding personal opinions about healthcare delivery (Beardsmore & McSherry, 2017). Patients have the desire to be more involved in decisions regarding the provided individual care (Cuevas et al., 2017; Dierckx et al., 2013; Dang et. al, 2017). Dierckx et al. (2013) found that a significant number of patients desired the invitation to participate in the decision-making process but neglected to convey that to the healthcare provider. Keller et al. (2014) reported that patients who were made to feel in authority were more likely to be receptive to the recommendations of the physician.

The use of shared decision-making can be used as a positive enforcer for advancing patient commitment in personal healthcare discussions (Dierckx et al., 2013). The feedback that is provided from patients regarding the observed provider behavior including the patient’s perspective on noted cultural sensitivity and attitudes can help to positively influence the care that is provided to patients visiting that facility (Tucker , Moradi, Wall, & Nghiem, 2014). Providers should deliver care that keeps the patient as the focal point of the interaction, which directly influences the level of satisfaction (Dang et al., 2017). The patient-provider relationship can no longer be viewed as one sided with the provider having all the authority but as a partnership that enables the patient to be more involved in the healthcare process (Chertoff, 2015). Providers who promote patient involvement help to support keeping patients engaged and interested in the care provided (Lee Kee et al., 2015).

Effective Communication

The relationship that exists between the patient and the provider should have honest and effective communication as a key component to facilitate an environment of information sharing (Al-Amin & Makarem, 2016; Thomas, 2014; Waitzman, 2014). The quality of communication can affect health outcomes (“Communication,” 2014). Communication considered as inadequate between the patient and the provider can have a negative effect on patient outcomes (Earl et al., 2013). Effective communication from the patient’s point of view can serve as a method to encourage adherence to recommended treatment options can be viewed as a precursor for patient satisfaction (“Communication,” 2014).

Patient-Provider Communication

Lee King et al. (2015) conducted a study that evaluated the patient-provider relationship from the patient’s point of view, which produced results that showed that patients desire to experience comfort when interacting with a healthcare provider. The patient has the responsibility to share information with the provider regarding health decisions so that providers will be able to understand why a patient did or did not comply with healthcare treatment plans (Nazione & Silk, 2013). Dang et al. (2017) reported that patients diagnosed with Human Immunodeficiency Virus (HIV) are often apprehensive about sharing health concerns with the provider due to the dread of having those concerns dismissed.

Patients reported that there is a need to have a healthcare provider that is concerned about them enough to take the necessary time to discuss any trepidation that may arise (Dang et al., 2017). Patients who take the initiative to engage in behavior that supports a healthy lifestyle by taking a more active role in personal healthcare are reported to be more satisfied with the type and level of communication with the healthcare provider (Cinar & Schou, 2014).

A positive exchange between the patient and the provider can give the patient the impression that the provider is interested in what is important based on stated views, which can influence adherence (Keller et al., 2014). Patients who do not voice individual preferences related to healthcare decision-making create a missed opportunity that might give the provider the opinion that the patient prefers to be a passive participant only (Dierckx et al, 2013). The patient should be willing to offer insight to persuade the provider that there are benefits to helping the patient conquer health concerns (Nazione & Silk, 2013).

Provider Bias and Discrimination

There is a correlation between the clinical interaction that exists within the patient-provider relationship and the ethnic or racial bias noted by the patient (Blair et al, 2013). Provider biases are commonly attributed to race (Nazione & Silk, 2013). Providers can base opinions on preconceived biases when there is no information provided by the patient to justify healthcare behaviors such as nonadherence to medical recommendations and directives (Nazione & Silk, 2013). Saha et al. (n.d.). reported that a significant number of HIV positive minority patients are commonly placed at a disadvantage when an attempt is made to formulate a sustainable relationship with healthcare providers. The level of trust that a patient has for a provider is influenced by the detection of bias on behalf of the physician (Cuffee et al., 2013; Peek et al., 2013).

According to Blair et al. (2013), patients who identified the detection of implicit bias determined that the style and type of communication differed when interacting with providers. The quality of patient-centered care was viewed as unsatisfactory from the vantage point of African American patients who interacted with providers that displayed implicit bias tendencies (Blair et al., 2013). Providers that have the tendency to display implicit biased behavior when interacting with patients are often unaware of that behavior (Hall et al., 2015). Implicit bias that providers have regarding African American patients can influence the way care is provided that will help to increase opportunities for health disparities and injustice to prevail (Hall et al., 2015).

Detected discrimination from the provider has a negative impact on the level of trust that the patient has which can perpetuate the incidences of nonadherence to medical advice received (Haywood et al., 2014). Discrimination within healthcare delivery needs to be evaluated because of the correlation that exists between unsatisfactory health outcomes and health disparities (Benjamins & Whitman, 2014). Providers who have the belief that minority patients will not adhere to medical advice can develop the disposition that those patients are beyond receiving help, which causes the provider to approach the healthcare plan with little faith in the patient based on individual ideals (Cuffee et al., 2013). Healthcare providers can have the perception that African American patients are not as responsible for their current state of health as opposed to patients of other racial or ethnic backgrounds (Nazione & Silk, 2013).

Clinical decision-making is often made more challenging because of hidden biases that are rooted in the stereotyping of minority patients (Chapman et al., 2013; Nelson, 2016). Physicians should acknowledge that the care that is provided might be interwoven with unintentional bias even if it contradicts normal behaviors and personal perceptions (Van Ryn, 2016). The provider has the responsibility to monitor individual attitudes to effectively combat health disparities that are the result of race relations (Nelson, 2016). When physicians are made aware of those behaviors and try to avoid acting on any personal biases when treating patients, it creates an opportunity to influence the negative injustices in the variance of healthcare delivery between racial groups (Van Ryn, 2016). When patients seek treatment, it is preferred that it is free of unsolicited personal opinions or judgement (Dang et al., 2017).

African-American Patients and Cultural Norms

Culture can have an impact on behavior and attitudes (Pullen et al., 2014). Within the African American culture, some of the opinions regarding healthcare stem from historical perspectives (Pullen et al., 2014. In African American culture, spirituality plays a significant role in health for some individuals (Drisdom, 2013). Faith is a significant component of the everyday lives of many African Americans so there is some resistance to accepting some forms of healthcare assistance and guidance (Drisdom, 2013).

African American patients have reported that there are challenges with not only obtaining care but also the necessary prescription medications that are necessary to improve health (Tze-Fang et al., 2013). The concern over the loss of finances has the probability of acting as a deterrent for African American patients that may need to schedule visits with a healthcare provider (Green et al., 2013). Improving the relationship between the patient and the provider is more likely to occur when the provider exhibits respect for the cultural views of the patient (Waitzman, 2014). African American females commonly make the decision to forego visiting a healthcare provider due to a lack of confidence in the healthcare system, which can create missed opportunities to impact health outcomes (Belgrave & Abrams, 2016). African American patients diagnosed with HIV or AIDS are more likely to not adhere to the prescribed treatment plan if those patients have the perception that the provider is not concerned about individual concerns and requests (Earl et al., 2013). Healthcare providers who oversee the care that is given to African American patients should take into consideration the validity of requesting the patient’s feedback regarding the care that is provided (Tucker et al., 2014).

Cultural Competency

The training given to physicians can influence how to perceive the individual needs of each patient to determine how care should be provided (Higashi, Tillack, Steinman, Johnston, & Harper, 2013). There is a need for cultural sensitivity courses to be incorporated in medical school training which will focus on the views from the patients who are disadvantaged or vulnerable (Tucker et al., 2014). Healthcare providers need to go through training that helps to support the need to improve education pertaining to interacting with various ethnicities and nationalities so that health disparities can be reduced and positively impacted (Nelson, 2016). Cultural competency training has been considered as the most effective method to use to train healthcare professionals as well as counteracting healthcare disparities although how it is presented and implemented varies based on the training site (Cuevas et al., 2017).

Saha et al. (n.d.). found that providers who incorporate cultural competence when treating African American HIV positive patients experience more positive health outcomes. Cultural competency or sensitivity is significant because when used effectively there is the likelihood of not only improving the quality of care that is provided but also to help to eliminate or reduce racial disparities within healthcare (Cuevas et al, 2016; Saha et al., n.d.). Cultural competency training should include focusing on how to appropriately utilize the role that is incumbent of a provider to understand how interactions occur and how personal beliefs may impact how medical treatments are delivered (Roberts-Dobie et al., 2013). Unrestrained discrimination from the perspective of the provider to the patient can negatively affect health outcomes (Cuffee et al., 2013; Han et al., 2015).

Cultural sensitivity training can be used to improve the communication between the provider and the patient (Richard, Ferguson, Lara, Leonard, & Younis, 2014). Providers also need to be exposed to cultural communication training which will assist with improving the methods of interacting with patients of different races (Dahlem et al., n.d.). Cultural competency within communication is important because it involves not only speaking but listening to the other party to gain an understanding of what is being conveyed (Hain & Sandy, 2013; Lee King et al, 2015). Providers who are skilled in interpersonal relations as well as active listening have a greater chance of recommending treatment regimens that will be accepted and implemented by the patient (Keller et al., 2014).

Summary

The patient-provider relationship is influenced by various variables that can affect how the relationship is formed and cultivated. The historical significance between

African Americans and healthcare creates boundaries that can stifle the positive interactions that can exist within the confines of the patient-provider relationship. The patient-provider relationship is first established through mutual trust. Patient satisfaction is influenced by the perception that the patient has regarding the type of interaction and the level of engagement and involvement that the provider supports and encourages. The communication that occurs within the patient-provider relationship is significant because it is how rapport is developed and trust is established. Effective communication requires that both parties are able to be actively engaged through consistent participation. This study evaluated the relationships that exist between variables by utilizing a quantitative survey design. Chapter 3 will provide a more in-depth examination of the research methodology that was used to collect and analyze the data from the outlined sample of the population.

Chapter 3: Research Method

Chapter 3

Introduction

This chapter explains how the data from the determined sample of the population was collected and analyzed by using a quantitative methodology. The research questions and hypotheses that were examined were:

RQ1: Does education level, income, or gender of African Americans affect the patient-provider relationship?

H_01: There is no statistically significant relationship between education level, income, gender, and the patient-provider relationship.

H_A1: There is a statistically significant relationship between education level, income, gender, and the patient-provider relationship.

RQ2: What is the effect, if any, that the patient-provider relationship has on African American patients' decisions to seek healthcare services?

H_02: There is no statistically significant relationship between the patient-provider relationship and African American patients' decisions to seek healthcare services.

H_A2: There is a statistically significant relationship between the patient-provider relationship and African American patients' decisions to seek healthcare services.

RQ3: What effect does the patient-provider relationship have on medication compliance and follow-up medical care?

H_0*3:* There is no statistically significant relationship between the patient-provider relationship and medication compliance and follow-up medical care.

H_A*3:* There is a statistically significant relationship between the patient-provider relationship and medication compliance and follow-up medical care.

RQ4: What effect, if any, does health insurance have on the quality of the patient-provider relationship?

H_0*4:* There is no statistically significant relationship between health insurance and the quality of the patient-provider relationship.

H_A*4:* There is a statistically significant relationship between health insurance and the quality of the patient-provider relationship.

The prevalent existence of health disparities is a costly issue within the United States (Moy & Freeman, 2014). The investigation of health disparities and the influence that those disparities have on the African American community is both necessary and relevant (Cuevas et al., 2016). Health disparities create challenges within the African American community since many of the resulting conditions and diseases are curable and avoidable (Jackson & Gracia, 2014). There is a need to understand why some African American patients make the decision to not use available healthcare services. Not having adequate insurance is the most significant reason for not seeking healthcare services, but the likelihood of obtaining healthcare treatment increases when income and insurance are not deterrents (Nelson, 2016; Pullen et al., 2014).

Mutual respect and understanding between both parties is required for the patient-provider relationship to be both impactful and beneficial (Bell et al. 2013; Hain & Sandy, 2013; Waitzman, 2014). The study may inform the influence that the patient-provider relationship has on an individual's desire and motivation to seek healthcare treatment.

Research Design

The study used a quantitative methodology to evaluate social experiences that occur between African Americans and healthcare providers. Quantitative methodology can be used to analyze data in order to draw conclusions (Watson, 2015). It can be difficult to measure what people think or feel so quantitative research can be used in order to determine if there are trends or relationships present within the data (Watson, 2015). The study incorporated a cross-sectional design since there was a need to only collect data at one point in time.

The cross-sectional design is often used in both survey research and the social sciences (Frankfort-Nachmias, Nachmias, & DeWaard, 2015; Shi, 2008). The application of quantitative methodology was pertinent to this study since the objective of the research was to determine if the patient-provider relationship had any influence on the patient's decision to seek healthcare services. A cross-sectional research design was selected because of its cost effectiveness, the shorter duration of time to perform data collection, and the ability to present results that are more comprehensive and inclusive. The limitations of a cross-sectional survey include being limited in the measure of precision of information that the respondents can convey from memory and inability to depict the direction of causal relationships by eliminating alternative interpretations (Shi, 2008).

Participants

The participants in this study were recruited from Shelby County, Tennessee. The participants were 40 to 65 year old African Americans who had health insurance and a male or female English-speaking primary care physician. The participants were recruited within Shelby County, Tennessee by enlisting the help of African American greek alumni organizations such as Alpha Phi Alpha, Alpha Kappa Alpha, Kappa Alpha Psi, Delta Sigma Theta, Phi Beta Sigma, Sigma Gamma Rho, and Iota Phi Theta. The average number of members over the age of 35 in African American alumni sororities and fraternities in Memphis, Tennessee is about 350 (B. Hill, personal communication, March 15, 2018). The leaders of the organizations were contacted to reach the intended sample of the population. The leaders distributed the survey link out to their members who met participant criteria. African American Greek alumni organizations are founded on service to the community and are advocates of giving back through their time and resources (Hughey & Hernandez, 2013). Owens et al. (2017) reported that one of the most successful methods for locating and recruiting African American participants is by contacting African American Greek alumni organizations. These organizations tend to be community-service oriented and can help to educate participants (Owens et al., 2017).

Instrumentation

Using the quantitative methodology, the sample population was asked to complete a survey that evaluated specific aspects of the patient-provider relationship. The survey that was administered focused on the quality components of interpersonal processes of care such as patient-physician interaction, communication, friendliness, and sensitivity (Stewart, Nápoles-Springer, Gregorich, & Santoyo-Olsson, 2007). The survey was administered by using Survey Monkey which is an online platform that will enable the survey to be shared via a link which can be designed and implemented in an expedited manner (Frankfort-Nachmias et al., 2015). The instrument that was used to collect the data is the Interpersonal Processes of Care (IPC) Survey which was used by the authors who administered it to diverse participant groups to characterize interpersonal processes as multidimensional (Stewart et al., 2007). The IPC Survey has been proven to be effective when evaluating different racial populations (Stewart et al., 2007). The IPC Survey which is comprised of 29 items can be used to study how facets of interpersonal care can affect health outcomes and its effect on health disparities (Stewart et al., 2007). Table 3 shows how the concepts from the IPC Survey correlates to the research study variables.

Table 3

Relation of IPC Concepts to Research Questions

Survey Concept	Relation to Research Questions
Communication	RQ1: Does education level, income, or gender of African Americans affect the patient-provider relationship?
Patient-centered decision making	RQ3: What effect does the patient-provider relationship have on medication compliance and follow-up medical care?
Interpersonal Style	RQ2: What is the effect, if any, does the patient-provider relationship have on the African-American patient’s decision to seek healthcare services? RQ4: What effect, if any, does health insurance have on the quality of the patient-provider relationship?

From “Interprocesses of care in diverse populations,” by Stewart et al., 1999 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955252/).

Permission was received from Dr. Stewart on September 1, 2017 to use this instrument to perform the data collection and can be found in Appendix A. The IPC Survey covers physician communication, patient-centered decision making, interpersonal style, and asks questions about the office staff members (Stewart et al., 2007).

Research Procedures

The population that was evaluated was within Shelby County, Tennessee. The statistics for Shelby County, Tennessee account that the total population exceeds 920,000 individuals (“Suburban Stats,” n.d.). Of that population, 483,381 are African American. From that total population, African American citizens between the intended age group of 40-65 encompasses 144,627 people. The average number of members over the age of 35 in African American Alumni sororities and fraternities in Memphis, Tennessee is about 350 (B. Hill, personal communication, March 15, 2018). The sample size was calculated by determining the proportion which was calculated as 0.156 from the targeted group from the total population. Using a sample size calculator (Sample Size Calculator, n.d.)., the sample size was determined as 203 with a confidence interval of 95% a confidence interval of 6. G*Power ® analysis was used to determine that only 43 responses were needed if the assumption is 80% power, .05 alpha, .15 effect size, and 5 predictors. Convenience sampling was used to locate a sampling unit that is the most readily available (Frankfort-Nachimas et al., 2015).

The participants were gathered by seeking participation from African American greek alumni organizations by contacting the leaders who distributed the survey link to their respective members, via e-mail, that are between the ages of 40-65. The nine organizations all have websites which provide either mechanisms to email directly from the website or list the email address of the respective president. The leaders received an email with background information about the study and the link that could be shared with their members. The email that was used can be found in Appendix C. The leaders received background information about the study, the researcher, and the aims of the research. Once IRB approval was granted, the emails were sent along with the survey link to the leaders of the organizations. Informed consent was sent in the email with the survey link. A copy of the informed consent form can be found in Appendix B. There was a statement at the beginning of the survey for participants to acknowledge that the informed consent was received. The confounders that were evaluated included age and whether the residence is in Shelby County, Tennessee. The survey was sent once initially, and when the participation numbers were too low, the survey was sent a second time. The time frame for data collection was one month. Participants needed access to the Internet to participate since the survey was only available online.

Data Analysis

The collected data were analyzed by using SPSS Version 23. The test that was conducted was a multiple linear regression, and there were five predictors (African American, insured, 40-65, English-speaking primary care physician, and residence in Shelby County, TN). The use of a multiple linear regression is applicable because if there is a relationship between the independent and the dependent variables, the data will produce a straight line and not a scatterplot (Casson & Farmer, 2014). Multiple linear regression was selected as the statistical test because there was a need to determine if there was a relationship between the independent variable and the dependent variables and if the independent variables could predict the type of patient-provider relationship.

Threats to Validity

Validity is important in research because the instrument that is used must measure what the researcher is interested in (Watson, 2014). Internal validity of research designs involve selection, history, maturation, experimental mortality, instrumentation, testing, regression artifact, and interaction with selection (Frankfort-Nachmias et al., 2015). Threats to internal validity occur when generalizations cannot be made regarding the audience that it was originally intended to target (Claydon, 2015). Threats to internal validity were addressed by not having any selection bias regarding the participants. Anyone that met the participant criteria were able to take the online survey. The use of a validated instrument reduced the negative consequences of using a tool that had not been previously measured.

External validity of research designs involves representativeness of the sample and reactive arrangements. Threats to external validity were addressed by ensuring that all participants were African American since that was the population that was the focus of the study and by providing the link to the online survey that participants were able to complete on their own. There were no threats to external validity as result of the study design and selected methodology.

Ethical Procedures

Permission to use the survey tool was granted from the author prior to it being used to collect the dissertation data. The Walden University's Institutional Review Board conducted a concise analysis of the ethical procedures that were submitted prior to the data collection being performed. The survey was strictly confidential and anonymous. The data were only accessible by the researcher who does not share the personal SurveyMonkey account with any other party. The data will be stored within a dropbox account that is password protected and is only accessible by the researcher. The data will be destroyed in July 2023.

Assumptions of the Study

The participant completed the survey completely and honestly. An adequate study population was available through African American greek alumni organizations. The study population was interested in participating in the study without a financial incentive and the participants were informed they were anonymous and were comfortable with the survey process.

Limitations of the Study

The Walden Institutional Review Board prohibits researchers from offering incentives to research study participants. The study population was limited. The participants were all residents of Shelby County Tennessee, so the results were not generalizable to the entire African American population in the United States. The participants were reluctant to complete the survey or to disclose individual demographic information. The recruitment of the sample population was done through African

American Alumni fraternities and sororities, so the participants were more educated which prevented the findings from being generalizable to all African Americans in the United States.

Summary

African Americans are adversely affected by health disparities within the United States (Jackson & Gracia, 2014). The research study investigated the relationship between the patient-provider relationship and health disparities by evaluating a sample from the African American population in Shelby County, Tennessee. The IPC Survey was administered through Survey Monkey, an online platform, using convenience sampling. A multiple linear regression was calculated by using SPSS Version 23 to analyze the collected data. Chapter 4 will describe and present the results from the data analysis.

Chapter 4: Results

Introduction

The purpose of this quantitative study was to evaluate how the patient-provider relationship has the potential to influence African American patients' decisions to access healthcare services. This study aimed to investigate the factors that might contribute to whether the patient-provider relationship is positive or negative. The goal was to understand why African Americans do not routinely go to the doctor or seek necessary and timely medical treatment. Many chronic diseases and conditions are prevalent within the African American community because there is not enough emphasis placed on why it is necessary and important for members of that population to make doctor visits a priority.

The research design of this study involved a cross-sectional quantitative methodology. A multiple linear regression was the selected analysis because there was a need to statistically determine if the independent variables predicted a positive patient-provider relationship. A cross-sectional design was selected because it was only necessary to collect data at one point in time. An online survey that was deployed via SurveyMonkey was used to collect the data for statistical analysis. A multiple linear regression was valuable to this study because there were multiple independent variables which provided value by uncovering the relationship between those values and the dependent or outcome variable. In this chapter, the results from the study will be presented. This chapter will include the research questions, the data collection process, results, and the summary. The data from the survey will be used to answer the research questions which will result in either accepting or rejecting the null hypotheses:

RQ1: Does education level, income, or gender of African Americans affect the patient-provider relationship?

H_01: There is no statistically significant relationship between education level, income, gender, and the patient-provider relationship.

H_A1: There is a statistically significant relationship between education level, income, gender, and the patient-provider relationship.

RQ2: What is the effect, if any, that the patient-provider relationship has on African American patients’ decisions to seek healthcare services?

H_02: There is no statistically significant relationship between the patient-provider relationship and African American patients’ decisions to seek healthcare services.

H_A2: There is a statistically significant relationship between the patient-provider relationship and African American patients’ decisions to seek healthcare services.

RQ3: What effect does the patient-provider relationship have on medication compliance and follow-up medical care?

H_03: There is no statistically significant relationship between the patient-provider relationship and medication compliance and follow-up medical care.

H_A3: There is a statistically significant relationship between the patient-provider relationship and medication compliance and follow-up medical care.

RQ4: What effect, if any, does health insurance have on the quality of the patient-provider relationship?

$H_0$4: There is no statistically significant relationship between health insurance and the quality of the patient-provider relationship.

H_A4: There is a statistically significant relationship between health insurance and the quality of the patient-provider relationship.

Data Collection

Primary data were collected from participants by using the Interpersonal Processes of Care (IPC) Survey which was relevant to this study because it can be used to depict how components of interpersonal care such as communication, decision making, and interpersonal style that can affect health outcomes in addition to understanding the effect on health disparities (Stewart et al., 2007). SurveyMonkey was used to generate an online survey that was accessible via the generated link. After receiving the Walden University IRB's approval (# 05-18-18-0374684), the survey data were collected between June and July 2018. Descriptive statistics were evaluated to determine how the overall group answered the survey based on the responses that were received, which helped to describe the overall responses.

There were 56 responses that were collected, and 11 of those responses were eliminated either due to the participant not completing the entire survey or not meeting the stringent participant criteria. The demographic questions that were asked at the beginning of the survey helped to identify and eliminate participants that did not meet the qualifications such as whether the individual was African American, lived in Shelby County, Tennessee, had health insurance, and was between the ages of 40 and 65.

Most of the respondents were African American females which accounted for 82.2% of the responses. The age group that had the most number of participants were respondents who recorded their age as between 40 and 49, which yielded 60% of the total responses. The 50–59 age group accounted for 22.5% of the responses, and participants between 60 and 65 had the least amount of responses 17.8%. A detailed summary of the demographic characteristics of the 45 survey participants is outlined in Table 4.

Table 4

Demographic Information on the 45 Survey Respondents

	Frequency	Percent
Female	32	82.2
Male	8	17.8
Age 40–49	27	60
Age 50–59	10	22.5
Age 60-65	8	17.8

* Percentage of total population (*n* = 45) that completed the online survey.

All of the participants included in the data analysis lived in Shelby County, TN, were African American, had health insurance, were between the ages of 40 and 65, and had an English-speaking primary care physician. There are nine African American sororities and fraternities and each organization has different chapters based on locations throughout the city. One sorority had three chapters within the targeted area. Although the responses were limited, the data that was collected does represent the targeted population, which was African Americans between the ages of 40 and 65.

Results

Descriptive statistics including the mean and standard deviation for each independent variable are presented in Table 5. The mean is the most commonly used measure of central tendency by taking the observed values of a variable and dividing it by the total number of observations (Shi, 2008). Doctors making assumptions about education level had the highest mean and gender had the lowest.

Table 5

Descriptive Statistics for the Independent Variables

	N	Mean	Standard Deviation
Gender	45	.82	.387
Make assumptions about education level	45	1.60	1.009
Make assumptions about income level	45	1.51	.843

Statistical Assumptions

For this research, multiple regression was the statistical test that was utilized. In a multiple regression, there are four main assumptions that must be met (Casson & Farmer, 2014). The first assumption that must be achieved is for the continuous predictor variables and the outcome variable to have a linear relationship (Casson & Farmer, 2014). Linearity can be assessed through an evaluation of the relationship between the *y* and *x* on the scatter plot (Casson & Farmer, 2014). It is required that the predictors have a linear relationship, and they must be considered as additive (Casson & Farmer, 2014). The second assumption that must be met is that the outcome or dependent variable is continuous (Casson & Farmer, 2014). The third assumption is no random component to *x* exists which includes a measurement error (Casson & Farmer, 2014). The fourth assumption is that the mean error is zero which is a condition of *x* (Casson & Farmer). Linearity, homoscedastity, independence, and normality are all involved in the checking of the residuals after the initial regression is ran (Field, 2013).

Research Question 1:

RQ1: Does education level, income, or gender of African Americans affect the patient-provider relationship?

$H_0 1$: There is no statistically significant relationship between education level, income, gender, and the patient-provider relationship.

$H_A 1$: There is a statistically significant relationship between education level, income, gender, and the patient-provider relationship.

Determining the influence on the patient-provider relationship through its correlation with gender, income, and education was the focus of this first research question. A multiple regression was run to predict patient-provider relationship from gender, assumption about education level, and assumption about income level. There was linearity as assessed by partial regression plots and a plot of studentized residuals against the predicted values. There was independence of residuals, as assessed by a

Durbin-Watson statistic of 1.954. There was homoscedasticity, as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values. There was no evidence of multicollinearity, as assessed by tolerance values greater than 0.1. There were no studentized deleted residuals greater than ±3 standard deviations, no leverage values greater than 0.2, and values for Cook's distance above 1. The assumption of normality was met, as assessed by a Q-Q Plot. The multiple regression model statistically significantly predicted the patient-provider relationship, F(3, 42) = 6.340, p < .0005, adj. R2 = .27. All three variables added statistically significantly to the prediction, p < .05. The null hypothesis was rejected. Regression coefficients and standard errors can be found in Table 6.

Table 6

Summary of Multiple Regression Analysis

Variable	*B*	SE_B	β
Intercept	5.211	.297	
Gender	-.479	.269	-.231
Assumption about education level	-.113	.156	-.142
Assumption about income level	-.359	.187	-.377

Note. * *p* <. 05; *B* = unstandardized regression coefficient; SE_B = standard error of the coefficient; β = standardized coefficient

Research Question 2

RQ2: What is the effect, if any, that the patient-provider relationship has on African American patients' decisions to seek healthcare services?

$H_{0}2$: There is no statistically significant relationship between the patient-provider relationship and African American patients' decisions to seek healthcare services.

$H_{A}2$: There is a statistically significant relationship between the patient-provider relationship and African American patients' decisions to seek healthcare services.

Determining the effect that the patient-provider relationship has on African American patients' decisions to seek healthcare services was the focus of the second research question. The Pearson correlation coefficient tests were performed for each variable using SPSS. As shown in Table 7, all three of the negative type of behaviors impact the patient-provider relationship. Therefore, the null hypothesis was rejected.

Table 7

Correlations of Behaviors and the Patient-Provider Relationship

Correlations				
	Patient-provider relationship	How often were office staff rude to you?	How often did office staff give you a hard time?	How often did office staff have a negative attitude toward you?

(table continued)

Patient-provider relationship	Pearson Correlation	1	-.461**	-.489**	-.391**
	Sig. (2-tailed)		.001	.001	.008
	N	45	45	45	45
How often were office staff rude to you?	Pearson Correlation	-.461**	1	.761**	.822**
	Sig. (2-tailed)	.001		.000	.000
	N	45	45	45	45
How often did office staff give you a hard time?	Pearson Correlation	-.489**	.761**	1	.808**
	Sig. (2-tailed)	.001	.000		.000
	N	45	45	45	45
How often did office staff have a negative attitude toward you?	Pearson Correlation	-.391**	.822**	.808**	1
	Sig. (2-tailed)	.008	.000	.000	
	N	45	45	45	45

**Correlation is significant at the 0.01 level (2-tailed).

Research Question 3:

RQ3: What effect does the patient-provider relationship have on medication compliance and follow-up medical care?

$H_0$3: There is no statistically significant relationship between the patient-provider relationship and medication compliance and follow-up medical care.

H_A3: There is a statistically significant relationship between the patient-provider relationship and medication compliance and follow-up medical care.

Determining effect that the patient-provider relationship has on medication compliance and follow-up medical care was the focus of the third research question. The Pearson correlation coefficient tests were performed for each variable using SPSS. As shown in Table 8, all three of the independent variables impact the patient-provider relationship. Therefore, the null hypothesis was rejected.

Table 8

Correlations of Provider Actions and the Patient-Provider Relationship

Correlations

		Patient-provider relationship	How often doctors tell you about side effects you might get from a medicine?	How often did doctors ask if you would have any problems following what they recommended?	How often did doctors tell you what could happen if you didn't take a medicine that they prescribed for you?
Patient-provider relationship	Pearson Correlation	1	.539**	.363*	.421**
	Sig. (2-tailed)		.000	.014	.004
	N	45	45	45	45
How often doctors tell you about side effects you might get from a medicine?	Pearson Correlation	.539**	1	.235	.613**
	Sig. (2-tailed)	.000		.120	.000
	N	45	45	45	45
How often did doctors ask if you would have any problems following what they recommended?	Pearson Correlation	.363*	.235	1	.309*
	Sig. (2-tailed)	.014	.120		.039
	N	45	45	45	45
How often did doctors tell you what could happen if you didn't take a medicine that they prescribed for you?	Pearson Correlation	.421**	.613**	.309*	1
	Sig. (2-tailed)	.004	.000	.039	
	N	45	45	45	45

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Research Question 4:

RQ4: What effect, if any, does health insurance have on the quality of the patient-provider relationship?

$H_0$4: There is no statistically significant relationship between health insurance and the quality of the patient-provider relationship.

H_A4: There is a statistically significant relationship between health insurance and the quality of the patient-provider relationship.

For this research question, all 45 responses were provided by African Americans that have health insurance. As a result of all of the respondents having health insurance, there were not two different sets of data which created a need to determine if the IPC instrument was reliable. Cronbach's α was evaluated by using SPSS to determine if the reliability of the IPC Survey. Cronbach's α measures the amount of correlation that exists between items by using statistics (Connelly, 2011). When analyzing Cronbach's α, there are not independent and dependent variables that are used, but the score that is obtained on one item should be used to predict the score that will be obtained on another item (Connelly, 2011). The reported Cronbach's α value presents the overall reliability of the scale that was used. All of the values should correlate with the reported total in a scale that is reliable. The Cronbach's α value was calculated to be .84 which means that the IPC subscale is reliable. In Table X, the Cronbach α value is reported and shown with the values that Cronbach α would be if any single item was deleted.

Based on the statistical analysis of using Cronbach’s α, the null hypothesis can be rejected. Since 100% of the participant data that was used in the analysis was submitted by individuals that had insurance, one can justify the conclusion that in order to have a patient-provider relationship, it is necessary for the patient to have insurance.

Table 9

Reliability Statistics

Cronbach’s Alpha Generated from Reliability Statistics is equal to .84

Item	Cronbach’s α if Item Deleted
How often did doctors speak too fast?	.84
How often did doctors use words that were hard to understand?	.84
How often did doctors ignore what you told them?	.82
How often did doctors appear to be distracted when they were with you?	.83
How often did doctors seem bothered if you asked several questions?	.82
How often did doctors really find out what your concerns were?	.84
How often did doctors let you say what you thought was important?	.83
How often did doctors take your health concerns very seriously?	.83
How often did doctors explain your test results such as blood tests, x-rays, or cancer screening tests? *(table continued)*	.83
How often did doctors clearly explain the results of your physical exam?	.83

(table continued)

How often did doctors tell you what could happen if you didn't take a medicine that they prescribed for you?	.83
How often doctors tell you about side effects you might get from a medicine?	.82
How often did doctors ask if you would have any problems following what they recommended?	.84
How often did doctors ask if you felt you could do the recommended treatment?	.83
How often did you and your doctors work out a treatment plan together?	.83
How often did doctors ask if you would like to help decide your treatment?	.83
How often were doctors concerned about your feelings?	.83
How often did doctors treat you as an equal?	.82
How often did doctors make assumptions about your level of education?	.83
How often did doctors make assumptions about your income?	.83
How often did doctors pay less attention to you because of your race or ethnicity?	.83
How often did you feel discriminated against by doctors because of your race or ethnicity?	.83
How often were office staff rude to you?	.82
How often did office staff talk down to you?	.82
How often did office staff give you a hard time?	.82
How often did office staff have a negative attitude toward you?	.83

The overall values reported for each item should not exceed the reported .84 value of Cronbach's α and Table 9 confirms that those values do not. Therefore, the null hypothesis was rejected.

Summary

Chapter 4 included a detailed overview and interpretation of the findings. There were four research questions that each had two hypothesis that were evaluated using statistical analysis. The first research question evaluated whether gender, education level, or income affected the patient-provider relationship. The results show that there is a statistically significant relationship between the independent variables of the patient provider relationship and dependent variables education, income, gender, seeking healthcare, compliance with medication, and having insurance. The second research question aimed to determine what effect, if any, the patient-provider relationship has on the African American patient's decision to seek healthcare services. The predictive model with negative behaviors had a statistically significant relationship with the patient-provider relationship. The third research question sought to answer what effect, if any, the patient-provider relationship has on medication compliance and follow-up medical care. The predictive model with the three independent variables pertaining to the medication compliance and follow-up care had a statistically significant relationship with the patient-provider relationship. The fourth research question investigated whether health insurance has an effect on the quality of the patient-provider relationship. Based on the Cronbach α value that proved that the scale was reliable, the null hypothesis was rejected. The IPC Survey was used to cultivate understanding regarding the interpersonal interactions that occur during medical visits which was applicable to this study. Chapter 5 will present a discussion of the findings.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this quantitative study was to form a discussion regarding the patient-provider relationship and its effect on racial health disparities. The IPC survey was used to collect data to in order to statistically analyze if the interactions that occur during medical visits influence African American patients' decisions to seek medical treatment. The survey data were collected between June and July 2018.

Four research questions and corresponding hypotheses for each question were evaluated. The data were analyzed by using correlation, multiple regression, and reliability testing. The aim was to understand why African American patients do not go to the doctor which could explain why there is such a prevalence of chronic diseases within that population. The results indicated that there is a statistically significant relationship between the patient-provider relationship and the behaviors of the provider.

Interpretation of Findings

The theoretical model that was used for this study was the behavioral model of health services use. Ronald Andersen created the model in the late 1960s to help explain why and how decisions are made regarding the utilization of health services (Andersen, 1995). The use of the behavioral model of health services use was applicable to this study because its premise is that healthcare use can be determined by identified factors such as demographics, socioeconomics, and health status that can influence decisions (Gai & Feng, 2013). The constructs of the behavioral model of health services use include predisposing, enabling, and need characteristics (Butler et al., 2008). In this study, all three constructs were evaluated in order to identify a sample of the population to evaluate.

There is a need for more education to be provided to minority populations regarding the how to access available resources and how to use the healthcare system (Nonzee et al., 2015). The focus of this study was to gather information that can be used to educate African Americans and healthcare providers. The goal was to evaluate what effect the patient-provider relationship had on the healthcare use behavior of African American patients. The first hypothesis ($H_0 1$) was that there was no statistically significant relationship between education level, income, gender, and the patient-provider relationship. The independent variables were related to the patient-provider relationship at a statistically significant level, with F(3, 42) = 6.340, $p < .0005$, and adj. R2 = .27. Gender ($\beta = -.439$) had a higher unstandardized regression coefficient higher coefficient than assumptions about education level ($\beta = -.113$) and income level ($\beta = -.359$). The null hypothesis that gender, education level, and income had no statistically significant predictive role in relation to the patient-provider relationship was rejected.

The second hypothesis ($H_0 2$) was that there was no statistically significant relationship between the patient-provider relationship and African American patients' decisions to seek healthcare services. Staff being rude to the patient ,giving the patient a hard time, and having a negative attitude all positively correlated with the patient-provider relationship. A conclusion was made that there is a statistically significant relationship between the behavior of the staff and the patient-provider relationship.

The third hypothesis ($H_0 3$) was that there was no statistically significant relationship between the patient-provider relationship and medication compliance and follow-up care. Physicians telling the patient about side effects, asking the patient if there were problems with recommendations , and lack of medication adherence all positively correlated with the patient-provider relationship. The conclusion was made that there is a statistically significant relationship between medication compliance, follow-up care, and the patient-provider relationship, and the null hypothesis was rejected.

The fourth hypothesis ($H_0 4$) was that there was no statistically significant relationship between health insurance and the patient-provider relationship. A reliability test, Cronbach's α, was used to test this hypothesis since 100% of participants had health insurance. The value of Cronbach's α was .84 and none of the values of the survey questions exceeded that value, so the null hypothesis was rejected.

These findings speak to the cultural norms of African Americans and how provider discrimination and bias has an adverse effect on the patient's ability to trust the provider. African American patients want to feel comfortable with their provider, and they want the opportunity to be involved with their healthcare which can have an effect on patient outcomes (Hain & Sandy, 2013). This study adds to the current literature by providing information that there is a possible correlation between the patient-provider relationship and its effect on African American patients' decisions to seek healthcare services.

Limitations

The participants were all from the same geographical location within Shelby County, Tennessee. All participants are members of alumni chapters of African American sororities and fraternities, which means that it can be assumed that they all have completed some higher education. There were 37 women and 8 men that completed the survey which created a limitation due to the smaller sample size. The use of Cronbach's α also creates a limitation due to the smaller sample size since it requires a larger sample size. Some of the alumni chapters were uncomfortable participating due to the nature of the questions that were asked on the survey although the survey was completely anonymous and confidential.

Recommendations

The results of this study provide evidence that there is a statistically significant relationship between the patient-provider relationship and the attitudes and behaviors of medical care teams that provide health services for African American patients. This study only evaluated African American patients, but future research could delve deeper to determine if the gender or race of the provider impacts the patient-provider relationship. This study could also be expanded to evaluate whether the type of insurance has an influence on the patient-provider relationship. Future research might seek to gather data using the interventional methodology during the interviewing process to gather more information about medical visit experiences. There could also be an opportunity to compare the level of education of the participants as well as the area of residence as social determinants. Adding different demographic questions would provide a greater opportunity for generalizations to be made since there would be a greater variety in the participant pool.

Implications for Social Change

Conducting studies that seek to inform the intended audience by presenting findings that are relevant and applicable to practices is important. The literature seeks to validate ideals and knowledge through a rigorous process of research and statistical analysis. There is a need for vulnerable populations such as African Americans to have accessible data that outlines the importance of seeking timely and routine medical treatment. The numbers of African Americans that are affected by manageable chronic diseases is on an upward trend (Ferdinand & Puckrein, 2015; Thomas, 2014; Williams et al., 2014). Healthcare providers can use the information from this study in order to improve interactions that happen during medical visits. Educating African Americans about the importance of timely medical treatment could positively affect racial health disparities. Providers may read the findings of this study in order to improve their practices and interactions with African American patients in order to positively affect their frequency of medical visits.

Conclusion

The purpose of this study was to learn more about why African Americans do not go to the doctor on a consistent basis. Gaining insight regarding that phenomenon is critical to supporting efforts to positively influence social change. To learn more about the intended audience, that population must be reached through research efforts, and there is a need for more research to be done that gains the perspective of the patient. The health demographics of Shelby County, Tennessee were evaluated in order to determine whether the published data aligned with the goals of the research which validated. In Shelby County, Tennessee, there is a need to positively impact racial health disparities that are affecting so many within that area. The data gathered from this research supports what can be found within the current literature. African American patients want to be involved in their healthcare experiences and respected during the process. Until vulnerable populations are given a voice and are able to participate in research studies such as this one, there will not be opportunities for positive social change.

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Appendix A: Interpersonal Processes of Care Survey: IPC-29

The next questions are about your experiences talking with your doctor(s) at ____ *[clinic name]* over the past 12 months. If you see more than one doctor at _____, please tell us, on average, how often they did the following:

	Never	Rarely	Sometimes	Usually	Always
1. How often did doctors speak too fast?	1	2	3	4	5
2. How often did doctors use words that were hard to understand?	1	2	3	4	5
3. How often did doctors ignore what you told them?	1	2	3	4	5
4. How often did doctors appear to be distracted when they were with you?	1	2	3	4	5
5. How often did doctors seem bothered if you asked several questions?	1	2	3	4	5
6. How often did doctors really find out what your concerns were?	1	2	3	4	5
7. How often did doctors let you say what you thought was important?	1	2	3	4	5
8. How often did doctors take your health concerns very seriously?	1	2	3	4	5
9. How often did doctors explain your test results such as blood tests, x-rays, or cancer screening tests?	1	2	3	4	5
10. How often did doctors clearly explain the results of your physical exam?	1	2	3	4	5
11. How often did doctors tell you what could happen if you didn't take a medicine that they prescribed for you?	1	2	3	4	5
12. How often did doctors tell you about side effects you might get from a medicine?	1	2	3	4	5

Now I have some questions about how you and your medical doctors decide about your healthcare.

	Never	Rarely	Sometimes	Usually	Always
13. How often did doctors ask if you would have any problems following what they recommended?	1	2	3	4	5
14. How often did doctors ask if you felt you could do the recommended treatment?	1	2	3	4	5
15. How often did you and your doctors work out a treatment plan together?	1	2	3	4	5
16. If there were treatment choices, how often did doctors ask if you would like to help decide your treatment?	1	2	3	4	5

These questions are about the personal interactions between you and your doctor(s). Please continue to think about your experiences over the past 12 months. First,

	Never	Rarely	Sometimes	Usually	Always
17. How often were doctors compassionate?	1	2	3	4	5
18. How often did doctors give you support and encouragement?	1	2	3	4	5
19. How often were doctors concerned about your feelings?	1	2	3	4	5
20. How often did doctors really respect you as a person?	1	2	3	4	5
21. How often did doctors treat you as an equal?	1	2	3	4	5
22. How often did doctors make assumptions about your level of education?	1	2	3	4	5
23. How often did doctors make assumptions about your income?	1	2	3	4	5
24. How often did doctors pay less attention to you because of your race or ethnicity?	1	2	3	4	5
25. How often did you feel discriminated against by doctors because of your race or ethnicity?	1	2	3	4	5

The next four questions ask about the doctor's front office staff, meaning the receptionist or the person you talk to on the phone to make an appointment.

	Never	Rarely	Sometimes	Usually	Always
26. How often were office staff rude to you?	1	2	3	4	5
27. How often did office staff talk down to you?	1	2	3	4	5
28. How often did office staff give you a hard time?	1	2	3	4	5
29. How often did office staff have a negative attitude toward you?	1	2	3	4	5

Appendix B: Request for Study Participation

Date

Dear Mr. or Ms.:

My name is Andrea Curry, and I am a doctoral candidate at Walden University. I am an alumnus of Hillcrest High School and Christian Brothers University both located here in Memphis, Tennessee. I am working on my PhD dissertation, and I am soliciting help from your organization to collect my data.

My study will evaluate the relationship between the patient-provider relationship and health disparities. Health disparities can be best described as the variance at how healthcare is accessed when evaluating racial groups. The African American community is affected by health disparities at alarming rates which provides understanding regarding why there are higher instances of chronic diseases and conditions within that population. The hope of this study is to understand why African Americans make the decision to not utilize available healthcare services.

Participant criteria is the following: 40-65-year-old African American living in Shelby County, Tennessee with health insurance that has an English-speaking primary care physician. The online survey contains 35 questions. The responses are completely confidential, and participation is voluntary.

I know that African American sororities and fraternities are founded upon the principle of service to the community, so I hope that we will be able to partner together to help to educate African Americans and the medical community as a result of this research study. I have also attached the informed consent form. Should there be any questions for me, I can be reached at andrea.curry@waldenu.edu. Thank you very much for your time.

Sincerely,

Andrea Curry
Walden University Doctoral Candidate