2020

Perceptions of Physician Influence on Healthcare Accessibility

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Walden University
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Abstract

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MBA, Saint Leo University, 2015

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Dissertation Submitted in Partial Fulfillment

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Doctor of Philosophy

Health Services—Public Health Policy

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Abstract

A significant portion of the U.S. population across the country has limited access to quality healthcare; however, this situation is more pronounced in rural areas. One potential solution is for healthcare practitioners to move their services to underserved rural areas to improve healthcare coverage. No previous studies have explored the perceptions of practitioners regarding their influence on healthcare access, particularly the potential impact of moving healthcare services to underserved areas. Thus, the purpose of this research was to address this gap. A qualitative phenomenological approach was adopted. A sample of 24 participants was selected using purposive sampling, from the target population of medical doctors in the southeastern area of the United States. Open-ended interview questions used during data collection, prompted respondents to provide insightful feedback. A deductive coding procedure was used to mirror the 6 dimensions of healthcare access. The results point to 3 major themes: (a) physicians increase healthcare acceptability and awareness through their knowledge and experience; (b) physicians increase accommodation through consideration of patients' needs and coordination of care, and (c) physicians increase resource availability through use of electronic medical records. This research study affords a clearer understanding of physicians' perceptions and may guide the development of informational awareness-raising materials for physicians and also alludes to the need to promote positive relationships between physicians and patients to maximize healthcare accessibility in the United States.

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Dedication

This dissertation is dedicated to my lovely wife, Naa Kordee Jacobs-Abbey. I want to personally thank her for her dedicated support and prayers throughout my years of study. I also want to thank her specifically for putting up with me while I compiled my research. Furthermore, I dedicate this work to my lovely children, Keone Rayne, Keona El-Nissi, and Kenaniah El-Roi Jacobs-Abbey.

I thank Jesus Christ, my Lord and Personal Savior, who granted me the grace and ability to successfully complete this study.

Finally, this work is dedicated to my late mother, Madam Constance Doris Betty Sackey. Even though she was not alive to witness the successful completion of my PhD, her encouraging words, guidance, and unconditional love for me while she was alive made a lasting and significant impact on me and fueled my passion to rise to higher heights. I will always miss her and will continue to make her proud.

Acknowledgments

My dissertation would not be complete today were it not for the support and guidance of many wonderful people, for whom I would like to express my profound gratitude and appreciation.

First and foremost, I would like to thank my committee chair, Dr. Christopher Miller, for all of his insight, guidance, and support throughout my study. Thank you, Dr. Miller. Your leadership pushed me to pay attention to details, a skill that has made me a better problem solver. I will forever be grateful for your patience and faith in me even when I was having a difficult time with my research. I value all of the opportunities you have given me, both in my research and outside of that, as well as the relationship we have developed. Indeed, it was a pleasure to work with you.

I would also like to express my appreciation and gratitude to my committee member, Dr. Kimberly Dixon-Lawson. Thank you for your support and advice through the years. Your quick responses to my questions and detailed review of my research study were greatly appreciated.

I would also like to extend my deepest gratitude to Apostle Dr. and Rev. Mrs. Ahia-Armah, senior pastors of Kingslight Chapel International, for your continuous prayers and support. I would also like to acknowledge my friends who have helped and supported me throughout my dissertation. Dr. Sheilla Amedeka—thank you for being a great friend, confidant, and so much more. I will always appreciate all our talks about research.

Dr. Chibunna Emmanuel Nwaobia, thank you for your brotherly love and your continuous support. I recall our midnight phone calls and sharing of ideas and strategies to get the research going. You are more than a brother, and I am sincerely grateful for our friendship.

Finally, I would not have been able to complete my dissertation if it was not for the love and support of my family. I am forever grateful to my lovely wife, Naa Kordee Jacobs-Abbey—you have always been there for me, and if it was not for your continued love and support, I would not have been able to finish my degree, let alone start it. You have taught me how to be strong in all circumstances and to successfully maneuver any obstacles that come my way. I cannot tell you how much I appreciate all you have done for me and how much you have helped me during my graduate studies. I hope one day I can repay you for all you have done, and I love you.

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Chapter 1: Introduction to the Study

Introduction

Greater understanding of physicians' perceptions of their influence on healthcare accessibility may inform efforts to improve health care policy and patient access. In this qualitative study, I investigated these perceptions using a sample of physicians in family practice and internal medicine who served patients in urban, suburban, and rural areas. This research is important because access to healthcare directly impacts the quality of life of American citizens. Researchers have indicated that rural communities are at high risk of poor healthcare provision, but there is a significant gap in the literature pertaining to perceptions of physicians on how and why current levels of accessibility exist.

Access to healthcare is critical for all American citizens, as well as for legal immigrants who move to the United States (Essounga-Njan, 2015). Citizens who are from rural areas or lower socioeconomic demographics in urban environments are at risk of untreated illness, preventable hospitalizations, lack of preventative care, and delayed care, if they are able to receive any care at all, despite a wealth of legal stipulations and laws that are supposed to prevent obstacles to health care access (Garfield et al., 2016). The perceptions of physicians concerning problems of health care access represent a gap in literature. This study, in addressing this gap, may allow for a fuller understanding of how and why current levels of accessibility exist, as well as potential barriers to access (as perceived by physicians) and the lived experience of physicians related to accessibility of healthcare.

In Chapter 1, I introduce the research topic by discussing the study's (a) background, (b) problem, (c) purpose, (d) research questions, (e) theoretical framework, (f) nature, (g) definitions, (h) assumptions, (i) scope and delimitations, (j) limitations, and (k) significance. The chapter closes with a summary. In the second chapter of the dissertation, I present a strategic review of recently published literature.

Background

In recently published research, there has been an emphasis on the correlation between access to healthcare services and individual quality of life, and on practitioner-influenced factors that strongly impact access to healthcare. However, there exists a gap in the literature pertaining to physicians' perceptions of their influence on access to healthcare in the United States. This study was developed in order to fill this gap in understanding.

One example of recently published research on factors affecting healthcare access was written by Douthit et al. (2015), who conducted a literature review of prior researchers' efforts to ascertain whether there were specific factors affecting healthcare accessibility in urban and rural areas. They concluded that significant disparity exists between the comparatively high accessibility of healthcare in urban areas and the comparatively low accessibility of healthcare in rural areas (Douthit et al., 2015). One of their findings pertaining to the present study was that the perpetuation of poor healthcare accessibility in rural areas has been influenced by difficulty in attracting and retaining competent healthcare practitioners. As a result, residents of communities in rural areas of

the United States are significantly more likely to experience poor health due to inadequate healthcare provision.

The strategic review of relevant literature conducted by Douthit et al. (2015) indicated that rural residents were often reluctant to seek healthcare out of cultural or financial concerns. Scarcity of services, physicians, and public transport seemed to play a secondary role, but the review did not indicate whether lack of healthcare providers in rural areas had a direct impact on quality of life, or why it is so difficult to hire and retain rural healthcare practitioners. However, Essounga-Njan (2015) also conducted a review of relevant literature and argued that there are additional reasons for lower healthcare accessibility in rural areas, potentially influencing the pull factors for healthcare practitioners. Those reasons are (a) poverty, (b) lack of focus on primary care and public health, and (c) lack of universal healthcare coverage. The final finding by Essounga-Njan is significant, as 19 U.S. states failed to adopt the Medicaid expansions provided by the Patient Protection and Affordable Care Act (ACA), suggesting that one of the major hindrances to rural healthcare provision is the failure of the states to provide for their citizens.

Garfield et al. (2016) conducted a study assessing the consequences of this decision by the 19 states that failed to expand Medicaid provisions. The results identified that those individuals who did not have access to healthcare were significantly more likely to have poorer health outcomes overall, as well as that financial burdens for economically disadvantaged people and families grew. Garfield et al.'s research is of import to this study because it sheds light on the lived experience of those individuals

whose lives are seriously and negatively impacted by the lack of healthcare providers in various parts of the United States. More than that, it suggests that there will be long-term impacts to rural communities suffering from untreated illnesses (Garfield et al., 2016). Similar findings were identified by Graves et al. (2016). As identified by Douthit et al. (2015), geographical disparities exist in healthcare provision across the United States. Graves et al. (2016) furthered this point by identifying that nurse practitioner laws also have an influence over the provision of healthcare services in rural areas. Graves et al. did not further their research, and so left a gap in understanding pertaining to whether healthcare practitioners feel that they are hindered in their practice within rural communities due to law or practical issues of distance. Research conducted by Renedo et al. (2015) suggested that healthcare access problems in rural areas are the fault of practitioners who fail to influence patient healthcare access and quality of life through multidisciplinary collaboration, but it is unknown as to whether this is what healthcare practitioners perceive to be the issue.

Either way, Rice et al. (2014) found that, despite the existence of the ACA, the United States had not made a single significant item of progress toward providing healthcare to all citizens. Many laws have dictated that the United States should be providing healthcare services to all citizens, but in practice, this is not the case (Rice et al., 2014). Furthermore, after the 2008 financial crisis, many citizens lost their healthcare coverage after losing their jobs. Many of these people subsequently either gained employment but not healthcare, or were able to obtain neither (Schaller & Stevens, 2015). Furthermore, the issues being experienced in rural communities are just as prevalent for

lower socioeconomic demographic groups living in urban environments (Rice et al., 2014). In the following section, I continue this discussion by synthesizing the literature into a problem statement.

Problem Statement

Access to healthcare is a core factor that influences individual and societal quality of life (Essounga–Njan, 2015). Access to healthcare is critical to achieving or maintaining standard measures of good health. In this context, the term *access* encompasses the availability of healthcare services, in a timely manner, so as to achieve optimal health outcomes for each individual patient (Institute of Medicine, 1993; Renedo et al., 2015). The ACA was enacted in 2010 to improve the delivery of quality healthcare services and to make healthcare more accessible across the United States (Obama, 2016). However, factors such as poverty, lack of focus on primary care and public health, and lack of universal health coverage still prevent many U.S. citizens from accessing healthcare services (Essounga–Njan, 2015). U.S. citizens of low socioeconomic status may be unable to obtain affordable health insurance, such that the costs of accessing healthcare may be prohibitive (Garfield et al., 2016). Low healthcare accessibility is associated with untreated illness, preventable hospitalizations, lack of access to preventative care, and delayed care, all of which are associated with increased financial burdens to the individual, future healthcare services, and the U.S. economy through loss of able workers and productivity (Agency for Healthcare Research and Quality [AHRQ], 2016).

A study conducted by Rice et al. (2014) 4 years after the ACA was signed into law indicated that the United States is among the top countries that have failed to enact any significant improvements in healthcare access for lower socioeconomic groups, as well as for residents of rural communities and urban residents living below the poverty line. Given the negative impact of low healthcare accessibility on individual quality of life, particularly for citizens of low socioeconomic status (Douthit et al., 2015), significant research is needed to explore the factors that improve or reduce access to healthcare in the United States. Previous researchers have found that all healthcare practitioners (e.g., nurses, social workers, psychologists, and/or medical doctors) may improve access to healthcare by choosing to move their work to underserved rural areas (Graves et al., 2016). Practitioners may also increase accessibility by identifying and treating people who have risk factors for chronic or other illnesses, but no current symptoms, and by encouraging patients to accept preventative care such as vaccinations and healthier lifestyle choices (U.S. Department of Health and Human Services [USDHHS], 2014). Additionally, practitioners may increase healthcare accessibility by increasing the likelihood that patients will receive appropriate care (AHRQ, 2016). However, no studies were found in which researchers specifically explored physicians' perceptions of their influence on healthcare access for patients in the United States. The problem being addressed in this research is that, without data regarding physicians' perceptions of their influence on healthcare access, appropriate education and practical action cannot be taken to expand healthcare services to those U.S. citizens who are currently underserved.

Purpose of the Study

The purpose of this study is to explore the perceptions of physicians in regard to their influence over healthcare accessibility. Throughout the development of this research study, and after completing the review of recently published research in the second chapter of this study, no single study was found in which researchers specifically explored physicians' perceptions of their influence on healthcare access for patients in the United States; thus, there was a significant gap in the study and understanding of this problem. To address this gap, a qualitative, a phenomenological approach was used to ascertain the perceptions of physicians in relation to their influence over healthcare accessibility. Online questionnaires were administered to physicians in the Sentara Medical Group, headquartered in Norfolk, Virginia. The group was composed of partnerships and physicians in private practice currently in contract with the Sentara chain and its hospitals. It was hoped that the wealth of medical centers in the region would allow for the anonymity of respondents to this study, while also allowing for a large pool of possible participants to source from. However, to be more specific about participant sourcing, it should be noted that only doctors who had practiced in the United States were sourced for the research. This is because physicians who practice in the United States, particularly in internal medicine, are trained to deal with patients of all ages. The purpose of the questionnaire was to gain new insight into best practices for physician contributions to healthcare accessibility for patients.

Research Question

The research question was as follows: How do physicians perceive themselves as influencing patients' access to healthcare?

Theoretical Framework

The theoretical framework that guided this study was Penchansky and Thomas's (1981) model of healthcare access. Penchansky and Thomas identified five factors, termed *dimensions*, that influence access to healthcare for all patients in the United States. Patients are dependent on each factor in order to have access to quality healthcare. The first of these dimensions, related to healthcare accessibility, is the availability of healthcare resources, which include, but are not limited to, personnel, facilities, and technology, as well as factors affecting the availability of these resources, such as wait times. The second dimension is availability as a geographic and spatial consideration, including the proximity or remoteness of the needed resources, such as hospitals, urgent care facilities, healthcare practitioners, and emergency services. The third dimension is accommodation. As a dimension, accommodation is the consideration of the coordination and integration of services that are available, and their perceived quality by patients. Affordability is the fourth dimension; the theme of affordability is described as the consideration of both direct and indirect costs of healthcare. The fifth dimension, acceptability, is used to account for patient and provider characteristics, including preferences and attitudes toward one another. More recently, Saurman (2016) proposed a sixth dimension, awareness, including awareness of evidence for treatment and practice guidelines.

Penchansky and Thomas (1981) developed a model of healthcare access because *access* had not previously been defined in the healthcare literature and presented a limitation for study and action in healthcare. Penchansky and Thomas described their intention in their work, as developing a taxonomic classification of factors affecting access, with the five dimensions (and Saurman's sixth dimension, awareness) composing the second level of classification, and with each dimension being further subdivided into its constituent elements (e.g., direct costs and indirect costs under affordability). Penchansky and Thomas's model, with Saurman's (2016) addition, made it possible to relate physicians' perceptions of their influence on healthcare access for patients to the existing body of research and theory on healthcare access.

Nature of the Study

A qualitative design was used to explore and better understand physicians' perceptions of their influence on patients' access to healthcare. In quantitative research, the participants' ability to express themselves is limited to the survey response options, which are determined according to existing theory and knowledge and thus do not gather data on the *how* and *why* of a phenomenon (Silverman, 2016). As the purpose of this research was to better understand the perceptions of healthcare practitioners in regard to healthcare accessibility, a quantitative research methodology limited the scope of the questions, query, and therefore understanding of said perceptions.

In qualitative research, the data drives the findings, and participants are able to express themselves beyond the confines of existing theory and knowledge (Silverman, 2016). Thus, while quantitative research allows relationships among causes and effects

to be generalized from large samples (McMillan & Schumacher, 2014), qualitative research allows for in-depth exploration of phenomena that have not been explored sufficiently for possible outcomes to be defined in terms of a limited number of categories (Silverman, 2016; Taylor et al., 2015). Qualitative methods were appropriate for this study because previous researchers had not explored practitioners' perceptions and experiences of the phenomena of interest, such that detecting trends in practitioners' thoughts and experiences might make it possible to contribute to existing knowledge and extract actionable data to address the problem.

A phenomenological approach was used to explore physicians' perceptions of the phenomena of interest, in order to gain a better understanding of whether and how physicians perceived themselves as influencing healthcare accessibility. The goal of phenomenological research is to understand the essence of a phenomenon as it is subjectively perceived by a small number of individuals who have direct experience of it (Moustakas, 1994). Thus, participants' reports of their perceptions and experiences are the data for a phenomenological study and are used by the researcher as a basis for understanding the phenomena of interest (Moustakas, 1994). A phenomenological approach was appropriate for the study because the purpose was to better understand healthcare practitioners' perceptions of their influence on healthcare accessibility for patients.

In order to appropriately gather data, online questionnaires administered through the SurveyMonkey application was administered to doctors who had practiced in internal medicine. This group was of interest because physicians who practice in internal

medicine are trained to deal with patients of all ages. Eastern Virginia Medical School shares a campus with Sentara Norfolk General Hospital, which, along with Sentara hospitals in nearby Virginia Beach, serves suburban and rural populations that include diverse demographic groups. The questionnaire consisted of a series of open-ended questions to allow for exploration of each answer. The questionnaire items were written in such a way as to elicit physicians' perceptions of their influence on healthcare access factors, based on data that previous researchers had identified as physician influenced, which are discussed further in the second chapter of this study. These factors included (a) choosing to work in underserved rural areas, (b) identifying and treating people who have risk factors but no current symptoms, (c) encouraging patients to accept preventative care such as vaccinations, and (d) increasing the likelihood that patients will receive appropriate care (AHRQ, 2016; Graves et al., 2016; USDHHS, 2014). Additional items in the questionnaire were also designed to elicit participant perceptions, but of other means by which participants may have influenced patients' healthcare access. This also presented an opportunity to identify physician influences on healthcare access that may not have been examined by previous researchers.

Definitions

Patient Protection and Affordable Care Act (ACA): Also known as *Obamacare*, this federal statute was signed into law by President Barack Obama, the 111th President of the United States, in 2010. The act provided a wealth of rights and protections that made accessing healthcare coverage a fair and easy process for patients (Obama, 2016).

Dimensions: Term developed by Penchansky and Thomas (1981) to define various factors that combine to create a model of healthcare access. Saurman (2016) added a sixth dimension to this model, which was awareness. With Saurman's addition, the six dimensions of the model of healthcare are (a) availability of resources, (b) availability as a geographic location, (c) accommodation, (d) costs, (e) acceptability, and (g) awareness.

Healthcare resources: Refers to the various elements that make up some of the dimensions of the model of healthcare access; these include, but are not limited to, personnel, facilities, technology, factors affecting the availability of these resources, including geographic location, and associated costs (Penchansky & Thomas, 1981).

Physician: A person qualified to practice medicine and administer medicine to patients in the United States (Institute of Medicine, 1993).

Quality of life: A standard of health, happiness, and comfort experienced by an individual (Institute of Medicine, 1993); in the case of this research, the quality of life of those patients and citizens living in underserved communities with limitations placed on their access to healthcare.

Assumptions

It was assumed that the physicians participating in the research were aware of the strong correlations between obstacles to accessing adequate healthcare and quality of life, as the core purpose of their profession was to treat their patients in order to improve their patients' lives. It was also assumed that the participants were aware of particular factors associated with this field of research, such as preventative care, serving underserved rural

areas, identifying risk factors in patients, and other means of increasing appropriate care provisions, or would at least have an opinion on these topics. It was also assumed that the participants would answer the questionnaire items in an honest manner.

Scope and Delimitations

Within the scope of this research, the chosen methodological design was deemed appropriate, in that questionnaires allow for depth of investigation beyond that involved in quantitative data collection. Three questionnaire items presented to the physician participants were open ended and asked the participants to describe specific factors that they felt were associated with limitations of healthcare provision, quality of life for patients, their own lived experiences as healthcare providers, and what, obstacles if any, they felt existed that had not been discussed in previously published literature on this subject. The participants were also asked to discuss their personal feelings regarding all of the factors listed above, as well as any others that they brought to the attention of the study. No single demographic of patient or physician was left out of the research.

Various other forms of research were considered for this study. For instance, the option of conducting a comparative study of the perceptions of patients and physicians, was considered but subsequently rejected this option because the perceptions of patients who lacked access to healthcare would have been significantly more biased than those of physicians. In qualitative research, the data drive the findings, and participants need to feel able to express themselves beyond their professional knowledge and practice by discussing their personal feelings on a particular subject (Silverman, 2016), so any form of research that might hinder this process was rejected.

In order to mitigate any limitations that might hinder the reliability of the data being collected, the following protocol was adopted: (a) no generalizations can be made from the findings of this research, but the findings do shed significant light on the complex nature of the public health problem (i.e., lack of access to healthcare), and (b) though the research cannot be repeated exactly, the general design of the research can be repeated in smaller contexts to shed light on localized problems with access to healthcare for citizens in the immediate geographic area. Following this, in order to mitigate sources of bias, this research has adopted various guidelines from the Belmont Report to remove all potential signifiers of participants' identities. The purpose of this was to protect the reputations of the participating physicians, as well as to ensure that they knew and felt that they could talk openly and honestly without professional or personal repercussions (Department of Health, 2014). Finally, as more than one physician completed the online questionnaire for this research, the design of the analysis procedure ensured that any anomalies in responses would be noted but that the actual research findings would be taken from repeated themes in the responses.

Limitations

The most significant limitation of this study was that the qualitative design cannot be exactly replicated by researchers in other geographic areas of the United States or the world. When qualitative research takes place in a natural setting, with a semistructured approach to data collection that affords participants freedom in how they answer questions, exact replication is almost impossible (Bloomberg & Volpe, 2018). Another potential limitation of the research was that the physicians' perceptions of their influence

on access to healthcare might have been biased, in that they might have felt attacked, given that the purpose of the research was to explore their perceptions of their influence on a significant social and public health problem.

Significance

Previous researchers have found that healthcare practitioners may have an impact on healthcare accessibility for patients (e.g., AHRQ, 2016; Graves et al., 2016), and that improved accessibility positively affects patients' quality of life (AHRQ, 2016; Douthit et al., 2015). However, no qualitative studies have specifically explored physicians' perceptions of their influence on healthcare accessibility for patients. Physicians' perceptions may influence healthcare accessibility and patient quality of life, so this qualitative exploration of physicians' perceptions may contribute to a better understanding of a potentially significant factor in the delivery of high-quality healthcare.

This better understanding may be used to guide the development of informational and awareness-raising materials for physicians to maximize healthcare accessibility for patients, while also contributing to and expanding the scope of Penchansky and Thomas's (1981) model of healthcare access for future researchers. Additionally, the results of the study indicate physician contributions to healthcare accessibility that have not been explored by previous researchers, and therefore present actionable information for healthcare services. Raising awareness and informing physicians about ways in which they can influence healthcare accessibility may result in improvements in healthcare accessibility for patients across the United States.

Summary

Access to healthcare has a direct impact on the quality of life of American citizens (Essounga–Njan, 2015). There continue to be limitations in access to healthcare for citizens across the United States in both rural and urban communities, despite the existence of federal laws that stipulate practices to advance access to healthcare for these populations (Renedo et al., 2015). Many researchers have explored limitations in access to healthcare, but no single study has explored the perceptions of physicians concerning their influence on expanding healthcare provision. It is hoped that this research will shed light on potentially new dimensions that impact access to healthcare. Chapter 2 continues with an exploration of previously published research pertaining to the problem and purpose of this research.

Chapter 2: Literature Review

Introduction

In an ongoing international review of healthcare access and obstacles, Davis, Stremikis, Squires, and Schoen (2014) used a comparative analysis to show how, despite having the most expensive health care system in the world, the United States consistently underperforms relative to other countries on most dimensions of performance. The United States ranks last among the 11 nations studied in the report, which incorporated patients' and physicians' survey results on care experiences and ratings on various dimensions of care. The study also indicated how the United States ranks behind most countries on multiple measures of health outcomes, quality, and efficiency. The USDHHS (2014) acknowledged that although the ACA had enabled 20 million adults to obtain health insurance, millions still had no coverage. Additionally, data from the *Healthy People Midcourse Review* (USDHHS, 2014) indicated significant disparities in access to care by sex, age, race, ethnicity, education, family income, and geographic location. Americans living in rural areas frequently lack access to primary care services due to workforce shortages (USDHHS, 2014). In order to address these issues, the USDHHS encouraged researchers to focus on efforts to deploy a primary care workforce with a more equitable geographic distribution that was trained to provide culturally sensitive care to diverse clients.

Previous researchers have found that healthcare practitioners (e.g., nurses, social workers, psychologists, and medical doctors) have improved access to healthcare in various ways: through working in underserved rural areas, by identifying and treating

people who have risk factors but no current symptoms, by encouraging patients to accept preventative care, and by increasing the likelihood that patients will receive appropriate care (AHRQ, 2016; Graves et al., 2016; USDHHS, 2014). Because of their ability to impact access to healthcare in these ways, an investigation into physicians' perceptions of their influence on healthcare access for patients is needed to provide details on how high-quality healthcare can be delivered to all citizens regardless of geographic location. Thus, the purpose of this study was to gain increased understanding of physicians' perceptions of their influence on patients' access to healthcare.

The search strategy section of this chapter includes a description of the literature search methods used to find the literature and research treated in subsequent sections. The theoretical foundation section includes a discussion of the dimensions of the model of healthcare access proposed by Penchansky and Thomas (1981): availability of healthcare resources, availability as a geographic consideration, accommodation, affordability, and acceptability, as well as Saurman's (2016) sixth dimension of awareness.

The literature review section includes descriptions of the ways in which healthcare access and barriers to care have been approached in recent studies, analysis of the relevance and weaknesses of these approaches, and discussion of their applicability to the present study via the selected theoretical framework for the study. Finally, the summary and conclusions section include a synthesis of these findings into an overview of the state of research in this area, and discussion of the research gap that the present study addressed.

Search Strategy

The search strategy for this literature review began with specific attention to Penchansky and Thomas (1981) model of healthcare access. Iterative searches were conducted within Google Scholar, Academic Search Premier (EBSCOhost), ProQuest, Emerald Insight, JSTOR, and Science Direct databases to retrieve articles containing key search terms and combinations of key terms. These key terms included *Affordable Care Act*, *model of healthcare access*, *healthcare coverage and quality of life*, *access to health services*, *measuring healthcare access*, *practitioner impact on care access*, *practitioner impact on quality of life*, *barriers to healthcare access*, *improving healthcare access*, *accessing care in rural versus urban areas*, *coverage gaps*, *physician recruitment and retention*, *healthcare resources*, *accommodation*, *acceptability (patient and practitioner preferences and attitude)*, *coordination and integration of services*, *direct and indirect costs of healthcare*, *awareness of evidence for treatment*, and *practice guidelines*.

The keywords and combinations of keywords listed above were entered into each of the listed databases and search engines within each of the following disciplines: social work, psychology, various medical practitioner areas, and nursing. Reference pages for relevant articles were searched for additional relevant sources, which were then located by searching in the aforementioned databases and search engines. For this review, five book chapters and 93 journal articles were read in full text. A total of two book chapters and 69 journal articles were included, with 86.7% of the source material published in the last 5 years.

Conceptual Framework

As discussed in Chapter 1, the conceptual framework for this study was Penchansky and Thomas's (1981) model of healthcare access. The six dimensions of healthcare access include: (a) the availability of healthcare resources, (b) availability as a geographic consideration, (c) accommodation, (d) affordability, (e) acceptability, and (f) Saurman's (2016) sixth dimension, awareness. The appropriateness of this paradigm stemmed from the way it facilitated the connection between physicians' perceptions of their influence on healthcare access to the existing body of research and theory on healthcare access.

Acting on their observation that the term *access* was much used but underdefined, Penchansky and Thomas (1981) proposed a taxonomic definition of *access* in their seminal article "The Concept of Access: Definition and Relationship to Consumer Satisfaction." To generate their model of access and its five original dimensions, Penchansky and Thomas analyzed interview data on patient satisfaction. They presented the concept of access as a general concept composed of five distinct areas that collectively indicated fit between patients and healthcare providers.

In 2002, Wyszewianski revisited the model to review the enduring relevance of the original dimensions and to highlight the ongoing challenges for researchers using the model. According to Wyszewianski, the first challenge is to recognize the interdependence between the different dimensions of access, and the second is to locate appropriate measures of the different dimensions. A great deal of literature has been focused on the dimension of affordability and health insurance, but Wyszewianski argued

that the other nonfinancial aspects of access should not be dismissed. Of the Penchansky and Thomas dimensions detailed in chapter 1, Wyszewianski provided additional context to aid in the understanding of accommodation and acceptability.

As part of the coordination and integration of services, accommodation has also been called *adequacy* (Saurman, 2016) and has been considered to include the ways in which providers organize their practice/facility to meet client constraints and preferences (Wyszewianski, 2002). Included within this dimension are issues such as hours of operation, how telephone communications are handled, and the client's ability to receive care without prior appointments. Likewise, the dimension of acceptability was elaborated beyond patient and provider characteristics to include the extent to which a client is comfortable with provider characteristics such as age, sex, social class, and ethnicity, as well as the diagnosis and type of coverage used by the client. Wyszewianski (2002) further noted that the dimension of acceptability was frequently neglected, and that the importance of the interdependent nature of the dimensions could not be overstated. Efforts toward improving access overall may be hindered when one or more dimensions is ignored.

An important addition to the healthcare access model came from Saurman (2016), who argued that a sixth dimension, awareness, is integral to access and should be applied by scholars using the theory to develop, implement, or evaluate healthcare services and access. Saurman categorized awareness as involving communication and information; facilities or practitioners maintain awareness through effective communication and

information-dissemination strategies with practitioners, patients, and the community, with consideration of cultural contexts and the recipient's knowledge of healthcare.

When taken together, the six dimensions of Penchansky and Thomas's (1981) model of healthcare access were useful in this study because they indicated clear, delineated factors affecting access that could be used in reviewing previous literature. Further, the framework could also serve as a basis for developing an online questionnaire to question physicians about their perceptions of their influence on patient access to healthcare, and for interpreting the resulting data in relation to previous theory and research.

Review of the Literature

As a starting point, it is useful to consider the concept of quality of life, specifically with regard to how previous researchers have defined it in relation to the six dimensions of healthcare access. When quality of life is considered in the context of health and disease, it is commonly referred to as *health-related quality of life* (HRQoL) to differentiate it from other aspects of quality of life (Karimi & Brazier, 2016). Traditionally, life expectancy and causes of death have been used as key indicators of population health (USDHHS, 2010; Davis, Stremikis, Squires, & Schoen, 2014). As life expectancy has increased globally, the USDHHS Healthy People Foundation has joined the World Health Organization (2015) in arguing for the importance of evaluating and improving people's quality of life beyond those key indicators. The rationale for assessing quality of life in relation to additional indicators is that the traditional measures

of health status included no information about the quality of the physical, mental, and social domains of life (USDHHS, 2010).

The Office of Disease Prevention and Health Promotion (ODPHP, 2018) defined HRQoL as a "multi-dimensional concept that includes domains related to physical, mental, emotional, and social functioning. It goes beyond direct measures of population health, life expectancy, and causes of death, and focuses on the impact health status has on quality of life" (p. 1). Health officials and medical practitioners use HRQoL and well-being to measure the effects of chronic illness, treatments, and short- and long-term disabilities. The ODPHP noted that there are several existing measures of HRQoL, although methodological development in relation to HRQoL and well-being is ongoing (ODPHP, 2018).

HRQoL is directly tied to the issue of access to health care, as one's health status has a major impact on quality of life (Essounga–Njan, 2015; Ju et al., 2017). In an overview on access to health services, the USDHHS (2014) defined access to health services as

> the timely use of personal health services to achieve the best health outcomes. It requires 3 distinct steps: gaining entry into the healthcare system (usually through insurance coverage), accessing a location where needed health care services are provided (geographic availability), finding a health care provider whom the patient trusts and can communicate with (personal relationship). (p. 1).

Similarly, the 2015 National Healthcare Quality and Disparities Report by the AHRQ (2018) included having health insurance, having a usual source of care,

encountering difficulties when seeking care, and receiving care as soon as wanted as measures of access to care. When compared to the HRQoL definition and to the dimensions of access detailed by Saurman (2016) and Penchansky and Thomas (1981), the focus of these governmental agencies may be seen to have omitted one or more dimensions. The DHHS listed coverage, services, and timeliness as the three components of access to health services, and this three-factor model was endorsed by the AHRQ (2018) report. These three components corresponded roughly to Penchansky and Thomas dimensions of affordability, accessibility, and availability, respectively.

Obama (2016) claimed that the ACA was "the most important healthcare legislation enacted in the United States since the creation of Medicare and Medicaid in 1965." The ACA has made significant impact on longstanding challenges to improving the accessibility, affordability, and quality of health care. In relation to insurance coverage, the uninsured rate has declined overall by 43% since the ACA was signed into law. This decrease was confirmed by Uberoi, Finegold, and Gee (2016), and by the AHRQ (2018). In the Office of the Assistant Secretary for Planning and Evaluation (ASPE) Issue Brief on Health Insurance Coverage and the Affordable Care Act, Uberoi et al. reviewed the most recent survey and administrative information about gains in health insurance coverage since the ACA's 2010 enactment. The authors drew from data from the National Health Interview Survey and the Gallup-Healthways Well-Being Index. Between 2015 and 2016, the data indicated an increase of 2.4 million newly insured adults, with the coverage gains shared across population groups. The research findings in Obama's 2016 article documented improvements in access achieved by reducing the

number of nonelderly adults unable to afford healthcare, reducing the amount of debt from medical bills, and reducing the number of nonelderly adults reporting only fair or poor health. Despite these gains, Obama acknowledged that there was still work to be done in continuing to improve accessibility, affordability, and quality of healthcare in the United States.

Availability

The dimension of availability includes the presence of properly trained medical personnel, facilities with appropriate technological capabilities, and consideration of how long patients must wait before receiving care (Penchansky & Thomas, 1981). Primary care providers (PCPs), clinical preventive services, and emergency medical services (EMS) are all crucial links in the chain of care. According to the USDHHS (2014), outcomes of access to a usual and ongoing source of care (i.e., a provider or facility where one regularly receives care) include greater patient trust in the provider, better patient–provider communication, increased likelihood that patients will receive appropriate care, and lower mortality from all causes. The AHRQ (2018) has found a reduction in disparities in having a usual place to go for medical care, which is a measure of realized access. Along racial lines, increases in realized access were not found to be statistically significant for Whites from 2010 to 2015, but the percentage of people with a usual place to go for medical care increased overall for Blacks and Hispanics during those years.

In presenting an annual report from the Association of American Medical Colleges (AAMC), Dall, West, Chakrabarti, and Iacobucci (2018) stated the purposes of

updating and improving workforce projections, presenting new analyses, and identifying future directions for research. Overall, the researchers sought to continue advancing a collective capacity for developing improved health workforce projections with data-driven analysis. This updated report included predictions of future physician supply derived from considering trends in determinants of physician supply, as well as the sensitivity of projections to these determinants. Among other things, the demand projections reflected the changing demographics of an aging population, as well as changes in health insurance coverage, the delivery of care by advanced practice registered nurses (APRNs) and physician assistants (PAs), and a growing emphasis on achieving population health goals and improving care access and delivery as ongoing trends in health care.

Key findings of Dall et al. (2018) included continued projection that physician demand will outpace supply, leading to a shortage in PCPs of between 14,800 and 49,300 by 2030, as well as a projected shortfall in non-primary-care specialties of between 33,800 and 72,700 physicians by 2030. From 2016 to 2030, the primary driver for the rising demand is expected to be the aging U.S. population, with those age 65 and older projected to increase by 50% (or 162-179 million). An additional trend driving the need for more physicians is the pursuit of population health goals (e.g., reducing excess body weight; improving control of blood pressure, cholesterol, and blood glucose levels; and reducing the prevalence of smoking). The researchers echoed previous research (e.g., Stapleton, Schröder-Bäck, Brand, & Townend, 2014) in supporting the view that the health of the nation would benefit from more equitable access to care. Interestingly, the

report included analyses of implications for physician demand if populations facing

higher barriers to accessing care (i.e., racial and ethnic minorities, the uninsured, and

those living outside metropolitan areas) had patterns of health care use similar to those of

a population with fewer barriers to access. The resulting estimates indicated the demand

for physicians shifting up by an additional 4% (31,600 physicians) if people living in

nonmetropolitan areas without medical insurance had care utilization patterns equivalent

to those of insured persons with similar demographics and risk factors who live in

metropolitan areas.

One of the trends that may have the greatest impact on supply and availability is

the rate of physician retirement (Kripalani, Theobald, Anctil, & Vasilevskis, 2014;

Zuckerman 2016). At present, more than a third of currently active physicians will be 65

or older within the next decade. Additionally, there has been a trend of reduction in

physicians' working hours; between 2002 and 2016, there was a trend toward physicians

of all ages working fewer hours, with the result of reducing the full-time physician

supply. This trend was generally seen as a positive one, however, because reducing work

hours also reduces physician burnout as well as the number of errors while providing

care, thus translating into lower care costs and higher care quality.

Timeliness

The USDHHS (2014) defined *timeliness* as the ability of the healthcare system to

quickly provide care after a need is recognized. The Institute of Medicine identified

timeliness of care as a key aspect of quality (Ray, Chari, Engberg, Bertolet, & Mehrotra,

2015). Aspects of timeliness include the availability of appointments and care for illness

or injury when it is needed, and time spent waiting in doctors' offices and emergency departments. Delay between the identification of a need and meeting the need through testing or treatment negatively impacts both an individual's health status and the cost of care. Delay in receiving care can impact patients' HRQoL via emotional distress, more complications, and more hospitalizations.

Ray et al. (2015) investigated disparities in time spent seeking medical care in the United States by assessing how time associated with medical visits varied across socioeconomic variables and visit characteristics. The dataset for this study was drawn from the American Time Use Survey data from 2005 to 2013 and the National Ambulatory Medical Care Survey, a nationally representative survey of office-based physician visits. For a large sample of patients reporting clinic time, Ray et al. estimated etime spent traveling for care as well as total time, or the sum of clinic time and travel time, and compared these estimates with face-to-face time with a physician. To estimate and adjust associations between total, clinic, travel, and face-to-face times and respondent or patient socioeconomic characteristics and visit characteristics, the researchers used linear regression. The presented results indicated disparities associated with race, education, and employment. Individuals with less education, racial/ethnic minorities, and unemployed individuals experienced significantly longer clinic time as well as longer travel time. Though the face-to-face time with providers did not vary across demographic groups, Ray et al. found that the total time burden was 25% to 28% longer for racial/ethnic minorities and unemployed individuals; this indicated that the time burden was spent in activities related to receiving care. The researchers concluded that the excess

time burden and associated costs are a deterrent to seeking care, especially for populations already experiencing racial and financial barriers.

Collins, Suskin, Aggarwal, and Grace (2015) also examined wait times and their relation to outcomes for cardiac rehabilitation patients. The aim of the study was to review the effects of early Cardiac Rehabilitation (CR) and to describe the wait time frame associated with positive outcomes. The researchers reviewed existing literature on CR wait times from 2002 to 2013 and synthesized the results narratively. The results indicated that early access was safe and had positive effects on cardiac function. The window for obtaining the most positive effects on functioning was to receive treatment within the first three months of the cardiac event. The overall wait times ranged from 8.5 days to 127 days, with Collins et al. confirming seventeen days as the optimal wait time in balancing risk and benefits.

Technology

Issues of timeliness were also considered in Comino's (2017) review of literature on primary care best practices. In his analysis of the Australian healthcare system, Comino covered five factors associated with best practices. The factors discussed, which fit into the dimension of availability, included: organizational factors (appointment system, recall/reminder systems and information management, type of care organization, practice work-/caseload, and practice size), and workforce factors (technical skills, practice, knowledge, teamwork/ skill mix, geographical distribution of workforce, and, workforce shortage). In his review of intervention studies to improve access related to

these organizational factors, Comino divided the results into three areas: reorganization of practice, systems to support practice, and, external supports for practice.

The strategies used to reorganize practice and systems for supporting practice (Comino, 2017) are the most useful for the present study regarding ways providers and their organizations may be able to positively influence patient access to care. Under reorganizing practice, eight strategies were listed, including: group visits, disease specific clinics, multidisciplinary teams, changing appointment systems, telephone triage by GP, after hours GP clinic and services, enhanced staff roles, and telephone consultations for follow up. Under systems to support practice, six strategies were listed, including: call/recall system, patient and provider reminders, a computerized monitoring system, a patient register, and decision support (e.g. flow charts). The implementation level for the majority of these strategies is that of the practice or PHC organization. Results on the effectiveness of these strategies indicated that most interventions included a single strategy, and that multi-strategy interventions tended to have more positive results. Finally, 77% of studies employing service organization strategies reported enhanced access. Thus, specific and effective strategies for practice organization were found to exist, with the employment of multiple strategies being associated with enhanced effectiveness.

Many of Comino's (2017) recommendations for updating primary care best practices included the use of technology to facilitate access and communication between patients and providers. In its description of Meaningful Use, the CDC (2017) referred to the Health Information Technology for Economic and Clinical Health (HITECH) Act and

presented the use of interoperable electronic health records throughout the United States

health care delivery system as a critical national goal. *Meaningful Use* was defined as the

use of certified EHR (Electronic Health Record) technology in a meaningful manner (e.g.

for electronic prescribing) to ensure that it facilitates the electronic exchange of health

information to improve healthcare quality. The CDC description of meaningful use was

based on five priorities: (1) Improving quality, safety, and efficiency, and reducing health

disparities, (2) Engaging patients and families in their health, (3) Improving care

coordination, (4) Improving population and public health, and (5) Ensuring adequate

privacy and security protection for personal health information (p.1). The implementation

of meaningful use has occurred in three stages: from 2010 to 2011, from 2012 to 2014,

and, 2015 to 2017. Each stage set specific requirements for the use of technology by

providers and health facilities in order to qualify for EHR Medicaid/Medicare incentive

payments.

Jones, Rudin, Perry, and Shekelle (2014) joined Rudin, Motala, Goldzweig, and

Shekelle (2014) in systematically reviewing Health Information Technology (IT) use and

associated impacts on care. Through a review of literature, Jones et al. (2014)

investigated the significant increase in the use of IT spurred by governmental incentives

since 2010. Over 200 studies that related the use of health IT to quality, safety, or

efficiency were included in the review. According to Jones et al., nearly 60% of the

studies evaluated clinical decision support and computerized provider order entry. The

researchers noted, however, that other relevant meaningful use aspects were rarely

evaluated. The results of using health IT had uniformly positive results in 56% of the

studies considered, and an additional 21% reported mixed-positive results. The researchers noted that details on implementation and context were poorly conveyed, such that their ability to determine why IT implementations were successful or not was limited. The authors concluded with a call for increased reporting of implementation effects and context.

In their separate review of health IT, Rudin et al. (2014) specifically examined evidence of the use and effect of Health Information Exchange (HIE) on clinical care. The data synthesis of twelve related studies indicated that HIE reduced use and costs in emergency departments. However, the researchers noted that HIE was only used in 10% of patient encounters. Findings drawn from other studies on attitudes toward HIE use and barriers indicated that patients, providers, and other stakeholders in health care see value in the use of HIE, but that its use is impeded by technical and workflow issues, costs of the technology, and concerns with the privacy of patient data (see also Dzau, McClellan, McGinnis, & Finkelman, 2017; Wager, Lee, & Glaser, 2017).

Accessibility

While availability includes consideration of specific healthcare resources like personnel, facilities, technology, and wait times, accessibility indicates the geographical proximity or remoteness of the needed resources (Penchansky & Thomas, 1981). Douthit, Kiv, Dwolatzky, and Biswas' (2015) review of research published before and after the passage of the ACA indicated a contrasting picture of access. In their examination of barriers to access for rural residents in the United States, the researchers found significant disparities in healthcare access for rural and urban residents. The findings indicated a

reluctance to seek healthcare among rural populations, based on financial and cultural constraints. Added to those constraints were a scarcity of services, a lack of trained physicians, insufficient public transport, and poor availability of broadband internet services. As a result, rural residents were found to have lower levels of health. From a provider perspective, rural areas were found to have difficulty in attracting and retaining a sufficient number of physicians to maintain an appropriate level of care.

Buerhaus, DesRoches, Dittus, and Donelan (2015), as well as the USDHHS (2014), indicated that improving healthcare access requires increasing access to and use of evidence-based preventative service, including preventative care, much of which may be provided by nurse practitioners. In their study on primary care nurse practitioners (PCNPs), Buerhaus et al. compared the practice characteristics of PCNPs with those of PCPs. The researchers mailed a survey to 72 clinicians (467 PCNPs and 505 PCPs). The participants were asked about compensation and billing practices; characteristics of patients treated; PCNPs' use of their own National Provider Identification number to bill services; how PCNPs spend their time; clinical and nonclinical activities performed; and whether PCNPs have privileges to admit and oversee the care provided to patients, as well as to write orders independently of physicians. The results indicated that PCNPs are more likely to practice in urban and rural areas than PCPs, as well as being more likely to provide care in a wide range of communities, and to treat Medicaid recipients and other vulnerable populations. Most PCNPs work with PCPs, and both groups tend to believe that increasing the supply of PCNPs will result in greater collaboration and team practice. Although PCNPs and PCPs deliver similar services and spend their time in nearly

identical ways, PCNPs work fewer hours and see fewer patients, and only a handful of PCNPs have their salary adjusted for productivity and quality performance. Government and local regulations were found to be impediments to the ability of PCNPs to admit and care for patients in hospitals and long-term care facilities, or to write treatment orders without a physician's signature. Buerhaus et al. concluded that increasing the number of PCNPs would expand access to primary care, particularly for vulnerable populations and for those gaining access to health insurance through the Affordable Care Act.

The regulations impeding a larger PCNP population from practicing are discussed in Graves, Mishra, Dittus, Parikh, Perloff, and Buerhaus (2016) examination of the role of geography on the primary care workforce. These researchers determined that more restrictive nurse practitioner scope-of-practice laws were associated with reduced access to primary care services. In their investigation, the researchers drew from the 2013 Area Health Resource File (AHRF) and U.S. Census Bureau county travel data. The measures used included determining the population percentage of low, medium, and high-accessibility areas, as well as the number of uninsured per PCP, the number of geographically accessible primary care physicians (PCPs), nurse practitioners (PCNPs), and physician assistants (PCPAs) per 100,000 population. The findings on geographic accessibility showed that rural areas had more accessible PCNPs or nonphysician clinicians, but findings also showed that rural areas had the largest number of uninsured per PCP in 2012. Restrictive scope-of-practice laws were also found to reduce the overall primary care workforce capacity.

In their 2014 study, Haggerty, Roberge, Lévesque, Gauthier, and Loignon explored differences between urban and rural healthcare-seeking trajectories and resulting implications for measures of accessibility. The researchers gathered primary interview data from 750 participants in urban, rural, and remote access areas. Then they conducted follow-up questioning through mailed questionnaires to 316 participants of the initial group. The aim was to develop a method to compare health service accessibility between urban and rural populations. Through the study the researchers sought to understand context-specific accessibility barriers and facilitators. The findings regarding accommodation and barriers for rural and urban participants were that rural care-seekers relied more on telephone access and experienced more organizational accommodation, but had fewer care options, while urban care-seekers cited the barrier of distance more frequently. Regarding the consequences of access difficulty, the researchers identified four that occur across different geographic settings and at almost every stage of care-seeking. The most frequent consequence was having to restart all or part of the process after encountering obstacles to care. The other, more significant, consequences included abandoning the care-seeking process, bypassing primary care through use of emergency room services, and aggravation of health problems as a result of delay in receiving care.

In a more recent article, Haggerty and Levesque (2017) used the qualitative data from the previously cited study to develop and validate a measure of organizational accessibility which reduced the differential impact of geography when considering consequences of difficult access for patient-initiated care. In the quantitative stage of this mixed methods study, the researchers applied statistical tests to the qualitative data.

Measures in the analysis included the development of items for healthcare barriers followed by common factor and confirmatory factor analysis to identify constructs and compare models. To test the urban-rural differential they used item response theory analysis. This theory was also used to examine individual item performance; adjust response options and exclude redundant items. Lastly, the researchers used logistic regression to examine predictive validity of the subscale on access difficulty/outcome.

Results indicated both geographical and organizational issues as well as consequences tied to difficulty of access. Further testing and results led to the development of a 6-item subscale of "Effective Availability and Accommodation" (p. 322) which allowed for valid comparisons between urban and rural healthcare access. One of the most useful aspects of this study was the subscale developed for organizational accommodation. This subscale included likert-scale questions on ease of obtaining advice from the patient's closest clinic, ease of accessing a doctor via phone for medical advice, and the usual wait time to get an in-person appointment. The final item asked whether their clinic offers regular walk-in services, provides medical advice by telephone, offers a visit with another doctor, and offers to see clients between scheduled visits. For the validation scale sample, the median for these items was 3.5 on a 5.0 scale, which is equivalent to less than moderately easy. Both articles by Haggerty and Levesque (2014, 2017) are relevant to the proposed study for three reasons: it referenced the theoretical framework of Penchansky and Thomas (1981) as a key text in determining the definition of access; it included qualitative methods for initial data collection and analysis; and, the subscale on organizational accommodation provided valid areas on

which the present researcher can question the practices of the providers who complete the online questionnaire.

As multiple scholars in health research have noted (Amante, Hogan, Pagoto, English, & Lapane, 2015; Richard, Furler, Densley, Haggerty, Russell, Levesque, & Gunn, 2016; Vimalananda, Gupte, Seraj, Orlander, Berlowitz, Fincke, & Simon, 2015), the use of health Information Technology (IT) is proliferating due to financial incentives offered by the ACA and wide-ranging benefits for both patients and providers. Kontos, Blake, Chou, and Prestin (2014) highlighted the importance of assessing how eHealth technology has empowered patients, especially those in vulnerable populations. Kontos et al. drew data from National Cancer Institute's 2012 Health Information National Trends Survey (HINTS) and used multivariable logistic regression models on the data of nearly 4,000 participants to assess sociodemographic impacts on eHealth use among adult Internet users. The assessment included the sociodemographic factors of race/ethnicity, socioeconomic status (SES), age, and sex, and considered three health communication domains: health care, health information–seeking, and user-generated content/sharing. In the results Kontos et al. reported no evidence of a divide in use by race or ethnicity but significant differences in use by SES especially for health care or information seeking purposes. Lower levels of education were associated with less use of the internet to look for a health care provider, use email or the Internet to communicate with a doctor, track their personal health information online, use a website to help track diet, weight, and physical activity, or download health information to a mobile device. Consistent predictors of eHealth use were found in the female population for health care and user-

generated content/sharing domains; age was a key influence in using eHealth for health information–seeking. In their conclusion, Kontos et al. highlighted the gap for elderly males with lower SES and called for studies on health literacy and eHealth literacy and their influence on eHealth engagement across social groups. Furthermore, of relevance to this study, the researchers encouraged greater awareness among clinical care providers and public health communicators on the factors influencing the use of eHealth in order to better address communication inequalities and persistent disparities in health.

Accommodation

Accommodation includes the coordination and integration of services (Penchansky & Thomas, 1981). Among other dimensions of access, Davis, Stremikis, Squires, and Schoen (2014) compared how the U.S. healthcare system performs against 10 other nations on four indicators of quality, including: effective care, safe care, coordinated care, and patient-centered care. According to the survey data, the U.S. fares best on provision and receipt of preventive and patient-centered care. The researchers noted, however, that lower scores on safe and coordinated care pull the overall U.S. quality score down. Davis et al. noted that the U.S. ranks last on indicators of efficiency, with poor performance on measures of national health expenditures and administrative costs, as well as on measures of administrative hassles, avoidable emergency room use, and duplicative medical testing. U.S. physicians struggle to receive relevant clinical information from specialists and hospitals, complicating efforts to provide coordinated care. Milani and Lavie (2015) confirmed that the current delivery model in the U.S. healthcare system is not constructed to manage chronic disease while at the same time

promoting health IT as a means to increase efficacy and practitioners' ability to coordinate care. Specifically, the researchers advocated for greater use of health IT to combat chronic disease by both engaging chronic patients and facilitating team-based care. Davis et al. (2014) acknowledged significant strides made by the U.S. in adopting health information technology and undertaking payment and delivery system reforms, motivated by the passing of the ACA. They concluded that the continued adoption of health information technology should enhance the ability of U.S. physicians to identify, monitor, and coordinate care for their patients, particularly those with chronic conditions.

In their analysis of the opportunities and barriers in the use of mobile health technologies, Weinstein, Lopez, Joseph, Erps, Holcomb, Barker, and Krupinski (2014) also noted the spike in interest prompted by ACA incentives. The researchers noted multiple areas of telehealth technology, including night-time radiology coverage, urgent services (e.g. telestroke and teleburn services), mandated services (e.g. delivery of health care services to prison inmates), and video-enabled multisite group chart rounds (i.e., Extension for Community Healthcare Outcomes programs). Weinstein et al. discussed traditional barriers to the increased use of telehealth technology such as Medicare lagging behind Medicaid for reimbursement in some states, and continued issues with interstate medical licensure rules. They concluded that progress continues to be made in those areas and write optimistically regarding telemedicine as a disruptive innovation with the potential to change the face of healthcare delivery.

In their mixed-methods study, de Grood, Eso, and Santana (2015) assessed the perceptions of physicians regarding the newly developed electronic transfer of care (e-

TOC) communication tool in order to identify potential barriers and facilitating factors in its adoption. The researchers conducted the study in a tertiary care teaching center where both acute care physicians (AcPs) and community care physicians (CcPs) needed to communicate electronically regarding patients discharged from hospitals to the community. Data from surveys regarding the e-TOC tool were analyzed statistically and through thematic analysis. Both sets of physicians identified barriers in the adoption of the tool. The AcPs highlighted issues with timeliness, usability, and presentation, while the CcPs identified accessing the web-based TOC summaries as a barrier. The responses of the CcPs also showed that they thought the summaries were timely and the quality of information supported continuity of care. In their conclusion, de Grood et al. reported the overall reception toward the e-TOC communication tool was a positive one, and that the tool could be beneficial for other health research teams considering the implementation of e-health technologies into healthcare systems.

In her evaluation of a multi-location care coordination program in Georgia, Parker (2017) began with the statement that care coordination programs work to reduce the health insurance barrier for high-need patients. The program analyzed was the Sams Care Coordination Program, which connects charity clinics to local hospitals. This allows the clinic to expand their capacity through the use of licensed medical social workers for intensive case management, enhancing communication through the use of the Epic electronic medical records (EMR) system, and stabilizing staffing. Parker conducted a cost-avoidance and hospital utilization analysis in evaluating the program. The results of the cost avoidance analysis showed that the hospital saved over $1.5 million in direct and

assumed costs for the two-year period analyzed. The hospital utilization portion of the study showed that emergency department visits were reduced by nearly 2,000 each year. In her conclusion, Parker cited the sustainment of funding as the largest barrier in continuing the program, with the hopes of future funding dependent on the healthcare system or local hospitals. In her recommendations for future research Parker suggested that improvements in chronic disease management and overall health reported by clinic staff be quantified, and that patients of the clinic be surveyed on health behaviors, disease management, and patient satisfaction.

Affordability

In order to discuss the dimension of affordability, there must first be an understanding of direct and indirect costs. According to Boccuzzi (2003), healthcare cost is divided into two quantifiable categories, with direct cost representing those costs associated with using in-patient, outpatient, and pharmaceutical services. Indirect costs are those acquired from a lessened ability or inability to work due to symptoms or mortality associated with a given health issue. Examples of indirect costs include work loss, worker replacement, and reduced productivity from illness and disease (Boccuzzi, 2003). In assessing indirect costs associated with health issues, Boccuzzi contended that while difficult to quantify, indirect costs are an important component for measuring the additional impact of a disease beyond medical costs associated with direct in- and out-patient care. He called for those concerned with healthcare spending (e.g. governments, payers, and employers) to look beyond direct costs associated with illness to include appropriate estimates or measurements of indirect costs.

In the course of his analysis of issues and challenges related to the measurement and analysis of indirect costs, Boccuzzi described both disease morbidity and mortality costs. Those who lose work time because of their illness or disability are associated with disease morbidity, and mortality costs are the present value of future earnings lost by individuals who die prematurely, as well as worker replacement costs for the employer. According to Boccuzzi, indirect costs represent a significant percentage of the total cost associated with many diseases. As an example, he cited data which estimates indirect costs associated with the cardiovascular disease process to be as high as one-half of the total economic burden of the disease. Measuring indirect cost associated with an illness is easiest when a person misses work as a result of a medical condition. The amount of time lost due to illness will vary according to differences in terms of acute versus chronic conditions and level of severity. Those with lower levels of health will both suffer from a reduced ability to contribute while at work and will miss more work.

Opportunity costs are a less-studied area of indirect cost for patients and include patient time burden (measured in minutes) and patient time costs (measured in dollars) spent by patients traveling to, waiting for, and receiving medical care (Ray, Chari, Engberg, Bertolet, & Mehrotra, 2015). According to Ray et al., disparities in this domain have received less attention, with no rigorous national estimates of opportunity costs associated with outpatient medical care. To rectify this the researchers used the nationally representative 2003-2010 American Time Use Survey to estimate opportunity costs associated with outpatient visits. Estimates of opportunity costs were calculated for employed adults using self-reported hourly wages and for unemployed adults using a

Heckman selection model. They also used the Medical Expenditure Panel Survey to compare opportunity costs with direct costs (e.g. patient out-of-pocket, provider reimbursement) in 2010. With this survey data on time associated with medical visits, Ray et al. estimated that patients incurred $52 billion in opportunity costs while obtaining medical care in 2010. The researchers concluded that accounting for patient opportunity costs is important when evaluating methods to improve the efficient delivery of care.

Insurance coverage is a key area of discussion when evaluating healthcare costs and affordability for U.S. patients. The ACA's attempt to reform the health insurance marketplace included financial assistance for low- and moderate-income people to purchase coverage and federal support for states that expanded their Medicaid programs to cover more low-income adults (Obama, 2016). Uninsured rates dropped more in states that expanded Medicaid programs than in those which did not. Also credited with the overall reduction in uninsured is the ACA's provision allowing young adults to stay on a parent's plan until age 26. This covered an estimated 2.3 million people after it took effect in late 2010. However, Obama warned that while the ACA has greatly improved the affordability of health insurance coverage, survey data indicated that large populations of uninsured individuals still want coverage but report being unable to afford it.

The USDHHS (2014) listed multiple consequences associated with being under- or uninsured. These consequences included: increased likelihood of having poor health status, reduced likelihood of receiving medical care, increased likelihood of delayed diagnosis, and increased likelihood of premature mortality. In the most updated version

of *Access and Disparities in Access to Health Care*, the AHRQ (2018) found that gaps

between those designated poor and near poor decreased over the 2010-2015 period,

though those in households with the latter designation were more likely to be uninsured.

When considering gaps by race, Hispanics and African Americans were more likely to be

uninsured than Whites. Hispanics had worse access to care on 14 of the 20 access

measures when compared with Whites. African Americans had worse access to care than

Whites for about half of access measures, and Asians, American Indians, and Alaska

Natives had worse access to care than Whites for about one-third of access measures.

In their international comparative analysis of the healthcare systems of 11

different countries, including the U.S., Davis, Stremikis, Squires, and Schoen (2014)

drew from data in the Commonwealth Fund 2013 International Health Policy Survey to

argue that the absence of universal coverage in the U.S. contributes to people going

without needed health care because of cost more often than in the other countries.

According to the survey data, also reported on by Osborn, Squires, Sarnak, Schneider,

(2016), the U.S. ranked last on measures of equity with Americans most likely to say they

had access problems related to cost. Those with below-average incomes were much more

likely to report not visiting a physician when sick; not getting a recommended test,

treatment, or follow-up care; or not filling a prescription or skipping doses when needed

because of costs. As of 2013, when the data for this study was gathered, one-third or

more lower-income adults in the U.S. said they went without needed care because of

costs in the past year on each of these indicators. When compared to Canada's healthcare

system, Canadian patients have little to no financial burden, but experience wait times for

specialized services. The authors of the study used the survey data to refute the misperception that trade-offs between universal coverage and timely access to specialized services are inevitable by data from the Netherlands, U.K., and Germany, which also provide universal coverage with low out-of-pocket costs while maintaining quick access to specialty services.

Haggerty and Levesque (2015) looked specifically at Canada's publicly funded universal healthcare system with the intent to develop a survey-based measure of healthcare access and affordability. The relevance of this study to U.S. care access stems from the need for direct measures of health care affordability from the user perspective and for the monitoring of equitable access to publicly funded health care initiatives. The researchers conducted focus group explorations of access and cost barriers for those seeking care. After the initial questionnaire, delivered via phone to 750 participants, they developed a self-administered questionnaire to be mailed to additional participants. This survey asked participants about problems with the frequency of access due to five affordability dimensions: frequency of not taking prescribed drugs, frequency of skipping laboratory tests/exams, frequency of not accessing services prescribed by a doctor but not covered by insurance, level of difficulty in accessing care due to loss of income from missed work for appointments, and the level of difficulty in accessing care because of the additional costs. Examples of services suggested by providers but not utilized included physiotherapy, psychotherapy, and nutrition. The subsequent data was subjected to exploratory and confirmatory factor analysis, then ordinal logistic regression modeling, to examine how individual items and the subscale score predicted indicators of difficult

access. The researchers looked for effect modification by income categories. Data analysis brought forth three themes related to health care affordability: difficulties in accessing services due to loss of work income when seeking care during regular working, indirect costs due to travel and parking, and costs of diagnostic services and other services not covered by Medicare/health insurance. As would be expected, affordability problems were more prevalent among low-income than high-income respondents. Each unit increase in the subscale score predicted an increased likelihood of abandoning care seeking, emergency room use, and health problem aggravation.

Shartzer, Kenney, Long, and Odu (2016) conducted an analysis of the adults in the U.S. who were still uninsured as of March 2015. The authors focused on the reasons uninsured individuals gave for remaining uninsured, the potential eligibility for financial assistance on ACA coverage, and potential barriers to expanding coverage. The authors drew from data collected during the March 2015 round of the Health Reform Monitoring Survey (HRMS). The data was used to assess the characteristics of adults ages 18 to 64 who had remained uninsured more than one year after the ACA's implementation. Two-thirds of the uninsured were potentially eligible for full or partial coverage through Medicaid or the Marketplace, but barriers were found to include eligibility limitations based on immigration status, low awareness of available assistance, and costs that remained prohibitive despite subsidies. For another 22.6 percent of uninsured adults, their state's decision not to expand Medicaid was seen as a major barrier to coverage.

Undem (2015) reported on the findings of a national survey on the uninsured which was commissioned by the Robert Wood Johnson Foundation. Key findings about

the uninsured included a desire to have insurance combined with a feeling that insurance was unaffordable. About half (43%) of the respondents had looked for insurance plans, most of them through the Marketplace. Of those who looked for insurance, nearly 80% said they still could not afford coverage; however, 60% were confused about or had not heard of the tax credit. Undem concluded that while most respondents valued and wanted insurance, they saw cost as the biggest barrier, thus indicating a need for additional education around the tax credit.

In an updated brief by Garfield, Damico, Stephens, and Rouhani (2018) on the coverage gap for uninsured adults in states that do not expand Medicaid, the researchers presented estimates and impacts on the people in non-expansion states. The *coverage gap* is shorthand for the two million poor uninsured adults across the U.S. whose income is above current Medicaid eligibility but below the lower limit for Marketplace premium tax credits. Under the ACA, Medicaid eligibility is extended to nearly all low-income individuals with incomes at or below 138% of poverty ($28,676 for a family of three in 2018). The expansion was designed to fill in known gaps in Medicaid eligibility and was seen as a way to provide insurance coverage to low-income individuals. Premium tax credits for Marketplace coverage were to serve as a way to cover people with moderate incomes. This expansion was intended to be national, but a 2012 Supreme Court ruling made it optional for states, with the result of 17 states not expanding their programs as of June 2018.

Adults in the coverage gap are concentrated in states with the largest uninsured populations: Texas (29%), Florida (17%), Georgia (11%), North Carolina (9%), and the

remaining 34% distributed among the other thirteen states (Garfield et al., 2018). When divided into geographical regions of the South, West, Midwest, and Northeast, nearly nine of 10 adults in the coverage gap reside in the South. In the non-expansion states all non-disabled, childless adults remain ineligible and, because the ACA envisioned low income people receiving coverage through Medicaid, there is no financial assistance for those below poverty for other coverage options. Notably, over half of non-elderly adults in the gap are aged 35-54, or near elderly at ages 55-64. According to the data, adults in these groups are likely to have increasing health needs and to leave those needs untreated until Medicare eligibility at age 65. Almost a quarter of those in the gap include poor parents whose income places them above Medicaid eligibility, with the result that around 161,000 uninsured children have a parent in the coverage gap. The authors concluded that it is unlikely that those who fall in the gap will be able to afford ACA coverage without assistance, and that persons remaining in the gap face access barriers to care, including serious financial consequences, should they require care for health problems. The authors noted that clinics and hospitals serve as important safety nets for uninsured populations, but increased demand and limited resources place additional strain on those providers.

Another group of uninsured adults include those who have lost their jobs. Schaller and Stevens (2015) reported on changes in health, healthcare access, and healthcare utilization after job loss that lead to long term effects. The data sample for this study included over 10,000 individual job losses and longitudinal data on a wide variety of health-related outcomes. The results indicated that job loss has several impacts on health. The loss of income results in lower reported health levels, limitations in activity, and

decreased mental health. Across the sample there was evidence of reduced insurance coverage but no decrease in the use of healthcare, which translates into more direct costs for the unemployed. The findings indicated additional impacts for two groups, displaced workers with chronic conditions and those who lost their primary insurance with their job. In these populations there is a reduction in both doctor visits and use of prescription drugs.

Here it is useful to return to Obama (2016) to address the concern over prescription drug costs. He cited the ACA policies designed to address drug costs, including more substantial Medicaid rebates and the creation of a pathway for approval of biosimilar drugs, while also acknowledging that drug costs remain a concern for patients, employers, and taxpayers in general. Adding to this concern is the 12% increase in prescription drug spending that occurred in 2014. Relatedly, in 2014, Rice, Unruh, Rosenau, Barnes, Saltman, and van Ginneken critiqued the lack of improvement in healthcare accessibility post-ACA implementation. A key factor negatively impacting accessibility and access in the U.S. is the failure of policymakers to introduce spending controls used in most European healthcare systems (e.g. treatment guidelines designed to maximize efficacy while curtailing pharmaceutical and other costs), and the related lack of any provision for the establishment of institutes to assess the cost-effectiveness of pharmaceuticals. These omissions are the main contributors to the continued high cost of healthcare in the United States, such that economically disadvantaged people are frequently unable to afford proper care, and government healthcare subsidies are often inadequate.

Bradbury (2015) considered cost factors for physicians related to billing issues and delayed reimbursement from Medicare and Medicaid. The focus of the study was on office-based physicians and significant obstacles that limit Medicare and Medicaid participation. Bradbury noted how existing literature and popular press sources documented the matter of inadequate reimbursement as a disincentive for physicians to take on new Medicare and Medicaid patients. Bradbury drew the data for her study from the Health System Change's 2008 Health Tracking Physician Survey (HSC-PS), and the survey asked physicians across the U.S. about their practice and their views on the challenges they face as physicians. Two data sets were analyzed, one each for Medicare and Medicaid, and each set had around 3,500 respondents. The surveys included questions regarding the reason's physicians gave for limiting acceptance of new Medicare/ Medicaid patients, with the five possible reasons including billing issues, inadequate or delayed reimbursement, capacity constraints, clinical burden, and concerns about a Medicare audit. According to Bradbury, physicians indicated inadequate reimbursement as the greatest obstacle, though timeliness of reimbursement as well as paperwork requirements relating to filing of claims was a close second. Implications for policy were noted, with Bradbury encouraging policymakers to increase access through legislative measures increasing Medicaid rates, and by additional streamlining of processes that reduce arduous requirements of technical know-how.

Acceptability

As a dimension of access, acceptability is one of the least covered dimensions, despite the fact that patient and provider characteristics (e.g. preferences and attitudes

toward one another) have an immense impact on access to and receipt of quality health care. A good deal of research has supported the assertion that race, gender, and sexuality impact how patients choose and perceive their providers (Yahanda, Lafaro, Spolverato, & Pawlik, 2016; Sharma, Prigerson, Panedo, & Maciejewski, 2015; Boulware, Cooper, Ratner, LaVeist, & Powe, 2016; Foo, Frankel, McGuire, Zaslavsky, Lafata, & Tai-Seale, 2017; da Silva Wanderley & Sobral, 2017), and just as much research confirms the impact of race, sex and age biases on the supply of needed practitioners and on the quality of care given by providers (Hedden, Barer, Cardiff, McGrail, Law, & Bourgeault, 2014; da Silva Wanderley & Sobral, 2017; McKinley, Petrusa, Fiedeldey-Van Dijk, Mullen, Smink, Scott-Vernaglia, ... & Phitayakorn, 2014; Oberlin, Vo, Bachrach, & Flury, 2016). Yet existing research has been limited in its direct assessment of the degree to which these factors inhibit or encourage access.

The objective of Greene, Hibbard, and Sacks's (2018) study was to examine the extent to which individuals exhibit a preference for physicians based upon the race/ethnicity and gender of a physician's name. In an online survey of over 900 adults, the researchers showed participants a comparative display of four physicians' quality performance after randomizing the name of one physician. The results of regression models revealed that participants more frequently selected the physician with the randomized name when displayed with a white male name, compared to when presented with an African American male, African American female, or Middle Eastern name. Interestingly, the results showed that white male participants exhibited this pattern, while racial/ethnic minority participants did not. In their conclusion, the researchers suggested

that this kind of choice bias may be a contributing factor for why women and racial/ethnic minority physicians have lower incomes than white male physicians.

In a 2016 article, Himmelstein and Sanchez (2016) considered the reported impact of gender on doctor-patient communication with a specific focus on masculinity and men's choice of physician. The researchers were aware of data on mortality and morbidity indicating that men outrank women on several leading causes of death and have a shorter life expectancy overall. The hypothesis for this study was that the gendered health disparities may be influenced by psychosocial factors like masculinity. The researchers conducted three studies with a total of 546 patients to examine the role of masculinity in men's doctor choices and doctor–patient interactions. In Studies 1 and 2, men completed measures of masculinity, gender bias, and doctor preference. Using structural equation modeling, they tested the direct relationship between masculinity and male doctor preference and the indirect relationship of masculinity on male doctor preference through an association with gendered competence stereotypes. In the third study patients disclosed symptoms in private followed by an interview with a male or female interviewer in a clinical setting. With ANOVA tests, the researchers examined the interaction among symptom reporting, masculinity, and doctor gender, controlling for participant comfort. In the first two studies researchers found that masculinity encouraged choice of a male doctor directly and indirectly via beliefs that men make more competent doctors than women. In study three, the higher the men scored on masculinity, the less consistently they reported symptoms to male interviewers. This was not found to be the case when the patients were interviewed by females. The researchers concluded that

masculinity may affect men's health by encouraging choice of a male doctor with whom doctor–patient communication may be impaired.

Aware of the historical gender bias of patients against female physicians, Nolen, Moore, Rodgers, Wang, and Walter (2016) researched patient preference for physician gender emergency departments (ED). They sought to determine whether there were any associations between ED patient demographics and physician gender preference. The researchers surveyed patients presenting to an ED to determine association between patient demographics and patient physician gender preference in five ED situations. A total of 200 patients were surveyed. In their findings the researchers reported no gender related physician aversion in all five situations: for 'routine' visits (89. %), 'emergent' visits (89%), 'sensitive' medical visits (59%), 'procedural' visits (89%) or when receiving 'bad news' (82%). In the setting of 'routine' visits and 'sensitive' medical visits, there was a preference for a physician of the same sex as the patient.

A growing area of interest in the literature is the consideration of health disparities for LGBT persons (Cahill & Makadon, 2014; Stall, Matthews, Friedman, Kinsky, Egan, Coulter, ... & Markovic, 2016; Martos, Wilson, & Meyer, 2017; Qureshi, Zha, Kim, Hindin, Naqvi, Holly, ... & Ritch, 2018). In their study of healthcare utilization among rural LGBT populations, Whitehead, Shaver, and Stephenson (2016) combined consideration of the dimensions of accessibility and acceptability. They noted that the majority of studies which considered sexual orientation included data from participants in urban areas, which are generally more open-minded. The participants for this study were recruited to participate in an online survey on the connections between

sexual orientation, stigma, and use of primary care services. The 1,014 participants were divided into three groups for analysis: cisgender men, cisgender women, and transgender/non-binary persons. The LGBT individuals were asked specifically about their health care access, health risk factors, health status, outness to social contacts and primary care provider, and anticipated and realized stigmas. In their results, Whitehead et al. stated that lower utilization of health services was associated with the transgender/non-binary group, who scored higher on scales of stigma. Disclosures of sexual orientation were more frequent among cisgender men, who also reported greater utilization of health services. The researchers stated that the reported internalized, anticipated, and encountered stigma for LGBT individuals' shapes access to primary care in the rural context. In their recommendations for practice, Whitehead et al. promoted the development of interventions focused on decreasing stigma in healthcare settings and increasing patients' disclosure of orientation/ gender identity to providers. If such interventions were put in place, they would be likely to increase the use of primary and preventive health care services by LGBT people in rural areas.

Thus far the perspective on acceptability has been the patients', but acceptability has also been examined from the provider's perspective. Zestcott, Blair, and Stone (2016) presented evidence from the literature suggesting that disparities in health outcomes for stigmatized groups stem from the implicit biases of healthcare providers. In their systematic review of implicit racial/ethnic bias among healthcare professionals, Hall, Chapman, Lee, Merino, Thomas, Payne, et al., (2015) confirmed the existence of such bias and consider its influence on healthcare outcomes. The researchers noted that since

implicit attitudes are thoughts and feelings outside of conscious awareness, they can be difficult to consciously acknowledge and control, and can influence practitioner behavior without conscious will. The implicit biases found among healthcare professionals were similar to those in the general population, with levels of implicit bias against Black, Hispanic/Latino/Latina, and dark-skinned people similar across groups. Results also showed implicit biases as significantly related to patient–provider interactions, treatment decisions, treatment adherence, and patient health outcomes. Implicit attitudes were more often significantly related to patient–provider interactions and health outcomes than treatment processes. The majority of healthcare providers in this survey had negative attitudes toward people of color, while displaying implicit bias in terms of positive attitudes toward Whites. Hall, et al. recommended additional interventions targeting implicit attitudes among healthcare professionals in order to reduce the health disparities for people of color.

　　　　Ageism and sexism can also contribute to health disparities according to Chrisler, Barney, and Palatino (2016). Because women tend to live longer than men, they typically have more interactions with the healthcare system in old age. Ageist beliefs and stereotypes can interfere with healthcare seeking as well as physician diagnosis and treatment recommendations. When older women are perceived as too frail, they may not receive aggressive treatments. The researchers also stated that ageism results in disrespectful treatment of older patients, which is communicated through baby talk and other forms of minimization by physicians shrugging off of patients' complaints and concerns as 'just old age.' As other researchers on practitioner bias have suggested,

interventions are needed to improve doctor–patient relationships, facilitate adherence to treatment regimens, and reduce disparities in health and health care.

Dahrouge, Seale, and Hogg, et al. (2016) undertook a comprehensive assessment of family physician gender to determine the impact on the quality of primary care. The researchers cited a lack of data in this area, as previous studies were focused on primary and secondary prevention. Dahrouge et al. considered five key dimensions of primary care, including: indicators of cancer screening, chronic disease management, continuity, comprehensiveness, and access. After conducting a cross-sectional analysis using linked health administrative datasets (April 1, 2008 to March 31, 2010), a total of 4,195 physicians (31% female) were eligible. The results indicated positive impacts on quality of care by female physicians. Overall, there were no significant differences in the continuity or comprehensiveness measures. However, adjusting for provider and patient factors, patients of female physicians were more likely to have received recommended cancer screenings and diabetes management. Patients also had a higher number of referrals, as well as fewer emergency room visits and hospitalizations. The researchers concluded that patients under the care of female physicians experience multiple benefits.

Awareness

The dimension of awareness includes awareness of evidence for treatment and practice guidelines (Penchansky & Thomas, 1981). In their examination of social determinants of health equity in England, Marmot and Allen (2014) drew comparisons to the U.S. health system. As part of their review of health inequalities, the researchers enlisted the help of nearly 100 experts to establish an evidence base, in order to

demonstrate the most important influences on health and health inequalities. In their review of the evidence gathered, Marmot and Allen suggested that two areas must be considered before knowledge of social determinants of health can be used to address health equities. The first area is the perception that health is too frequently equated only with health care, with the result that many politicians and people assume that health and health care are the same. After the overconcentration on health care, *lifestyle drift* is described by the researchers as the tendency to focus on individual behaviors, such as smoking, diet, alcohol, and drugs, while ignoring drivers of these behaviors, the causes of the causes. Marmot and Allen argued that political objections to taking action on the social determinants of health are untenable, whether the objections take the form of claiming a lack of evidence on what to do or how to do it effectively. They dismiss lack of knowledge claims, as there is ample evidence showing relationships between social/ environmental factors and a wide range of health outcomes, as well as evidence about what has worked best internationally, nationally, and at local levels. Additionally, much practical evidence exists about short- and long-term actions at a variety of administrative levels for different populations. Even though cost-benefit evidence is more difficult to provide, Marmot and Allen claimed there is enough evidence showing how many interventions are efficient, equitable, and effective when designed and delivered in the right way. They concluded with the assertion that the case for governmental support in reducing health inequities and improving health outcomes is a moral one, as poverty and social exclusion cause increasing health inequalities.

Similarly, Essounga–Njan (2015) considered the explicit provisions in the ACA, which stated the concern for and duty of care the government owes to the populace. This is why Essounga–Njan's work, and that of Marmot and Allen (2014), are valuable in considerations of the dimension of awareness. In her research, Essounga–Njan compared the standards and quality of care found in the United States post-ACA to other countries with universal healthcare. Key in her discussion of quality of care and awareness of best medical practices was her proposed model of Universal Healthcare Coverage (UHC), which she supported with extensive citations from the literature comparing the U.S. to countries such as France and Canada. The model had six propositions for those covered by UHC: they are less likely to use emergency services, less likely to wait on need to see their PCP, less likely to develop serious health conditions tied to long term illnesses, and less likely to contract contagious illness. All of these factors combined will create a streamlined system able to give higher quality care, and finally, this system will result in lower healthcare costs. Also relevant to the discussion of dimensions of access is her definition of quality in healthcare, which included: timely access to patient records, elimination of errors, and no duplication of medical testing. Essounga–Njan contended that adhering to these quality factors is the expected minimum for practice in a healthcare system. Finally, Essounga–Njan suggested that political opposition to the ACA is the reason why it has been watered down in terms of a quality and streamlined system. She expressed the hope that U.S. policy will continue to evolve and give the level of concern and quality of care originally envisioned for the ACA.

In their review of the history of evidence-based medicine, Greenhalgh, Howick, and Maskrey (2014) critiqued the direction evidence-based medicine (EBM) has taken and suggested a new agenda to merge the scientific rigor of EBM with patient-centered practices for optimal care. The authors acknowledged the numerous successes in the 20-plus year history of EBM, with its practitioners committed to making clinical practice more scientific and empirically grounded to provide safer, more consistent, and more cost-effective care. They also noted a growing sense of crisis in the medical community in several significant areas of practice: the misappropriation of EBM by vested interests, the unmanageable volume of evidence for clinical guidelines, the discrepancy between statistically significant benefits and those in clinical practice, the favoring of inflexible, technology-driven practice over patient-centered care, and the inability of evidence-based guidelines to comprehensively assist in treating complex conditions. After detailing specifics on each of these issue areas, the researchers recommended strategies to address the above concerns. According to Greenhalgh, Howick, and Maskrey, the path to practicing true EBM is through patients, with practitioners applying expert judgement over mechanical rule following, the use of easily understandable and individualized evidence, a strong clinician-patient relationship with shared decision-making, and the application of these principles at the community level for evidence-based public health. To conclude their argument on the need to return to EBM's founding principles, the researchers provided a summary of actions needed from patients, practitioners, researchers and publishers, funders, and policy makers to enact the needed changes. The awareness in this research, and the awareness it suggested for practitioners, is useful to

establish a high standard for physicians who wish to improve access for their patient populations.

Another area encompassed by the dimension of awareness is the practice of Shared Decision-Making (SDM) between physicians and patients. Zeuner, Frosch, Kuzemchak, and Politi (2014) conducted a qualitative study which demonstrated a continued chasm between aspirations in this area and clinical practice. Zeuner et al. commented on the growing support for patient engagement in health decisions by the public and policymakers. They also claimed that SDM is not widely practiced in clinical settings. The purpose of their study was to explore clinician attitudes, beliefs, and perceived social norms around using SDM behaviors. Unlike the majority of the studies found for this review, Zeuner et al. used a qualitative approach, conducting semi-structured qualitative interviews with physicians in five practice areas. Twenty physicians were included in the study: five surgeons, five OB/GYNs, four medical oncologists, five internists, and one emergency medicine physician. Included in the results, the researchers described physician beliefs and perceptions of cultural- and system-level obstacles to the widespread implementation of SDM. Some of these obstacles included: how to engage in discussions of cost, uncertainty and clinical poise, and how to engage patients across various socioeconomic backgrounds. Zeuner et al. stated that a large number of participants expressed support for the use of SDM in practice. This positive perception, however, did not translate into actual use, as most of the physicians showed inconsistent beliefs about practicing specific SDM behaviors. In suggestions for intervention and future practice, the researchers promoted more extensive training of physicians at all

levels (pre- and post-licensure), as it would increase clinicians' confidence in their SDM skills. They also suggested that developing methods of integrating SDM into the institutional framework of hospitals and training could increase clinician motivation to practice SDM, ultimately changing medical culture so that SDM is supported.

With reference to underserved populations experiencing disparities in access, Colford, Kraemer, Contarino, Denizard-Thompson, Evans, Hairston, et al. (2018) reported on groups underrepresented in medicine (e.g. racial and ethnic minorities) and how their choice of where to practice may benefit groups experiencing health access disparities. Colford et al. referenced the definition of *underrepresented in medicine* by the Association of American Medical Colleges. The "racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population" definition is used in relation to the current number of underrepresented minorities in the U.S. (30% total population) and the current physician workforce identified as underrepresented minorities (< 10%). The most notable finding of Colford et al. was that underrepresented minority physicians are more likely to practice in underserved areas and care for patients in their own ethnic groups who are on Medicaid, uninsured, and of poorer health status, which provides a positive impact on health outcomes for underprivileged populations.

Conclusion

The literature covered in this review was assessed through the lens of the theoretical framework for the proposed study, Penchansky and Thomas's (1981) model of healthcare access. Several major themes associated with these dimensions have emerged

from the literature reviewed in this chapter. As this review indicated, the dimensions of healthcare access (i.e., resource availability, geographic availability, accommodation, affordability, acceptability, and awareness) overlap. Wyszewianski (2002) made a clear argument that the importance of the interdependent nature of the dimensions cannot be overstated, and that efforts toward improving access overall may be hindered when one or more dimensions are ignored. The definition of what constitutes access by governmental agencies (USDHHS, 2014; AHRQ, 2018) is characterized by omissions of one or more dimensions. The areas included in agency definitions correspond roughly to Penchansky and Thomas' (1981) dimensions of affordability, accessibility, and availability, respectively. This review has been conducted against the backdrop of the passage of the ACA, which has boosted the ability of the U.S. healthcare system to cover and care for more citizens. However, is clear from the literature that there is much left to be done to improve all dimensions of access (Obama, 2016; Douthit, Kiv, Dwolatzky, and Biswas, 2015; AHRQ, 2018; Essounga–Njan, 2015; Marmot & Allen, 2014)

Saurman (2016) and Penchansky and Thomas (1981) provided a useful framework for assessing the present level of access and for constructing a roadmap for improvement. Themes within the dimensions of Availability and Accessibility included barriers of physician workforce shortfalls, and distinct disparities associated with geography, race, education and employment. Dall et al. (2018) predicted that the present shortage of providers will continue through 2030, with the aging of baby-boomers being a huge factor in increased demand. Multiple researchers highlighted the impact of geography on access (Douthit, Kiv, Dwolatzky, & Biswas, 2015; Buerhaus, DesRoches,

Dittus, & Donelan, 2015; Haggerty, Roberge, Lévesque, Gauthier, & Loignon, 2014; Haggerty and Levesque (2017). The shortfall predicted by Dall et al. would be even greater if populations facing higher barriers to accessing care (racial and ethnic minorities, the uninsured, and those living outside metropolitan areas) had patterns of healthcare use similar to those of a population with fewer barriers to access. Buerhaus, DesRoches, Dittus, and Donelan (2015) and the USDHHS (2014) indicated that improving healthcare access requires increasing access to, and use of, evidence-based preventive service, including preventative care provided by primary care nurse practitioners (PCNPs). Graves, Mishra, Dittus, Parikh, Perloff, and Buerhaus (2016) determined that more restrictive nurse practitioner scope-of-practice laws were associated with reduced access to primary care services. Therefore, one means of addressing provider shortages is to reduce barriers for nurse practitioners, allowing them to practice without a supervising physician. Also, within the dimensions of Availability and Accessibility are issues of timeliness for patients. In their report on disparities in time spent seeking medical care in the U.S., Ray, Chari, Engberg, Bertolet, and Mehrotra (2015) highlighted distinct disparities associated with race, education, and employment. Individuals with less education, racial/ethnic minorities, and unemployed individuals experienced significantly longer clinic time as well as longer travel time. The excess time burden and associated costs serve as a disincentive to seeking care, especially for populations already experiencing racial and financial barriers. Relatedly, the literature on meaningful use emphasized both the immense increase in the use of health IT (e.g. Electronic Health Record technology, telehealth, Health Information Exchange,

electronic transfer of care) and the inadequacy of present implementation of technology

(Jones, Rudin, Perry & Shekelle, 2014; Rudin, Motala, Goldzweig & Shekelle, 2014).

The question pertinent to the proposed study is how practitioners can impact this area of access. Comino (2017) presented strategies for primary care best practice that could be used as a guide for the present study, regarding ways providers and their organizations may be able to positively influence patient access to care. Many of Comino's recommendations for updating primary care best practices also touch on the use of technology to facilitate access and communication between patients and providers. Kontos, Blake, Chou, and Prestin (2014) considered the state of health literacy and eHealth literacy given the growing use of eHealth technology to empower patients, especially those in vulnerable populations. Kontos et al. encouraged greater awareness among clinical care providers and public health communicators of the factors influencing the use of eHealth. Doing so would assist in addressing communication inequalities and persistent disparities in health.

In the dimension of Accommodation/ Adequacy, researchers noted several gaps in access. Davis, Stremikis, Squires, and Schoen (2014) and Milani and Lavie (2015) critiqued the current delivery model in the U.S. healthcare system, noting that the U.S. performs poorly overall when compared to other similarly developed nations on four indicators of quality: effective care, safe care, coordinated care, and patient-centered care. A key factor in lower U.S. scores on safe and coordinated care stems from lagging in the use of health IT. Dominant in the literature was a call by researchers for greater use of health IT by health providers. Greater use would aid in combating chronic disease by

both engaging chronic patients and facilitating team-based care (Davis et al., 2014;

Milani & Lavie, 2015; Weinstein et al., 2014). Another way practitioners and health

organizations can increase access is through developing more care coordination programs

where charity clinics are connected to local hospitals (Parker, 2017).

The dimension of Affordability has the most literature directly associated with it;

however, the bulk of this literature was focused on insurance and direct costs, with

minimal attention to indirect or opportunity costs (Boccuzzi, 2003; Ray, Chari, Engberg,

Bertolet, & Mehrotra, 2015). According to Ray et al., no rigorous national estimates exist

for opportunity costs associated with outpatient medical care. Although they are more

difficult to measure, the literature is clear that indirect and opportunity costs have a major

impact on realized access for patients. In particular, patient time burden (measured in

minutes) and patient time costs (measured in dollars) spent by patients traveling to,

waiting for, and receiving medical care are disincentives to seeking care. Ray et al.

estimated that patients nation-wide incurred $52 billion in opportunity costs obtaining

medical care in 2010. The way physicians can impact this dimension of access ties to that

suggested for the dimensions of Accommodation and Adequacy. Practitioners may not be

able to directly influence whether their state expands Medicaid/Medicare access, or

reduces the cost of prescription drugs, but greater use of health IT may be a way to

reduce some of the opportunity costs incurred by patients.

Wyszewianski (2002) made clear that the dimension of acceptability is frequently

neglected despite its being a dimension where aware providers can have the greatest

impact on achieved access. The literature in this review indicated that patient and

provider characteristics, including preferences and attitudes toward one another, have an immense impact on access to and receipt of quality health care (Greene, Hibbard, & Sacks, 2018; Himmelstein & Sanchez, 2016; Whitehead, Shaver, & Stephenson, 2016; Chrisler, Barney, & Palatino, 2016). This literature review highlighted the existing disparities that exist for populations stigmatized by racial/ethnic bias, age, gender, and sexual orientation (Hall et al, 2015; Zestcott, Blair, and Stone, 2016). While some of the stigma may be internalized/anticipated by prospective patients, the largest impact of implicit biases comes from practitioners. Researchers in this area of access agreed that a higher level of awareness is needed by practitioners in order to improve doctor–patient relationships and increase achieved access.

The final dimension of access comes from Saurman (2016), who categorized Awareness as involving communication and information. In this dimension practitioners maintain awareness through effective communication and information-dissemination strategies with patients and the community, with consideration of cultural contexts and the recipient's knowledge of healthcare. The dimension of awareness also includes awareness of evidence for treatment and practice guidelines. Marmot and Allen (2014) and Essounga–Njan (2015) critiqued U.S. policymakers and healthcare administrators for ignoring or minimizing the ample evidence that Universal Health Coverage mitigates many of the present issues with access. While individual physicians cannot force the adoption of UHC, they can modify other aspects of practice associated with Awareness. Greenhalgh, Howick, and Maskrey's (2014) critique of evidence-based medicine (EBM) serves as a call to practitioners to reassess what 'evidence-based' means. They suggested

that the path to practicing true evidence based medicine is through patients, with practitioners applying expert judgement over mechanical rule following, the use of easily understandable and individualized evidence, a strong clinician-patient relationship with shared decision-making, and the application of these principles at the community level for evidence based public health. Relatedly, Zeuner, Frosch, Kuzemchak, and Politi's (2014) demonstrated a continued chasm between aspirations in Shared Decision-Making (SDM) between physicians and patients. The suggestion for practitioners who wish to improve access for their patient populations is to improve their awareness by gaining additional training and practice with SDM.

After reviewing the literature for this study, it became clear that while all of the dimensions are addressed through prior research in some way, the dimensions are rarely considered collectively, as smaller parts of the bigger picture of access. Because of this gap, the interplay among and impact of each of these dimensions on each other is missing in the literature. Methodologically speaking, the bulk of the literature reviewed relied on quantitative methods. Only four of the included studies used qualitative or mixed methods (Haggerty et al., 2014; Haggerty & Levesque, 2017; de Grood, Eso, & Santana, 2015; Zeuner et al., 2014). This also constitutes a gap in the literature, as the questions asked and answered via quantitative methods are not the same as those answerable through qualitative research. The present study will serve as an attempt to address these gaps in the literature. The next chapter will include a more detailed discussion of the method that was employed in this study.

Chapter 3: Research Method

Introduction

The purpose of this research was to qualitatively investigate the perceptions of physicians regarding their influence over access to healthcare. Chapter 3 includes a thorough discussion of the chosen methodology for this research study. Toward this end, it is broken down into sections under the following major headings: (a) Research Design and Rationale, (b) Role of the Researcher, (c) Methodology, (c.i) Participant Selection Logic, (c.ii) Instrumentation, (c.iii) Procedures for Pilot Studies, (c.iv) Procedures for Recruitment, (c.v) Data Analysis Plan, (d) Issues of Trustworthiness, (d.i) Ethical Procedures, and (e) Summary.

Research Design and Rationale

The research question for this study was as follows: How do physicians perceive themselves as influencing patients' access to healthcare? Using a qualitative approach, I sought to investigate the perceptions of physicians in regard to their influence over access to healthcare, as this presents a gap in understanding within the field of healthcare and medical research. The single research question was developed with the aim of identifying the current state of understanding, interest, knowledge, and awareness physician's hold of their roles in granting access to healthcare to underrepresented members of the U.S. population. The study's theoretical framework was based on Penchansky and Thomas's (1981) model of healthcare access, with the amendment of Saurman's (2016) proposed sixth dimension of awareness.

The rationale for this research design was that, in order to explore perceptions, a qualitative approach is necessary to allow participants to express themselves beyond the confines of existing knowledge and theory (Silverman, 2016). Though a quantitative research design would have allowed for a larger sample of participants, the purpose of this research was to understand *how* and *why* physicians had certain perceptions, once these perceptions were identified. The phenomenon of interest, access to healthcare, is of interest to the medical and healthcare fields, as failures to provide affordable and accessible healthcare have a direct impact on the quality of life for those members of society who lack access (Rice et al., 2014). The term *access* as used in this study was defined in a manner consistent with Penchansky and Thomas's (1981) model of healthcare access, which denotes five dimensions, or factors, that combine to constitute access: (a) availability of resources, (b) availability as a geographic location, (c) accommodation, (d) costs, and (e) acceptability. Saurman (2016) added a sixth dimension, (g) awareness, to the model. Patients are dependent on each of these dimensions if they wish to have access to quality healthcare.

Narrative inquiry was chosen for this research because this methodology allows participants to provide reasoning for their opinions, perspectives, and lived experience in relation to the research theme. According to thought leaders in qualitative research such as Creswell and Creswell (2017), a researcher chooses the design of a study in order to narrow down the line of investigation to provide answers to the research questions. The methodology has allowed for exploration into the research questions as well as analysis of the data collected (Creswell & Creswell, 2017).

For this qualitative study, I decided to examine doctors living and working around a Sentara Medical Center in Virginia. The Sentara Medical Group, which is headquartered in Norfolk, Virginia, has many Sentara Medical Centers in the state. The group is composed of partnerships and physicians in private practice now in contract with the Sentara chain and its hospitals. It was hoped that the wealth of medical centers in the region would allow for the anonymity of respondents to this study, while also allowing for a large pool of possible participants to source from. However, to be more specific about participant sourcing, it should be noted that only doctors who had practiced in internal medicine were sourced for the research. This is because the physicians who had practice in Internal Medicine are trained to deal with patients of all ages. Furthermore, Sentara Medical Center is highly rated by Virginia's citizens. As of this writing, Virginia is home to 8.52 million people, a population almost 8 times greater than that of West Virginia (U.S. Census, 2018).

Virginia also has a high percentage of the population under the age of 65 living without health insurance—10.2% of citizens at the time of this writing. On top of this, 7.9% of Virginia's citizens are living with a disability and are under the age of 65 years (U.S. Census, 2018). The per capita income in Virginia is $36,268, with a median household income of $68,766, suggesting that most families and households do not have access to spare income for medical emergencies. Virginia has implemented community health practices, such as HealthyVB and the Community Health Assessment (CHA; Virginia Department of Health, 2018). Both schemes were designed for community outreach and improving access to healthcare for Virginians in the immediate region. The

purpose of the plan was to make Virginia the healthiest state in the nation, and it was hoped that this would be achieved by the year 2020. It is my hope that this research will assist local physicians in Virginia by highlighting what they believe to be the major hindrances to access to affordable healthcare and how these hindrances affect the citizens of their state. The physicians were asked to comment on experiences outside of the immediate region. The scope of the study was not limited to Virginia. The following section details my role within the research, as well as why I chose Virginia as the location for this study.

Role of the Researcher

My role as researcher in this qualitative study was to act as the primary instrument of data collection, following a methodological principle that can be attributed to Janesick (2015). The opportunity for researchers to act as their own instruments of data collection allows for varied approaches to gathering and analyzing data (Janesick, 2015). Though some researchers, such as Yin (2015) and Sanjari et al. (2014), have argued that having the primary instrument of data collection be the researcher can have a negative impact on a study, in that researchers can influence the way in which data are collected, which specific parts of data are used in a study, and how data are analyzed within a study (Antwi & Hamza, 2015). However, Bahrami et al. (2015) argued that researchers can take on a multitude of roles within the course of qualitative research, including but not limited to those associated with grounded theory, ethnography, content analysis, and phenomenology. In this research, the data-collection effort reflected a phenomenological approach.

In that this form of qualitative research depends on the researcher asking the most important, pertinent, and broad questions relating to the topic, Bahrami et al. (2015) argued that it gives researchers the main role in data gathering. Furthermore, Bahrami et al. stated that researchers validate the data by being the core instruments of data collection. However, this is highly dependent on the ability of researchers to communicate, ask the right questions, ensure that they remain objective in the data analysis process, and not let biases regarding their experience influence the final discussion (Bahrami et al., 2015).

In order to mitigate any biases, a coding structure based on phraseology and terminology was used to analyze the online questionnaire data. In addition, I had no immediate relationships with any of the potential participants and thus had no preconceived knowledge of the phenomena being studied. I also had no close friends or immediate family members who had not been able to receive quality healthcare in the immediate region, nor had I engaged in any communication with such individuals. This was the first time that I had conducted qualitative research with a participant cohort of doctors. I remained objective as a result of the strict measures taken to reduce and avoid sources of influence prior to, during, and after data collection and analysis. The following section continues with this discussion.

Methodology

The purpose of this section is to present a discussion of the methodology chosen for this research. The data contained in the following subsections are designed to

influence future research: (a) participants, (b) instrumentation, (c) procedures, and (d)

data analysis plan.

Participant Selection Logic

My intention with this research was to analyze data from online questionnaires for

physicians in which I asked open-ended questions regarding participants' perceptions of

their role as physicians in influencing access to healthcare. Physicians were defined under

the criteria for this study as individuals who had attended and graduated from an

American medical institution for higher education. The criteria also stated that the

participants had to be practicing physicians at the time of study and had to have been

practicing in the United States for no less than one decade. Physicians were asked

directly about their experience and demonstrated their employment history with paper

records that could not be used in this study due to data protection laws and ethical

liabilities. For this purpose, physicians were able to choose items such as graduation

certificates, workplace identification, personal identification, and published materials on

their work. These items were deemed valid due to the scrutiny given to authenticating

them via an online search. The physicians also had to receive written confirmation that

their appearance in this study, though anonymous, was permitted by the necessary

hospital and practice leadership.

Participants were recruited from the internal medicine physicians roster of

practicing doctors. The medical center was well equipped to care for patients with a wide

variety of medical needs representing all ages, diverse demographics, and almost all

illnesses. The staff were dedicated to providing superior patient care through an

integrated and coordinated and responsive approach to operations and services. The expertise required to practice under the umbrella of the Sentara Medical Group suggested that those physicians currently employed at their Family and Internal Medicine facility were experts in their fields. Twenty-four participants were recruited for the purposes of this study.

Selecting participants for this study was a critical component of the research process, in that participant responses determined the reliability and validity of the research being conducted (Creswell & Creswell, 2017). Purposeful sampling was employed when deciding upon the final participants of the research, as selecting relevant participants enabled me to collect a range of in-depth information about physicians' perceptions of their influence over access to healthcare. Furthermore, the physicians recruited for this research represented a broad range of personal demographics such as age, gender, and cultural upbringing. This allowed for a broad range of data to be collected from representatives from individual cultures.

Participants took part in this study voluntarily. Though a range of physicians were made aware of the research, 24 were chosen to take part, and they were considered the most diverse, and therefore the most likely to give a broad range of perceptions of their influence on access to quality healthcare. Twenty-four is considered a reasonable number of participants to present a thorough investigation into a phenomenon (Creswell & Creswell, 2017). I contacted the participants directly via public contact.

Instrumentation

I served several roles throughout the duration of this research study, including primary instrument of data collection and analysis. The purpose of this section is to (a) discuss the role of the researcher as the core instrument, (b) describe how technology assisted in the data collection process, and (c) present a justification of these tools. First, my role as the researcher and core instrument in this study has been validated through previous discussion in this chapter. Questionnaire items were developed and honed using the following principles:

1. An open-ended, semistructured question style was used to allow for lengthy and descriptive answers.

2. Leading questions were removed to avoid biases.

3. Questions were developed to be concise in order to avoid any confusion in the chosen language, phraseology, or terminology used.

4. All questions were framed without any association, with words such as *like*, *don't*, and *dislike* removed from consideration during development. (Yin, 2015)

Questionnaires were administered online through the SurveyMonkey application. Data were stored in my password-protected SurveyMonkey account. Once the questionnaires had been completed, I downloaded the compiled data in an MS Excel spreadsheet. I chose the data analysis process of applying a thematic analysis looking specifically for key terms, phrases, and any other answers delivered by the participants that fell under Penchansky and Thomas's (1981) model of healthcare access. As so much

of the contemporary research concerning access to healthcare has focused on the affordability aspect of the model, this was noted as a source of exploration within the questionnaire (Wyszewianski, 2002), as were all other elements of the theoretical framework, including the contemporary additions.

Procedures for Recruitment, Participation, and Data Collection

Data collection for this study begun with the selection of participants from the physician demographics employed at the Sentara Family and Internal Medicine Physicians. I contacted physicians via public contact through the SurveyMonkey questionnaire. Once potential participants had been reviewed for their individual practitioner demographics and whether their experience was consistent with the scope of this study, they were asked to complete the online questionnaire (Creswell & Creswell, 2017; Yin, 2015). Participants were able to complete the questionnaire from any location where they had Internet access, at any time that was convenient for them. It was estimated that the questionnaire would take each participant no more than 5 minutes to complete. Participants' responses were stored in my password-protected SurveyMonkey account. Data was downloaded in an MS Excel spreadsheet for analysis. The following section continues with a discussion of the data analysis plan.

Data Analysis Plan

The research question established for this study was designed to elicit data that would help further understanding of how physicians perceive their influence over access to healthcare in the United States. Through an investigation and data collection process involving the distribution of online questionnaires to physicians, I hoped that patterns

would emerge that might aid in answering the research question. This study used

Creswell's (2012) assertion that qualitative forms of investigation consist of reviewing

and consolidating data for the purpose of analysis. From here, data was organized into

emergent themes through a coding process based on the theoretical framework. The

decision to code using the themes of Penchansky and Thomas (1981) with Saurman's

(2016) addition of the sixth dimension of healthcare access was a significant choice, as it

allowed for structured analysis and discussion using each of the themes. Patterns were

identified and highlighted in NVivo 12 qualitative analysis software. Following this,

anomalies and points raised by individual participants was highlighted and noted for the

discussion in chapter 5.

Issues of Trustworthiness

In order to validate my credibility with the participant sample, I followed the

guidelines presented by Shenton (2004). First, I ensured that a full investigation was

conducted into the phenomenon of access to healthcare. Using strategic search terms,

such as those explored in Chapter 2, it was easy to identify the gap in research pertaining

to physicians' perceptions of their influence on access to healthcare. From here, the

purpose of this chapter of the study was to ensure that any other researchers wishing to

investigate the perceptions of physicians in their area were able to replicate as much of

this research methodology as possible. To ensure such confirmability, the final chapters

of the dissertation outline how findings emerged from the data and not my own

preconceived notions regarding physician perceptions (Shenton, 2004).

Credibility and dependability are the most important factors in establishing trustworthiness (Shenton, 2004). Shenton argued that his research into trustworthiness uncovered the following provisions for researchers to be able to promote confidence: (a) the adoption of research methods well established, (b) the development of an early familiarity with the culture of participating organizations, (c) random sampling, (d) triangulation (e) tactics to help ensure honesty in informants, (f) iterative questioning (g) negative case analysis, (h) frequent debrief sessions, (i) peer scrutiny of the research project, (j) the researchers "reflective commentary," (k) back, qualification, and experience of the investigator, (l) member checks, (m) thick description of the phenomenon under scrutiny, (n) examination of previous findings. Of Shenton's (2004) provisions, only two that won't be included: triangulation and iterative questioning. Triangulation won't be included in this study due to time constraints. Iterative question is also unnecessary in this research as the participants had an ethical requirement to answer honestly, as their answers have the potential to derive actionable results to help those United States citizens without easy access to healthcare.

Transferability and confirmability were ensured through a thorough explanation of the instrument, online questionnaire, and methodology employed to derive the findings of this study. It is hoped that future researchers will use the methodology of this research to identify physician perceptions of their influence over access to healthcare in other geographical contexts, as this is the purpose of the external validation process in qualitative research (Creswell, 2012; Creswell & Creswell, 2017; Shenton, 2002; Yin,

2015). The following section continues with a discussion of the ethical procedures employed in this study.

Ethical Procedures

This qualitative study was compiled using the clear guidelines and specific instructions developed by the Walden University Institutional Review Board. Participants are contacted via email to complete a survey. This survey took approximately 5 minutes to complete. Participation in the study was voluntary. Recipients of the survey could decline to participate and those who participated could discontinued with the survey at any time. All data was gathered securely, with access to data files strictly guarded. IRB approval was obtained to demonstrate complete compliance with data collections regulations and ethical procedures set forth by the Walden Institutional Review Board. The IRB approval number was 07-17-19-0649454.

Summary

This chapter outlined my intended methodology for the study. I had presented the reasons for the choice of methodology, and how those methodological structures had been honed by previous researchers to ensure that they support and validate the credibility of the data being collected. Chapter 4 continues with a presentation of the results.

Chapter 4: Results

The purpose of this qualitative, phenomenological study was to explore the

perceptions of physicians in regard to their influence over healthcare accessibility. The

research question used to guide this study was the following: How do physicians perceive

themselves as influencing patients' access to healthcare? Chapter 4 includes a

description of the setting of data collection, followed by a description of the relevant

demographic characteristics of the study participants. Next, this chapter includes

descriptions of the data collection and data analysis procedures used in this study,

followed by a discussion of the evidence of the trustworthiness of the study results.

Chapter 4 then proceeds with a presentation of the results, which are organized by theme.

This chapter concludes with a summary.

Setting

Data were collected online through the survey application SurveyMonkey. Using

this procedure allowed physicians to provide data at a convenient time and from a

location where they were comfortable, so they would be able to respond fully to all

questionnaire items. No organizational conditions arose during data collection that might

have influenced the interpretation of results.

Demographics

The study sample included 24 physicians who were practicing medicine at the

time of the study, and who had practiced or were practicing at the time of the study in one

medical center in the southeastern United States. Sixteen out of 24 participants (67%)

were female, and the remaining eight were male. Eighteen participants (75%) were

African American, four (17%) were White, one (4%) was Latina, and one selected

"Other" in the ethnicity field. Twelve participants (50%) were general practitioners,

seven (29%) were pediatricians, two (8%) were cardiologists, two were surgeons, and

one (4%) was a dermatologist. Table 1 indicates the relevant demographic characteristics

of individual study participants.

Table 1

Participant Demographics

Participant	Gender	Medical specialty	Ethnicity	Years of experience as a physician
P1	Female	General practitioner	African American	Less than 10 years
P2	Female	General practitioner	African American	10–15 years
P3	Female	General practitioner	African American	10–15 years
P4	Male	Cardiologist	African American	10–15 years
P5	Female	Pediatrician	African American	25–30 years
P6	Female	General practitioner	African American	20–25 years
P7	Male	General practitioner	White	10–15 years
P8	Female	General practitioner	African American	Less than 10 years
P9	Female	Dermatologist	African American	20–25 years
P10	Female	Pediatrician	African American	Less than 10 years
P11	Female	Pediatrician	African American	10–15 years
P12	Female	Pediatrician	Latina	Less than 10 years
P13	Female	General practitioner	African American	10–15 years
P14	Female	General practitioner	African American	Less than 10 years
P15	Female	Pediatrician	White	20–25 years
P16	Male	Pediatrician	African American	20–25 years
P17	Male	General practitioner	Other	10–15 years
P18	Male	General practitioner	White	10–15 years
P19	Female	General practitioner	African American	Less than 10 years
P20	Male	Surgeon	White	Less than 10 years
P21	Female	General practitioner	African American	10–15 years
P22	Male	Surgeon	African American	30–35 years
P23	Female	Pediatrician	African American	10–15 years
P24	Male	Cardiologist	African American	10–15 years

Data Collection

Each of the 24 participants completed one online questionnaire through the

SurveyMonkey application. Data were recorded by SurveyMonkey and were

downloaded into an MS Excel spreadsheet. Each participant took approximately 3

minutes to complete the questionnaire. The online questionnaire included 16 closed-

ended items and three open-ended items.

Data Analysis

Data from closed-ended questionnaire items were analyzed using descriptive

statistics (frequency counts and percentages) through the SurveyMonkey application.

Data from open-ended items were uploaded into NVivo 12 software for analysis. A

deductive coding procedure was used, with the deductive codes mirroring the six

dimensions of healthcare access developed by Penchansky and Thomas (1981) and

Saurman (2016): (a) availability of resources, (b) availability as a geographic location, (c)

accommodation, (d) costs, (e) acceptability, and (g) awareness. Qualitative data from

open-ended questionnaire items was sorted into those six categories to better understand

physicians' perceptions of their influence on the healthcare access dimensions. When all

data were sorted into the six deductive codes, the data under each code were reviewed to

identify the theme or themes they indicated. Theme-identification involved reviewing the

data under each deductive code to understand what they indicated, if anything, as an

answer to the research question.

Evidence of Trustworthiness

The trustworthiness of qualitative findings is enhanced through the implementation of procedures to strengthen the four components of trustworthiness (Shenton, 2004). The four components of trustworthiness are credibility, transferability, dependability, and confirmability. Procedures used to strengthen each of those components are described in the following subsections.

Credibility

Credibility is the extent to which the results in a study are accurate representations of the reality that they are intended to describe (Shenton, 2004). To strengthen credibility, participants were assured that their identities would remain confidential in order to encourage them to give honest responses. In gathering data about physicians' perceptions from physicians themselves, I also added to credibility by using the most direct source of information about the phenomenon of interest. Additionally, allowing participants to enter their own responses directly into the online questionnaire eliminated the need for a transcription process in which errors might have caused the data to misrepresent participants' intended responses.

Transferability

Transferability is the extent to which the findings in a study would hold true for other populations and samples (Shenton, 2004). To assist future researchers in assessing transferability, the study population and inclusion criteria for the sample have been described, and the respondents' eligibility to participate was confirmed both prior to and during data collection. Additionally, the demographic characteristics of individual study

participants indicated in Table 1 may assist future researchers in assessing the transferability of the results to other samples.

Dependability

Dependability is the extent to which the findings in a study would be reproducible in the same research context at a different time (Shenton, 2004). Transitory biases or circumstances unrelated to the phenomenon of interest that might influence the responses of individual participants are a threat to dependability, because their mutability over time can reduce the replicability of the results. To minimize the influence of temporary, individual participant biases on the results, data were collected from 24 participants using the same questionnaire instrument, to facilitate comparison of answers across participants. The high level of convergence in the data across participants was evidence that the data were minimally influenced by participants' individual biases.

Confirmability

Confirmability is the extent to which a study's findings represent the opinions and experiences of the study participants, rather than those of the researcher (Shenton, 2004). Confirmability in this study was strengthened through the use of Penchansky and Thomas's (1981) and Saurman's (2016) six dimensions of healthcare access as deductive codes to guide the analysis of the data. Using deductive codes derived from peer-reviewed research reduced the likelihood that any bias I had as the researcher would distort the analysis process and results. Confirmability has also been strengthened through the inclusion of direct quotes from the data as evidence for all findings in the

presentation of results in this chapter. The inclusion of direct quotes allows readers to independently assess confirmability.

Results

The research question used to guide this study was the following: How do physicians perceive themselves as influencing patients' access to healthcare? Three major themes emerged during data analysis to answer the research question: (a) physicians increase healthcare acceptability and awareness through their knowledge and experience; (b) physicians increase accommodation through consideration of patients' needs and coordination of care, and (c) physicians increase resource availability through use of electronic medical records. Participants did not report that they perceived themselves as influencing the geographic proximity or the cost of healthcare, so no themes emerged that corresponded to those access dimensions.

Theme 1: Physicians Increase Healthcare Acceptability and Awareness by Recommending Appropriate Care

Data associated with this theme were derived from four closed-ended questionnaire items and one open-ended questionnaire item. Qualitative data included in this theme were derived from two deductive codes, including *acceptability* and *awareness*, which were associated with the healthcare access dimensions of the same names. Penchansky and Thomas (1981) defined the acceptability access dimension as including patients' preferences and attitudes toward their providers and the care they received. Saurman (2016) defined the awareness access dimension as including patients' awareness of treatment and practice guidelines and the evidence behind them. These two

access dimensions were addressed in one theme because physicians perceived themselves as influencing both dimensions at the same time and in the same way when they provided patients with appropriate healthcare information and recommendations based on the physicians' knowledge and experience.

Findings indicated that physicians perceived themselves as increasing acceptability and awareness through the knowledge and experience that allowed them to recommend appropriate care. Asked in a closed-ended item whether they perceived their specialized knowledge as influencing patients' access to healthcare, all 24 participants replied affirmatively. On a different closed-ended item, participants indicated that they perceived themselves as positively influencing accessibility through their knowledge and skills (i.e., acquisition of knowledge, education, and specialized skills), their years of experience, and, to a lesser degree, their communication style. Table 2 indicates response frequencies for this item.

Table 2

Response Frequencies for Factor Most Strongly Contributing to Physicians' Perceptions of Their Own Influence on Healthcare Accessibility for Patients

Contributing factor	*n*	*%*
Knowledge and skills (i.e., acquisition of knowledge, education, and specialized skills)	11	45%
Years of experience	10	42%
Communication style	3	13%

Participants reported a high degree of satisfaction with the feedback they received from patients who followed their healthcare recommendations. This finding indicated that physicians perceived their recommendations as acceptable to the patients who acted on them. Table 3 includes response frequencies for the questionnaire item reading, "How satisfied are you with the overall results/feedback you receive from patients who follow through on information you recommended to them?"

Table 3

Response Frequencies for Satisfaction With Feedback From Complying Patients

Level of satisfaction	*n*	*%*
Very satisfied	17	70%
Satisfied	3	13%
Somewhat satisfied	3	13%
Neither satisfied nor dissatisfied	1	4%
Somewhat dissatisfied	0	0%
Dissatisfied	0	0%
Very dissatisfied	0	0%

Thus, when patients returned to participants and provided feedback about the results of their compliance with recommendations, 23 out of 24 participants experienced some level of satisfaction with the reported results, with 17 participants describing themselves as *very satisfied*. This finding was significant as evidence that the healthcare

that participants recommended was acceptable to patients not only because of how the advice was delivered (e.g., with good bedside manner), but also because the recommendations were effective in increasing complying patients' access to quality healthcare. This finding was consistent with the finding that participants perceived themselves as increasing healthcare accessibility primarily through knowledge and experience that enabled them to give appropriate, effective advice, rather than primarily through their communication style.

A further indication of physicians' positive influence on acceptability and awareness was their perception that patients reacted positively to the information at the time that it was given. Table 4 indicates response frequencies for the closed-ended questionnaire item, "How do patients generally react when you're providing specialized information about access to quality healthcare?"

Table 4

Response Frequencies for Patient Reactions to Healthcare Information

Patients' perceived level of satisfaction	*n*	*%*
Very satisfied	12	50%
Satisfied	7	29%
Somewhat satisfied	5	21%
Neither satisfied nor dissatisfied	0	0%
Somewhat dissatisfied	0	0%
Dissatisfied	0	0%
Very dissatisfied	0	0%

All participants perceived their patients as expressing some level of satisfaction with the healthcare information they provided, indicating that patients perceived the recommended healthcare as acceptable. Findings therefore indicated that physicians perceived their healthcare recommendations as acceptable to patients, both at the time that the advice was given and after the patients had acted on it. Participants perceived their knowledge and experience as enabling them to provide acceptable, informative (i.e., awareness-raising) recommendations.

Participants' responses to the open-ended questionnaire item "How do patients generally react when you're providing specialized information about access to quality healthcare?" provided further detail about how and why patients appeared to find participants' advice about quality healthcare acceptable and informative (i.e., awareness-raising) at the time that it was given. Participants' open-ended responses characterized patients' reactions to information about healthcare as expressing not only satisfaction, but also enthusiasm, interest, and gratitude. P1, for example, stated of patients' reactions to healthcare information, "They are extremely thankful and appreciative." P12 perceived patients as "thrilled that they have access to the information they needed." P2 and P14 described patients as "excited" to receive information about quality healthcare, and P11 described patients as reacting "happily." P5 described patients as "very interested and appreciative" when they received healthcare information, and P16 described patients as "very responsive and receptive." P18 stated, "[Patients] are very cooperative and accepting of the medical advice provided." P9 perceived patients as grateful to be

directed toward the healthcare they needed, even though compliance with the advice required some exertion:

> [Patients] are pleased that I am directing them towards a specialist who can better care for and treat their needs. It may be frustrating bouncing from one doctor to another, but patients generally know that it is in their best interest. (P9)

P19 added that patients reacted positively to the empathy implied by the physician's concern for their wellbeing: "Patients feel connected, as they feel my genuine concern and my role in their overall care." Thus, participants perceived their influence on the acceptability of healthcare access for patients as positive, and as being exerted primarily through their knowledge and experience. Participants consistently reported that patients appeared to find healthcare information acceptable both when it was received and after acting on it.

Theme 2: Physicians Increase Accommodation Through Consideration of Patients' Needs and Coordination of Care

Data associated with this theme were drawn from participants' responses to two closed-ended and two open-ended questionnaire items. Qualitative data included in this theme were derived from the deductive code *accommodation*, which was associated with the accommodation healthcare access dimension defined by Penchansky and Thomas (1981). The access dimension of accommodation includes the coordination and integration of services. *Accommodation* has also been called *adequacy* (Saurman, 2016), and has been considered to include the ways in which a provider's practice is organized

to meet client constraints and preferences (Wyszewianski, 2002). This theme is divided into two subthemes, *considering individual patients' needs* and *coordinating care.*

Accommodation subtheme: Considering individual patients' needs. Data associated with this subtheme were drawn from two closed-ended questionnaire items. Accommodation is increased partly by meeting clients' constraints and preferences, which are communicated by the client in the form of knowledge about his or her own healthcare needs, experiences, and wishes. Physicians can therefore increase accommodation as a dimension of access by taking clients' reported knowledge of their own healthcare into consideration when providing care. Table 5 indicates response frequencies for the closed-ended questionnaire item "How often does patients' knowledge of their own healthcare influence your perception about your role when it comes to access to quality healthcare?"

Table 5

Response Frequencies for "How Often Does Patients' Knowledge of Their Own Healthcare Influence Your Perception About Your Role When It Comes to Access to Quality Healthcare?"

How often patients' knowledge is an influence on physicians' own role perception	*n*	*%*
Very often	11	46%
Somewhat often	12	50%
Not often	1	4%
Does not play a role at all	0	0%

Thus, 23 out of 24 participants perceived themselves as accommodating patients'

knowledge about their own healthcare at least somewhat often. Patients' accommodation

needs may also be indicated by objective information about their backgrounds.

Participants expressed that they often took patients' background information into

consideration when providing or recommending care. Table 6 indicates participants'

responses to the closed-ended questionnaire item, "Do patients' backgrounds help shape

physicians' influence on their access to quality healthcare?"

Table 6

*Response Frequencies for "Do Patients' Backgrounds Help Shape Physicians' Influence
on Their Access to Quality Healthcare?"*

Response	*n*	*%*
Absolutely	17	71%
Somewhat	6	25%
Not at all	1	4%

Twenty-three out of 24 participants therefore reported that they took patients'

backgrounds into consideration at least somewhat when providing or recommending

healthcare. It may be noted that the single participant who reported not taking patients'

backgrounds into consideration at all (P18) was also the participant who reported not

often taking patients' knowledge of their own healthcare into consideration. P18 was

therefore an outlier with respect to these two questionnaire items, and his other responses

(which were consistent with those of other participants) did not indicate why he made these selections. The possibility that he misinterpreted the items cannot be eliminated.

Accommodation subtheme: Coordinating care. Data associated with this sub-theme were drawn from two open-ended questionnaire items, including, "How have you facilitated patient access in the past?" and, "What success have you had with facilitating patient access in the past?" Four out of 24 participants reported that they improved accommodation for patients by coordinating care with other providers. This sub-theme was closely related to the accommodation sub-theme Considering individual patients' needs, because effective coordination of care with other providers involved carefully determining patients' needs. For example, P14 stated that to establish a basis for coordination of care, "I have used direct communication and personalized interviews" with patients.

P8 reported assisting patients with guidance on finding and establishment of care with other providers, stating that she accommodated patients and coordinated care by, "Assisting the patients to navigate the complex nature of the health industry, providing community resources, and assisting to set up appointments for health maintenance." To accommodate patients, P17 would, "Coordinate with care providers to facilitate discharge to other facilities and secure prompt appointment with primary care physicians." P23 expressed why coordination of care was an important aspect of accommodation and how she achieved it:

Access isn't just a question of overcoming the hurdle of being seen by a provider, but rather being seen by someone with the level of expertise required for the best

clinical outcome. I have facilitated patient access in different forms beyond

addressing timeliness of care, but also by encompassing access to information and

expertise between and among care teams with the ability to disseminate and

effectively communicate that information, both to providers and patients. (P23)

Theme 3: Physicians Increase Resource Availability Through Use of Electronic Medical Records

Data associated with this theme were drawn from participants' responses to two

open-ended questionnaire items, including "How have you facilitated patient access in

the past?" and, "What success have you had with facilitating patient access in the past?"

Qualitative data included in this theme were derived from the deductive code *availability

of resources*, which was associated with the availability of resources healthcare access

dimension defined by Penchansky and Thomas (1981). Penchansky and Thomas defined

availability of healthcare resources as including, but not limited to, availability of

personnel, facilities, and technology, and factors affecting the availability of these

resources, such as wait times.

Eleven participants indicated that they positively influenced the availability of

healthcare resources by leveraging electronic medical records (EMRs) to increase the

efficiency of their offices. EMRs were perceived as increasing the availability of

resources by decreasing wait times for office visits and information requests, through

allowing patients and staff to quickly access healthcare records online. When EMRs

were implemented, patients were able to access their own records and results without

having to call the practice, and staff could access patients' records rapidly. Increased efficiency also allowed more patients to be seen in the practice.

P22 implemented electronic medical records (EMRs) to increase efficiency: "With the use of EMRs, the facilitating of patient records has been efficient, smooth and very quick." Increased efficiency associated with EMRs allowed P18 to accommodate a larger number of patients: "The use of EMRs has enabled my practice to see more patients." P21 stated that EMRs also accommodated patients by sparing them from having to remember and report details of their medical history at each visit: "Having the efficiency of EMRs around, accessing patient records is now a breeze. It also saves the patient time with remembering past information." P16 described the implementation of EMRs as, "A great success," because: "Many more patients now have access to me and my office. Turnaround time to address patient questions is quicker."

Implementation of EMRs also allowed patients to access their own records and results online, which P2 described as, "A good accomplishment," because, "[Patients do] not have to wait for the Dr. to call them with their test results but can look it up by downloading my chart on their phone." P16 stated, "Through online communication, patients do not have to wait until their next appointment to have questions addressed." P12 described patient portals to provide access to electronic records as another means of accommodating patients through greater efficiency: "By using a patient portal, [I give] patients the opportunity to view their progression at home if they have internet access." P5 also reported accommodating patients through making, "provision for online communications via patient portals."

Summary

The research question used to guide this qualitative, phenomenological study was: How do physicians perceive themselves as influencing patients' access to healthcare? Three major themes emerged during data analysis to answer the research question. The themes were based on four of the six healthcare access dimensions defined by Penchansky and Thomas (1981) and Saurman (2016).

The first theme indicated that physicians perceive themselves as increasing healthcare acceptability and awareness through their knowledge and experience. Findings indicated that physicians perceived their healthcare recommendations as acceptable to patients, both at the time the advice was given and after the patients had acted on it. Participants perceived their knowledge and experience as enabling them to provide acceptable, informative (i.e., awareness-raising) recommendations.

The second theme indicated that physicians perceive themselves as increasing accommodation through consideration of patients' needs and coordination of care. Consideration of patients' needs was based on the physician's knowledge of the patient's background and on the patient's knowledge (as reported to the physician) of his or her own healthcare needs and preferences. Coordination of care was provided by communicating directly with and facilitating patients' communications with other, appropriate providers.

The third theme indicated that physicians perceived themselves as increasing resource availability through use of electronic medical records. EMRs were perceived as increasing the availability of resources by decreasing wait times for office visits and

information requests, through allowing patients and staff to quickly access healthcare

records online. When EMRs were implemented, patients were able to access their own

records and results without having to call the practice, and staff could access patients'

records rapidly. Increased efficiency also allowed more patients to be seen in the

practice. Participants did not report that they perceived themselves as influencing the

geographic proximity or the cost of healthcare, so no themes emerged that corresponded

to those access dimensions. Chapter 5 includes discussion, interpretation, and

implications of these results.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to explore the extent to which physicians perceive that they influence patients' healthcare accessibility. I adopted a qualitative interpretative phenomenological approach to explore and investigate the perceptions that physicians have regarding their role in influencing patients' access to healthcare services. In this study, a qualitative interpretative phenomenological strategy allowed me to conduct an in-depth exploration of the present topic using individuals who had practical experiences of the phenomenon. Precisely, I explored physicians' influence on healthcare accessibility for patients. As indicated by current literature, it was important to conduct the present study because there had been no previous research that investigated the extent to which physicians influence patients' access to healthcare services. In addition, the use of a qualitative interpretative phenomenological approach was consistent with the research problem, which alluded to the lack of phenomenological research examining the extent to which physicians feel that they influence the accessibility of healthcare services for patients. The present study was guided by one research question that was developed in line with Penchansky and Thomas's model of healthcare access (Saurman, 2016). The framework was selected because it identifies five factors that influence access to healthcare services. As a result, the guiding question was the following: How do physicians perceive themselves as influencing patients' access to healthcare? In this way, the research question was congruent with the study and offered a holistic approach to examining how physicians influence patients' access to healthcare, especially when

integrating Penchansky and Thomas's framework concerning the factors that influence access to medical services. To achieve the study objective, I used survey questionnaire to gather views, opinions, and perceptions from physicians on how they strategically influenced patients' access to healthcare services in various settings. Regarding the sample size, I used a sample of 24 physicians who were purposely selected for the present study using the prescribed inclusion and exclusion criteria. Interview responses from the 24 participants were analyzed using NVivo 12 software. In this chapter, I present the key findings established from data analysis, interpretations of the data, key limitations of the present study, future recommendations, implications of the current findings, and concluding remarks.

Based on the analysis performed, I found that a majority of the physicians believed that they had the capacity to influence access to healthcare services by promoting awareness. The influence was based on the fact that physicians had firsthand knowledge relating to different medical conditions that they could capitalize on to convince patients to seek medical attention or refer them to healthcare facilities that they considered to be well equipped in handling their sicknesses. The findings show that physicians perceived themselves to be well informed about different medical conditions, treatment processes, and possible alternatives that undecided patients used. Second, the study found that nurses perceived themselves as being highly influential when it came to accessing healthcare services by providing reasonable patient care and accommodation to patients with different medical conditions. The study concluded that improved patient care and reasonable accommodation offered by physicians tend to influence patients'

perceptions and desire to seek medical services. Lastly, the study also found that a majority of the physicians felt that they were highly resourceful by enhancing patients' access to various resources. Most important to emphasize was that a majority of the physicians noted that enhancing access to medical records as well as providing various resources to patients creates a satisfying experience that motivates patients to seek medical services when faced with illness. In addition, access to medical records and other key resources gives patients the opportunity to participate in designing or implementing treatment plans that suit their unique needs. In turn, the study established that such practices tend to involve patients directly in their treatment plans and motivate them to seek medical attention in the future.

Interpretation of the Findings

In general, the present findings suggest that physicians have a pervasive influence when patients' access to healthcare services is referenced. In this regard, their influence has a far-reaching impact on patients' willingness or motivation to seek medical support for various medical conditions. In particular, the findings show that nurses play an invaluable role in helping patients understand symptoms related to various health complications, the type of services to seek, and valuable advice on how to get it or recommendations for alternative services, both within and outside the health facility. The study findings show that physicians have the ability to impact patients' help-seeking behavior for chronic illnesses such as depression, anxiety, or mental disorders. In effect, the study found that physicians' influence may motivate patients to search for professional medical attention and dispel cultural or religious practices that can impede

access to quality healthcare services. An increase in access to healthcare services has previously been linked to improved emotional, psychological, and physical well-being of patients.

One finding that has be emphasized in relation to the present analysis is the resourceful nature of physicians. In view of the present findings, I found that physicians are more resourceful in terms of knowledge and access to medical records. As a result, physicians tend to use their resourcefulness in various areas to influence patients' access to quality health services. The findings from the Survey questionnaire, which were considered as the baseline for the study, yielded a total of three themes. The three themes are critical to the present analysis, in that they emerge from the research questions that guided the current study. The three themes are as follows: increase healthcare acceptability and awareness by recommending appropriate care, physicians increase accommodation through consideration of patients' needs and coordination of care, and physicians increase resource availability through use of electronic medical records.

Theme 1: Physicians Increase Healthcare Acceptability and Awareness by Recommending Appropriate Care

In regard to the above theme, I found that physicians influence patients' access to healthcare services in various ways. For instance, it was evident that as a result of recommending different treatments to patients and raising their awareness of various treatments, the probability of patients seeking medical interventions was higher compared to instances in which physicians' guidance and healthcare recommendations were limited. Contextually, all 24 participants in this study identified a strong link between

healthcare service awareness and patients' willingness to seek medical attention when faced with different medical complications. In particular, most of the participants stated that they felt that they were highly influential in determining the extent to which patients would seek medical assistance as an indispensable role of increasing their awareness, including the need to seek professional attention and show adherence to medication. According to interview responses, the rate of healthcare access for patients with no access to physicians' advice was lower compared to that of patients who had direct contact with physicians for free consultations or recommendations for various complications.

The implication of the present study's findings is that physicians strongly consider themselves to be pivotal conduits in facilitating patients' access to quality healthcare services in different facilities. Amidst the need to enhance access to healthcare services in various healthcare facilities and promote a better life for the people, the present findings allude to the fact that the role of physicians has become multidimensional. The findings are consistent with those of Stall et al. (2016), who stated that physicians not only do perform their routine duties in hospitals, such as caring for patients, but also have a decisive role in promoting healthcare awareness and recommending that patients seek appropriate medical services, a situation that increases accessibility to healthcare services. Correspondingly, the present results are supported by Saurman (2016), who found that most of the physicians surveyed perceived themselves to be instrumental in creating healthcare awareness among patients with the aim of improving the accessibility of healthcare services. Therefore, the current findings should

be interpreted in the context that patients find it compelling to consider medical

recommendations given to them by healthcare professionals.

In view of the study findings, I concluded that by using their reputation over the

years through close collaboration with key stakeholders, physicians' influence has

instantaneously gained the approval of the community. Usually, but not uniquely, the

study found that when a physician recommends a given medical procedure or offers

certain advice, many people in the community are likely to take the advice seriously and

follow it regardless of the hospital they visit. Therefore, the study concludes that

physicians are central when it comes to patients' healthcare accessibility because they

tactfully create health care awareness among patients and recommend suitable treatment

for them. The study findings correspond with those of Osborn et al. (2016), who

concluded that by frequently recommending that patients seek medical services,

physicians significantly influence their access to medical services. Another key

interpretation that can be derived from the present findings, which concurs with Pizam,

Shapoval, and Ellis (2016), is that while doctors may focus on diagnosing diseases,

nurses can use their close relationships with patients to educate them about related health

complications. Apparently, this not only relieves the burden on medical practitioners, but

also makes certain that patients are well educated, informed, and directed on how to

navigate the system in search of better healthcare services. In addition, the present

findings, which are supported by Thom et al. (2016), seem to suggest that by creating

awareness among patients, physicians may strategically increase patients' desire to seek

medical assistance, particularly given the fact that physicians make certain that patients are properly informed about their health conditions.

Contextualizing that the modern era in the medical industry is purely concerned with the inclusion of patients in the provision of healthcare services, especially in planning and recommending treatment solutions for various conditions, the study also found that physicians may promote patients' compliance through informal communication and make them feel understood. This may, in turn, improve the level of satisfaction in patients, yield better results, and promote the healing process. Similar findings to support the present results were reported by Stall et al. (2016) and Vogus and McClelland (2016), who stated that physicians play a significant role in ensuring that the public is well informed and equipped with valuable knowledge that can be used to make key medical decisions. Corroboratively, the present findings concur with those of Thom et al. (2016), who associated increased healthcare accessibility for patients to the role of physicians in creating health care awareness and recommending that patients seek medical assistance from qualified personnel.

Second Theme: Physicians Increase Accommodation Through Consideration of Patients' Needs and Coordination of Care

The results from semistructured interviews generated two re-occurring subthemes that offered invaluable insights into the understanding of how physicians perceive themselves as influencing patients' access to healthcare. The two subthemes that were generated from the interviews were (a) considering individual patients' needs and (2) coordinating care. Based on the analysis performed from the semistructured interview

responses, each of the study participants independently identified these themes as being foundational in influencing patients' access to healthcare services regardless of their medical conditions. The codes that resulted in these themes revolved around the basic responses that participants provided about the extent to which their influence impacted patients' access to health care services. The present result reveals that physicians assume an influential position that directly dictates the extent to which patients will be persuaded to seek medical services. This is because the manner in which patients feel cared for will automatically determine their willingness to seek medical attention or refer their friends.

Based on the analysis performed, all participants strongly indicated that physicians had a great influence on patients' access to healthcare services. For instance, the study found that physicians provided customized communication with patients by showing them empathy, respecting their needs, empowering them toward self-care, and showing compassion when interacting with them. The above factors were found to significantly influence the extent to which patients are motivated to seek medical interventions in different health facilities. The present findings are supported by Digiacinto, Gildon, Keenan, and Patton (2016), who established that physicians may induce self-gratification in patients by providing them with the much-needed emotional support. The study also found that showing care to patients significantly influenced their decisions to seek medical help or recommend to their friends and families physicians who earnestly care for and support patients. In the same way, the study findings were supported by Osborn, Squires, Doty, Sarnak, and Schneider (2016), who stated that the ability of a physician to be empathetic, help patients understand their needs, have cordial

conversations with patients, and solidify their bond with patients by showing respect to their needs can significantly improve patients' access to health services. Most of the participants strongly stated that compassionate care, which they provided, could make patients feel more comfortable even when they were in great pain. Therefore, by showing compassionate care, the study concluded that physicians provide patients with valuable support and confidence toward a lengthy recovery process or to help them battle chronic illnesses. In the long run, the study established that such practices may considerably influence patients' willingness to seek medical services.

Furthermore, the participants emphasized the benefits of providing reasonable accommodations for patients with various conditions to influence patients' access to health care services. In view of the above findings, I concluded that providing reasonable accommodations to patients, such as adjusting facilities to suit them, changing work schedules to suit their needs, or changing tests, may influence patients' decision to seek healthcare services. The findings are consistent with previous results that suggested that reasonable accommodations include providing patients with services or devices to aid their hearing (Digiacinto et al., 2016; Pizam et al., 2016). Communication, seeing, and movement impact patients' decisions to seek medical services in hospitals where such services are provided to them. In the same way, the study findings are supported by Qureshi et al. (2017), who stated that provision of customized care to patients in hospitals by physicians improves their self-esteem and desire to seek medical attention when faced with different health conditions. A key interpretation or implication that can be derived from the present findings is that physician practices such as the provision of reasonable

accommodation and caring for patients may influence patients' access to healthcare services.

Theme 3: Physicians Increase Resource Availability Through Use of Electronic Medical Records

Based on the analysis conducted using participants' responses, the third theme that was identified by me relates to increased access to medical resources. In regard to the analysis conducted, 22 participants identified access to medical records by patients as one of the best ways through which they influence their access to healthcare services. Based on the study findings, it was evident that increasing access to medical records strongly motivated them because it gave patients the opportunity to take control of their care management, inducing remembering and reviewing test results or refilling various prescriptions. By supporting access to medical resources, the study found that physicians have valuable information that can help patients make informed decisions and be strategic partners in determining and designing the best treatment plan. Guided by the aforementioned results, most of the physicians who took part in the study felt that such practices may improve patients' access to health care services. The present findings are supported by Wager, Lee, and Glaser (2017), who also found that patients' access to medical records gives them much-needed information to make informed decisions in seeking healthcare services. Likewise, Vogus and McClelland (2016) also established that physicians influence patients' access to health care services by providing them with relevant information that directly integrates them in the treatment plan. Furthermore, Richard et al. (2016) noted that physicians can influence patients' access to healthcare

services by enhancing their access to medical records and improving physician–patient communication, adherence to medication, and patient empowerment. In effect, such practices create a satisfying experience that meaningfully influences the accessibility of healthcare services for patients.

Limitations

Whereas the study provides invaluable findings relating to the extent to which physicians influence patient's access to health care services, there are inexorable limitations that underpin the present findings that the researcher wishes to acknowledge. First, one of the weaknesses that the preset study has relates to nature of the sample used. In this study, the investigator used a homogenous sample of participants. In particular, all participants were recruited from one geographical area. As such, their views and perceptions of how physicians influence patients' access to healthcare services may differ if participants from a different location are used. Second, the study could have been limited by the sample size used in the analysis. Only 24 participants took part in the study, a practice that limits the extent to which the present findings can be generalized to different groups. Third, the present study could have been limited with methodological issues such as scheduling variability, including time off and unforeseen social demands that could have impeded the investigator's ability to exhaustively analyze all responses from participants. Most important to emphasize is the fact this was a qualitative study that is based on subjective data. As a result, responses from participants could be deceptive or biased to some extent. Sometimes participants tend to exaggerate their

responses or simply become untruthful. Therefore, in regard to the present findings, it is advisable for one to carefully consider the above limitations.

Recommendations

In view of the limitations and strengths of the present study, the investigator proposes a few recommendations for future studies on this topic. First, future qualitative phenomenological studies should focus on the use of open recruitment approach for study participants. In this study, the researcher only focused on a limited group of individuals who were recruited from the same geographical location. To enhance the generalization of the current findings, future studies should recruit participants from different regions. Second, to enhance the validity and applicability of the research findings, the investigator recommends future studies to use a large sample size. In this study, the investigator only analyzed responses from 24 participants. A large sample size increases the quality of analysis hence justifying the generalization of the findings.

Implications

In reference to the study findings, two implications can be derived for positive social change. The first implication for positive social change is the increased availability of information about the physicians' role in influencing the accessibility to healthcare services in patients. This qualitative phenomenological study foundationally explored the role that physicians play in influencing patients' access to healthcare services. The study findings will help policymakers to gain a deeper understanding of the multidimensional role that physicians have in a hospital setting, and how to integrate them positively to increase access to healthcare services in marginalized areas. More specifically, the

pervasive influence that physicians have in the lives of patients, their role in dictating patients' willingness to seek medical innervation, the beliefs and perceptions learned to facilitate the use of medical services, and physicians counselling experiences when interacting with patients when support is sought. The information gathered in this study, if well used, may decrease the gap in the modern literature concerning the extent to which physicians influence patients' access to healthcare services.

Second, the study findings can be used to support the development of key strategies for promoting strong relationships between patients and physicians. Strong ties between patients and medical practitioners, as evidenced by the present findings, increase patients' access to healthcare services. Therefore, if there is the need to enhance mutual relationship between patients and physicians, the study findings could offer support as a blueprint. Positive relationship between physicians and patients can help dispel the influence of cultural and religious misconceptions, which frequently obstruct patients from accessing medical intervention for various conditions.

In regard to practice, one major recommendation can be derived from the study findings. Based on study findings, which illustrate that physicians could significantly influence patients' access to healthcare services, health professionals should be culturally sensitive when interacting with patients, if the aim is to build strong relationships with patients. An understanding of patients' cultural factors is critical when influencing their decisions toward healthcare services. In addition, the understanding will help physicians support patients within the confines of their cultural backgrounds. The increased cultural awareness could help physicians to change the untrue misconceptions

they have in regard to the use of medical intervention to treat various health complications.

Conclusion

The foundational focus of this present study was to investigate the extent to which physicians perceive that they influence patients' access to healthcare services. As a result, the investigator sought to understand some traits- feelings, thoughts, behaviors, and practices that physicians use to enhance patients' access to healthcare services, which added to the exiting theory of knowledge and literature. The investigator grounded the study on Penchansky and Thomas's (1981) model of healthcare access, as applied in healthcare. By using a qualitative phenomenological strategy, the researcher interviewed 24 physicians on how they influence patients' access to healthcare. The study was important to be conducted because there has been no prior research that has examined the degree to which physicians influence patients access to healthcare services. From the study analysis, it was established that physicians may use different practices such as empathy, improved patient care, provision or reasonable accommodation as well as increasing patients' access to medical resources to influence their access to healthcare survives. The present findings allude to the need to promote positive relationships between physicians and patient if the primary objective is to enhance access to healthcare services.

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Appendix

Interview Questions

How do physicians perceive themselves as influencing patients' access to healthcare?

Supporting research questions

1. What is your area of specialization as a physician?

    a. What do you like or dislike about your role as a physician?

    b. In what way does your professional judgement as a physician influence your perception when providing patients with information about access to healthcare?

2. Do you possess enough specialized knowledge that could positively influence patients' access to quality healthcare?

    a. If yes, how would you describe your comfort-level when providing specialized information that could influence patients' access to healthcare?

        A. Extremely comfortable

        B. Very Comfortable

        C. Comfortable

        D. Neutral

        E. Not Comfortable

    b. could you tell me about the sort of specialized knowledge you provide to patients at your practice?

c. What factor(s) make you less comfortable when providing specialized information that could influence patients' access to healthcare?

d. How satisfied are you with the overall results/feedbacks you receive from patients who follow through on information you recommended to them?

    A. Extremely Satisfied

    B. Very Satisfied

    C. Satisfied

    D. Neutral

    E. Not Satisfied

e. How do patients generally react when you're providing specialized information about access to quality healthcare?

3. In what ways do you perceive yourself as an influencer of patients' access to quality healthcare?

4. Which factors play a key role in your self-evaluation or perception as an influencer of patients' access to quality healthcare?

5. In what ways do patients knowledge of their own healthcare influence your perception about your role when it comes to access to quality healthcare?

a. Do you think patients' backgrounds help shape physicians' perceived

influence on their access to quality healthcare?