

THE POWER IS IN THE TALE: INTEGRATING
DIGITAL STORIES IN MEDICAL TRAINING ON
PATIENT-RELATIONSHIP-CENTERED CARE

By Martha J. Moore-Monroy

A Dissertation

Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Education
in Educational Leadership

Northern Arizona University

May 2023

Approved:

Frances Julia Riemer, Ph.D., Chair

Jennifer M. Blaney, Ph.D.

Patricia L. MacCorquodale, Ph.D.

Samantha Sabo, DrPH

ABSTRACT

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MARTHA J. MOORE-MONROY

The paradigm shift in healthcare from “sick care” to a disease prevention model is driven by the need to address health inequities. The new paradigm requires a change from the current “distant yet concerned” attitude to patient-relationship-centered approaches. Two questions drive this study: (a) How we can prepare physicians during residency to practice under the new model, and (b) What role can digital stories play in the process?

The results of this hermeneutic phenomenological study offer a view into the lived experiences of eight medical residents (family medicine, psychiatry, pediatrics, and emergency medicine), each participating in three interviews. The content of the conversations leads to an appreciation and understanding of their perspectives on patient centeredness, factors influencing patient encounters, and their emerging professional identities. The substance of these conversations result in an unanticipated switch in the role of digital stories from an “experience” to a tool or catalyst encouraging the residents to reflect on their path to medicine, clinical practice, and professional identities.

The digital stories, coupled with the study design, provide the residents with an opportunity to assess their sources of inspiration, capacity, and resilience to be empathetic and engage in advocacy. The study results have implications for the use of digital stories in health education professional training, as well as integrating hermeneutic phenomenology to promote reflection and self-assessment at critical junctures in medical residency.

ACKNOWLEDGEMENTS

The path to this dissertation has been a long one with many detours along the way. Thank you to the dedicated medical residents for sharing a view of your world. I am grateful to the family and community medicine faculty and the medical director of the poison and drug information center: I would not have been able to complete study without you.

Thank you to my committee members: Dr. Blaney, Dr. MacCorquodale, Dr. Sabo, and especially my chair Dr. Reimer. Thank you, Dr. Riemer, for sharing your knowledge, inspiration, and guidance from the beginning. You helped me find my voice to become a better writer. Dr. MacCorquodale, thank you for your support from my undergraduate studies through my dissertation.

To my family. My husband Gerardo, I am eternally grateful for your support, especially taking over so I had time to work and your willingness to put our lives on hold. My daughters, Amanda, and Becky, thank you for encouraging me and making me laugh. I love the three of you to the moon and back. Thank you to my sisters at National REACH Coalition: Charmaine, Denise, Tonya, as well as Daniel Dawes, for your friendship and dedication to health equity social justice. I am grateful to my students, colleagues, community partners, and friends; your enthusiasm to heal the world motivates me. Josh thanks for reassuring me. Donna thanks for being my sounding board and understanding.

To members of my “CoHeart” thank you for going through this wild ride with me. I wouldn’t have made it through without you. Maryanne, I am grateful for our long discussions, encouragement, and virtual walks. Elizabeth, your memes, and eternal optimism kept us going. Mel, thanks for sharing my warped sense of humor and your friendship. Finally, I would be remiss if I didn’t recognize the Muppets Phenomena song:

<https://www.youtube.com/watch?v=Dnk0Be4a0aw>.

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DEDICATION

To Amanda and Becky. My funny, fierce, and brilliant daughters: you are my heart.

To my best friend and life partner, Gerardo, and our next great adventure.

And to my students, the promise of a bright future.

CHAPTER ONE: INTRODUCTION

For illness is a social state of affairs. It is also a psychological-moral state of affairs much more than a fact that is determinable from within the natural sciences. All this, which formerly made the family doctor a friend of the family, indicates the elements of the medical efficacy of which we today are often painfully deprived. But even today the doctor's power of persuasion as well as the trust and the cooperation of the patient constitute essential therapeutic factors which belong to a wholly different dimension than that of the physical-chemical influences of medications upon the organism or of medical interventions. (Gadamer, 1996, p. 20)

The United States is undergoing a fundamental paradigm shift in the focus of healthcare from “sick care” to a disease prevention model. The new paradigm has been accompanied by a general recognition of the need to work toward health equity and patient-relationship-centered care. Camara Jones and colleagues (2019) defines health equity as “a process, assurance of the conditions for optimal health for all people” (p. 345). Health inequities are differences in health outcomes that are systematic, preventable, and unfair. Disparate health outcomes are rooted in the inequitable distribution of resources in society, disproportionately impacting historically marginalized communities. Patient and community civil rights and activism elevate awareness and catalyze change in the healthcare system (Timmermans & Oh, 2010). The current paradigm change is rooted in policy change and the increasing diversity of the United States population and healthcare system.

Policy shifts in healthcare focus on eliminating health inequities at all levels, including state and county health departments, municipalities, other governmental bodies, and public health professional organizations (American Public Health Association, 2022). The Patient

Protection and Affordable Care Act and the renewed focus on patient-relationship-centered care serve as primary drivers of the new paradigm. The intentions of the Affordable Care Act include increasing access to healthcare coverage and shifting the United States healthcare system to a prevention model concentrating on health equity and the social determinants of health (Dawes, 2016, 2020). Most recently, the Health Equity and Accountability Act centers exclusively on health equity, addressing racial and ethnic health inequities (National Hispanic Medical Association, n.d.).

The increasing racial and ethnic diversity in the United States general population and healthcare providers serves as an additional stimulus for profound change in the healthcare system. Recent census results indicate that almost four out of 10 Americans identify as members of a racial or ethnic group other than White (Frey, 2020). The Association of American Medical Colleges reports increasing diversity in the applicants and students enrolling in medical school for the 2021-2022 academic year. African Americans constitute 11.3% of the matriculating class, an increase of 9.5% over the previous year. An accompanying more modest growth in Latino medical students is increasing by 7.1%, representing 12.7% of first-year students. Women comprise 55.5% of first-year students in the 2020-2021 academic year (Association of American Medical Colleges, 2021). The increasing numbers and racial and ethnic diversity of patients, combined with the growing diversity of healthcare providers, are changing the face of healthcare. The new healthcare environment centers on patient-relationship-centered care. Patient-relationship-centered care requires a collaborative partnership between providers, patients, and empathetic providers (Pedersen, 2009; Underman & Hirschfield, 2016).

Despite increasing emphasis on addressing the social determinants of health and patient-relationship-centered care, a gap exists in the literature related to training on social determinants

of health and emotional socialization in physician training (Gard et al., 2019; Sinclair et al., 2021). How do we effectively prepare physicians to align their clinical practices with the new care model? Secondly, how can we reshape professional identity? Digital stories, an arts-based approach, have the potential to address the training gap as a part of a comprehensive training curriculum. Digital stories are impactful 3–5-minute multi-media videos created by individuals based on their lived experiences (Hardy, 2007; Lambert & Hessler, 2020; Pratt, 2019). Digital storytelling and digital stories have shown promise to increase understanding of the impact of social determinants of health and patient-relationship-centered care for nursing and public health students (Christiansen, 2011; Hawthornthwaite et al., 2018; Sinclair et al., 2021; Watson, 2007). However, there are few examples in the literature on the use of digital stories in medical education and training (Moreau et al., 2018).

Statement of Problem

Although health is naturally the goal of the doctor's activity it is not actually 'made' by the doctor. Connected to this is something further: the goal of health is not a condition that is clearly defined from within the medial art. (Gadamer, 1996, p. 20)

This hermeneutic phenomenological study contributes to an understanding of how to increase medical residents' grasp of the importance of elements of patient-relationship-centered care through their experiences with digital stories. The results of this study provide insight into how digital stories, as arts-based immersive experiences, shape physicians' understanding of their practices under the new healthcare paradigm. Specifically, the investigation centers on how these arts-based experiences contribute to a comprehensive, immersive curriculum preparing physicians to practice under the new healthcare model. Medical residents have little time to master all the requisite skills and knowledge during their three- to six-year residencies. Digital stories can potentially address this conundrum as a flexible and brief, yet powerful, training

modality (Christiansen, 2011; Hardy, 2007; Lambert & Hessler, 2020). Digital stories fit well into residents' hectic and packed schedules. Training modalities using digital stories are exceptionally flexible. They can be administered online or in person and conducted in groups or individually.

Research Questions

- 1) How do healthcare providers experience digital stories in the context of their practice?
 - a) How does the experience influence their understanding of social determinants of health and political determinants of health?
 - b) How does the experience influence their understanding of integrating social determinants of health and the political determinants of health into treatment plans?
 - c) How do their experiences with the digital stories contribute to their understanding of a patient-relationship-centered approach?
- 2) How do health care providers' experiences with digital storytelling shape or inform their interaction and communication with patients?
 - a) How do providers' experiences with digital stories support emotional socialization?
 - b) How do digital stories move providers toward adopting a more patient-relationship-centered practice?

Research Problem

Numerous public health, medicine, and nursing studies center on the impact of the social determinants of health on the health inequities confronting historically marginalized communities (Barr, 2019; Commission on Social Determinants of Health, 2008; Daniel et al.,

2018; Dawes, 2020; Satcher, 2020). Recently, professional medical societies, including the American College of Physicians and the American Academy of Family Physicians, have enacted policies encouraging physicians to screen for the relevant social determinants of health impacting their patients' health (Adler et al., 2016; American Academy of Family Physicians, 2019; Daniel et al., 2018). Simultaneously, there are renewed efforts to implement patient-relationship-centered care. Park and colleagues (2018) report improvements in healthcare quality resulting from interventions integrating elements of patient- and family-centered care into clinical practice. Patient-relationship-centered care is grounded in the collaboration between patient and provider and in physician empathy.

Significant is patient-relationship-centered care's emphasis on patient perspectives, experiences, and personal health goals (Raja et al., 2015). The question is how to support and encourage primary care providers to understand the elements of patient-relationship-centered care and consider and integrate the relevant social determinants of health into treatment plans. Articles in the literature report the promise of digital stories in training current and future healthcare providers on social determinants of health (Christiansen, 2011; Hardy, 2007). Additional studies report on the use of digital stories and digital storytelling to shift the focus of healthcare professions students from disease-centered to more patient-centered approaches.

The focus of the current study is to assess how medical residents' experiences of digital stories documented through post-screening interviews impact their understanding of the importance of elements of patient-relationship-centered practices and consider the contextual factors (i.e., social determinants of health) affecting their patients' health. Drawing on a hermeneutic phenomenological framework, this qualitative study identifies gaps in the literature

on the potential of experiential training utilizing digital stories to increase provider understanding of the tenets of patient-relationship-centered care.

Researcher Location and Positionality

I am a public health professional with thirty years of experience in health promotion sciences, employed by a large public university in the southwest border region of the United States. My work includes teaching undergraduate and graduate courses focused on immersive experiences in research on women's health, health inequities, and program planning, implementation, and evaluation. In addition to my teaching responsibilities, I collaborate with historically marginalized racial and ethnic communities (rural and urban, locally and nationally) on community-based research and action to address health inequities. Most of my research and program development work centers on community health in Latino communities, chronic disease prevention, and reproductive, maternal, child, and family health. Digital stories and digital storytelling, whenever possible, are integrated into all my work. The guiding philosophy for my work is "community as an expert." The role of a public health professional is to provide support and capacity building to assist community efforts to achieve their self-identified health goals and objectives.

Outside my work at the university, I provide technical assistance to communities and governmental and non-governmental agencies on community-led approaches to addressing health inequities for racial and ethnic communities. I am the vice president of the National REACH Coalition board of directors. In my capacity as the vice president of the board, I provide technical assistance to policymakers, communities, and other organizations, as well as in collaboration with other national organizations, to advocate for national policy and funding to support the racial and ethnic health equity movement in the United States. This study provides

the opportunity to expand my work in health equity, healthcare workforce training, and arts-based approaches in clinical settings.

Theory

“...what we know from ‘science’ is incomplete and, therefore, can no longer be called a ‘doctrine.’ It consists of nothing other than the current state of ‘research’” (Gadamer, 1996, p. 4).

Hermeneutic phenomenology provides the philosophical foundation and methodological framework for the study. The roots of phenomenology lie in the philosophical ideas of Edmund Husserl and Martin Heidegger (Lavery, 2003; Peoples, 2021). Phenomenology is an interpretive school of thought which posits that we can best understand people through their lived experiences or “dasein” and the co-construction of knowledge and understanding (van Manen, 1997). Phenomenology is divided into two types, interpretive or hermeneutic phenomenology (founded by Martin Heidegger) and descriptive/transcendental phenomenology, also referred to as Husserlian phenomenology (founded by Edmund Husserl). Edmund Husserl is recognized as the father of phenomenology, which countered positivism in that it acknowledges the subjective nature of science (Connelly, 2010; Moustakas, 1994). Both philosophical schools recognize the subjective nature of research and are interpretive/constructivist frameworks. Both frameworks focus on how individuals “experience” phenomena in addition to their reactions and strive to capture the “essence” of lived experiences in their investigations (Connelly, 2010).

Transcendental phenomenology differs in several ways from hermeneutics. Primary among these differences is whether researchers can set aside/control or “epoche/bracket their bias” or pre-conceptions to avoid undue influences on the investigation (Connelly, 2010; Moustakas, 1994; Peoples, 2021). Hermeneutic phenomenologists not only emphasize the subjective nature of research but embrace it. Heidegger advances that our pre-conceptions and

past experiences intricately shape our very beings. Heidegger argues that as part of the social world, it is impossible to separate ourselves from our very existence in the social world (Connelly, 2010; Peoples, 2021; Standing, 2009; van Manen, 1997). Central to hermeneutics is Gadamer's concept of the "fusion of horizons," where understanding results from past experiences melding with the present (Gadamer, 1989, 1996). "Intentionality" defines the principal role of the investigator, which is to reveal the "essence" of an experience (Flood, 2010; van Manen, 1984, 2016). The hermeneutic circle refers to the iterative process of interpreting and revisiting an experience resulting in a new understanding/perspective.

A hermeneutic phenomenological approach is appropriate for this study due to the foundational principles of this school of thought:

- acknowledgement and interpretation of bias of both the researcher and participant
- epistemological focus on experiencing and understanding
- unit of analysis is the exchange between situation and individual
- acknowledgement of the pre-understanding (aka fore-conceptions) of phenomena
- iterative process of interpretation as a means of understanding
- dasein: people exist in the world and reside in it (Hermeneutic circle) (Lavery, 2003; Peoples, 2021).

Reflection and reflective practice in medical education is rooted in positivism, critical theory, and interpretive theory (Kauffman & Mann, 2013). The reflective practice incorporates an iterative process where theory and practice mutually impact each other. The reflective practice model in medical education integrates aspects of interpretive theory and hermeneutic phenomenology in that it posits that understanding an experience or situation is based upon both past and present events. Kauffman and Mann (2013) tie reflective practice to critical theory in

“Theory guides or enlightens action and understanding” (p. 12). They discuss the three iterative stages of reflective practices, which mirror basic principles of hermeneutic phenomenology: (a) experience, (b) revisiting the experience through reflection, and (c) re-evaluation.

Methodology

Hermeneutic phenomenological principles provide the framework for the study. Physicians completing their residency in family medicine and those in other specialties participating in a toxicology rotation comprise the participant co-researchers for the investigation. The participant co-researchers view two digital stories reflecting on specific aspects of health and resilience. The tenets of the patient-relationship-centered care model depicted in Chapter 2 (Figure 2) serve as the standards for choosing the digital stories the participant co-researchers view. In agreement with the standards of hermeneutic inquiry, the primary data collection method includes a series of three semi-structured interviews to identify fore-conceptions, capture the essence of the experience, and develop a co-construction of the meaning of the experience (Flood, 2010; Seidman, 2019). While viewing the digital stories, the participant co-researchers are asked to jot down two-word reactions to the stories. The interviews are recorded and transcribed; I supplement that data with field notes and journaling.

Definition of Key Terms

Cognitive meaning: The specific intention of the text as interpreted through standard language. Van Manen (1984) and Flood (2010) proposes that cognitive and non-cognitive meanings combine to create a complete understanding of the lived.

Dasein: Refers to individuals’ lived experiences. The term means “being” in the world; therefore, according to hermeneutic thought, it is impossible to separate ourselves from the social world, our experiences, and our personal history (Connelly, 2010; Peoples, 2020; Standing, 2009; van Manen, 1997).

Essence: The essence of an experience is the non-intellectualized and not yet reflected upon account of the lived experience (Flood, 2010).

Fore-conception: Preconceived notions and biases based upon an individual's life history (Standing, 2009).

Fusion of horizons: The fusion of horizons results from the hermeneutic circle. The fusion of horizons occurs when once the iterative process of the hermeneutic circle concludes and refers to the point at which the past and the present combine to create a new perspective (Gadamer, 1989).

Hermeneutic circle: The iterative process of interpreting and reinterpreting the text of the experience resulting in the development of a new perspective (Standing, 2009; van Manen, 1984).

Intentionality: The role of the researcher is to interpret the experience shared to uncover the essence of the experience.

Non-cognitive meaning: Poetic and transcendent aspects of the text when non-cognitive meaning combines with cognitive meaning to create a mutual understanding of the content or text (Flood, 2010; van Manen, 1984).

Chapter Summary

In his treatise *The Enigma of Health*, Gadamer (1996) describes the practice of medicine as more of an art than a science, emphasizing the critical role lived experience, practice, and understanding play in effective medical treatment. "...the fact that even now, the idea of the good doctor or even the medical genius has much more of the prized esteem we think characteristic of an artist than a man of science" (Gadamer, 1996, p. 21). The literature on the phenomenology of medicine supports using a hermeneutic framework for the current investigation. Kay Toombs (2001) notes that even though the phenomenological perspective has been overlooked in medical research, it has much to contribute to understanding the meaning of

health and to successful clinical communication, decision-making, and patient-provider relationships. The current study connects the demands/requirements of patient-relationship-centered care placed on providers to effectively practice under the new health care paradigm with a medical phenomenological perspective and methodology. Reflective medical training and practice, patient-relationship-centered care, digital storytelling and stories, and hermeneutic phenomenological perspective share principal constructs. The phenomenological exploration of digital stories as a potential method to impact medical providers' understanding of the basic tenets of patient-relationship-centered care is built upon the shared constructs. The results of this study show promise to inform the development of a more efficient and effective immersive training modality for medical residents.

CHAPTER TWO: LITERATURE REVIEW

Introduction

In the early 1940s, when I had my near-death experience with whooping cough and pneumonia, issues of access to health care and quality of care were both paramount, but they were also related to racial segregation, discrimination, and poverty. (Satcher, 2020, p. 36)

The primary aim of this literature review is to explore the potential of digital stories as part of more comprehensive training for providers on social determinants of health and patient-centered care. The review examines studies of the United States healthcare system paradigm shift and healthcare training. Further, it explores potential components of a new model of medical training that can increase healthcare providers' capacity to understand and integrate social determinants of health and patient-centered approaches in their practices. Digital stories are short videos (3–5 minutes) created by community members who share their lived experiences. These videos are narrated by the creators and combine photos, video passages, and music. Digital stories can be powerful tools for training and empathy.

Traditionally, medical education has focused on developing a detached yet concerned approach to patient care. The new healthcare paradigm requires an empathetic collaboration with the patient rather than an authoritarian approach. Finally, the new paradigm calls for a focus on equity and a whole-person approach rather than a disease focus. Teaching and learning under traditional graduate medical education reinforce racist, misogynist, and structural inequities.

Health inequities are differences in health status which are preventable, unjust, and systemic. They disproportionately impact historically marginalized communities, particularly communities of color. These inequities are centuries old and impact individuals, communities, and nations around the globe (Barr, 2019; Cooper, 2021; Dawes, 2020; Friel & Marmot, 2011;

Satcher, 2020). The COVID-19 pandemic has spotlighted the magnitude of national and global inequities (Cooper, 2021; Cefalu & Rodgers, 2021). Health inequities negatively affect society as a whole and those communities that are directly impacted. Beyond human suffering, health disparities have substantial economic costs far beyond the health system. In the United States, inequities are estimated to cost \$309 billion dollars annually (Daniel et al., 2018). The root causes lie in the social determinants of health and the political determinants of health (Barr, 2019; Daniel et al., 2018; Dawes, 2020; Satcher, 2020). The social determinants of health (see Figure 1) are conditions under which we work, live, worship, and play which contribute to disparate adverse health outcomes or protect individual and community health. Due to these social determinants of health, racial and ethnic communities have higher morbidity and mortality rates than members of White communities (Barr, 2019; Cooper, 2021; Daniel et al., 2018; Dawes, 2020). The chronic stress experienced by racial and ethnic communities resulting from all levels of racism directly impacts health outcomes. “This stress, sometimes referred to as ‘weathering,’ results from lifelong exposure to discrimination and racism, which manifests in all areas of life and causes a kind of accelerated aging that is visible at a cellular level” (Cooper, 2021, p. 173).

The political determinants of health are political processes, decisions, and policies that impact the inequitable distribution of resources. These systemic resource inequities result from political decisions, institutions, and processes and are the ultimate source of health inequities (Dawes, 2020). As Dawes (2020) states: "Girding all of the health determinants is one that rarely gets addressed, but which has power over all aspects of health; the political determinants of health" (p. 1). The political determinants of health have recently begun to gain traction with health equity researchers, advocates, and activists.

Literature Review Roadmap

The literature review places the study within the context of current and seminal research. The review identifies relevant studies and gaps in the literature on the paradigm shift in healthcare, physician education on patient and family-centered care and emotional socialization, and the use of digital stories in health care training. Chapter 2 also identifies the current study's potential contributions to the field of medical education concerning health equity, patient-centered care, and the role of digital stories in health care training. Specifically, the literature review draws on three content areas in the literature: (a) paradigm shift in healthcare, (b) graduate medical education and preparing physicians to practice under the new paradigm; and (c) the potential of a humanist arts-based approach with digital stories.

The Paradigm Shift in Healthcare

Health Inequities

Social factors such as low education, racial segregation, and low social support can have an effect on mortality that is similar to medical conditions such as acute myocardial infarction, cerebrovascular disease, and lung cancer. (Bleacher et al., 2019, p.13)

The United States spends more on healthcare than any other high-income nation, yet has worse health outcomes (Barr, 2019; Daniel et al., 2018; Devoe et al., 2016; Kiles et al., 2020; Wilkinson & Pickett, 2009). Adler and colleagues (2016) attribute this difference partly to the United States' substantially more significant primary investment in clinical services than that of other wealthy nations. Social determinants of health, such as limited access to culturally and linguistic appropriate services, racism, and other forms of systemic oppression are a few of the primary drivers of health inequities (Barr, 2019; Cooper, 2021; Dawes, 2016, 2020; Satcher, 2020).

Figure 1

Healthy People 2030 Social Determinants of Health



Note. From Office of Prevention (n.d.-c).

Health inequities disproportionately negatively impact historically marginalized communities categorized by low socioeconomic status, racial and ethnic status, and other oppressed groups (Adler et al., 2016; Barr, 2019; Cooper, 2021; Daniel et al., 2018; Satcher, 2020). Daniel and colleagues (2018) report a 15-year difference in life expectancy between privileged and marginalized communities. Kolak and colleagues' (2020) cross-sectional study of more than seventy thousand census tracts within the continental United States quantifies the impact of neighborhood-level (place-based) social determinants of health on health outcomes. Their results confirm and expand upon other studies that demonstrate how low socioeconomic status accounts for close to half the difference in health outcomes between groups. Additional

studies have determined that social determinants of health may account for up to 80% of the amendable contributors to population health outcomes, while clinical factors are attributable to 10-20% (Daniel et al., 2018; Schoenberger et al., 2021). “Our findings confirm and extend the literature associating social determinants of health indicators with health outcomes, including policy reviews based on both clinical research and population-based studies, which have hypothesized that 60% of early deaths in the United States are associated with nonclinical factors” (Kolak et al., 2020).

Racial and ethnic communities unduly suffer from health inequities. Health outcomes related to urologic oncology differences in morbidity and mortality rates exemplify inequities in just one health area. A literature review of urologic health outcomes conducted by Ufua and colleagues (2021) found that patients from racial and ethnic communities have lower screening rates for urologic cancer, resulting in a later diagnosis of cancer, worse outcomes, and higher mortality rates than White patients. These disparate outcomes result from differential access to care, lack of insurance coverage, and other social determinants. Latinos receive lower-quality health care measured by standard quality metrics and are less likely to be screened for cancer and cardiovascular disease (Dawes, 2020). Latinos are half as likely to have health insurance than White non-Latinos. Despite high employment rates, Latinos are less likely to have employers offering health insurance. Further, Latinos with limited English proficiency are less likely than other groups in the United States to have a regular source of health care (Office of the Assistant Secretary for Planning and Evaluation, 2021).

Over the past two decades, increased attention and investment by the United States government and healthcare system has been focused on health inequities and the critical role social determinants of health plays in health outcomes. Augmented federal funding for health

disparities research, interventions, and policy reach back to the Healthy People 2000 Goals established in 1990. The Healthy People 2000 Goals focus on simply reducing health disparities, and the subsequent Healthy People Goals (2010, 2020, 2030) focus on eliminating inequities (Marwick, 2000; Satcher, 2020). The Healthy People 2020 and 2030 strategic plans also incorporate specific objectives directly addressing social determinants of health (Office of Disease Prevention, n.d.-a). The United States Department of Health and Human Services has published its Healthy People 2030 goals for easy public access (Office of Disease Prevention, n.d.-b).

Central to this study is the historical change in national attention and investment in health equity work which has contributed to the paradigm shift in healthcare. During his tenure as Surgeon General, Dr. David Satcher shifted the focus of the Healthy People Goals to concentrate on the elimination of racial and ethnic health inequities rather than merely calling for a reduction in disparities (Satcher, 2021). Dr. Satcher's foundational work transforming the goals is significant because the new focus establishes measurable objectives and catalyzes public health equity efforts. The subsequent prioritization of health equity resulted in the following policy changes and health initiatives:

- Minority Health and Health Disparities Research and Education Act;
- Health Equity and Accountability Act;
- National Center for Minority Health and Health Disparities at the National Institutes of Health in 2000;
- Racial and Ethnic Approaches to Community Health Program at the Centers for Disease Control and Prevention; and

- publication of the first National Healthcare Disparities report in 2003 by the Agency for Healthcare Research and Quality, among others (Congressional Hispanic Caucus, 2020; Dawes, 2016, 2020; Satcher, 2020).

Bleacher and colleagues (2019) describe the crucial role strategies designed to address social determinants of health and integrate patient-centered care contribute to the healthcare system's ability to achieve the "quadruple aim." In healthcare, the quadruple aim focuses on reducing costs while improving population health, the patient experience, and the work-life of healthcare providers.

The evidence verifying and measuring the impact of the social determinants of health on health outcomes is substantial. Social determinants of health are no longer “categorized strictly as non-medical factors and, therefore, outside the scope of medical care” (Bleacher et al., 2019, p. 14.) National professional medical associations, including the American Medical Association, American Academy of Family Medicine, American Academy of Pediatrics, and American College of Obstetrics, have established standards, policies, screening tools, and best practices for clinicians on incorporating social determinants of health into clinical practice (American Academy of Family Physicians, 2019; Daniel et al., 2018; Davidson & McGinn, 2019). The development of policy and practices by these professional associations underscores institutional and professional recognition of the critical role focusing on social determinants of health plays in the efforts to eliminate health inequities. The American College of Physicians position paper states: “The [American College of Physicians] believes that understanding and addressing the social factors that affect health outcomes is a pressing issue for physicians and medical professionals in the communities they serve” (Daniel et al., 2018, p. 578). Bruno and colleagues

(2012) report that approximately 45,000 deaths annually can be attributed to the lack of insurance, just one type of social determinants of health.

Many questions remain about the ability of primary care providers to effectively screen and integrate the relevant social determinants of health into treatment plans (Bleacher et al., 2019). The value of the integration of social determinants of health into care plans is further underscored by the Institute of Medicine and the National Quality Forum's policy on the inclusion of social determinants of health data in electronic health records (Hughes et al., 2016). Hughes and colleagues (2016) suggest that recent advances in healthcare information and geospatial technology make it possible to link community-level data to a patient's zip code and provide baseline data on some of the relevant social determinants of health within the patient's community.

The political determinants of health are a relatively new concept focusing on political activities and policies resulting in the inequitable distribution of resources that affect associated social determinants of health. Dawes (2020) argues the ultimate elimination of health inequities requires an understanding of, and the ability to, address these upstream factors. Political action (or lack thereof) reinforces and supports systemic inequitable distribution of resources and power, hence social determinants of health and health inequities (Dawes, 2020). The political determinants of health are issues lying further upstream than social determinants of health. Political determinants of health are factors (policy, decisions, action and inaction, political systems, institutional factors, among others) influencing the inequitable distribution of resources shaping social determinants of health, resulting in "generational and situational poverty; broken educational, criminal and health systems; inadequate transportation; housing instability and insecurity; poor nutrition and diet; and lack of health literacy" (Dawes, 2020, p. 8). These

national efforts to eliminate health inequities demonstrate political determinants of health's critical role in the health equity movement.

The impact of “place” on health outcomes focuses on the political determinants of health at the intersection of planning and public health. The decisions and policies governing where to locate resources, such as green space, subsidized housing, recreational facilities, access to public transportation, sidewalks, and bike lanes, among other community resources, are developed by planners and decided through policy, codes, and other political processes. Browne et al. (2019) conducted a qualitative analysis focusing on the effort of local government planners in Victoria, Australia, to address social determinants of health through the urban planning process. The results of their study demonstrate the initial success of Victoria’s government’s strategies to address the social determinants of health to improve health outcomes.

Physicians have a primary responsibility to the health of the patients and the communities they serve. Furthermore, their advocacy role is bolstered by their high prestige and authority in the community. Their medical and health knowledge and expertise translate into influence and access to policymakers (Croft et al., 2012; Pettett, 2011). Fulfilling the advocacy role requires physicians to understand the social determinants of health and political determinants of health influencing individual, community, and population health. Croft and colleagues (2012) underscore the importance of physicians’ advocacy responsibility to society, particularly in supporting ethical health policy. Unfortunately, few residency programs include advocacy electives (Croft et al., 2012). Digital stories have a long advocacy track record (Lambert & Hessler, 2018). The current study can potentially increase residents’ understanding of social determinants of health and political determinants of health to support their advocacy role.

The socioecological model provides a framework for understanding social determinants of health and political determinants of health and their effect on health outcomes. The model focuses on individual and community/population health outcomes shaped by individual and community interaction with social structures and policy (Rimer & Glanz, 2005). Changes in individual and collective behavior influence social structures and policies at various levels of the socio-ecological system (Rimer & Glanz, 2005).

Closely related to the socioecological model are place-health models, grounded in the social construction of place. Andress and Purtill (2020) developed a place-health model; they describe how the construction of a place reinforces and reproduces the stratification system, resulting in the inequitable distribution of resources. The final piece of the model integrates a structural competency analytical framework. The structural competency framework moves the focus from cultural and individual impacts on health to include systemic and structural components in a medical diagnosis. The model identifies specific levels of trainee proficiency and associated metrics.

In addition to the emphasis on the impact of social determinants of health on health outcomes, there is a renewed focus on patient-centered care (Beach et al., 2005, 2006; Cooper, 2021; Park et al., 2018). Patient-centered care is closely tied to social determinants of health. Patient-centered care is conditional upon healthcare providers' understanding of the relevant social assets and barriers impacting their patients' health. Considerable evidence in the literature supports patient-centered care's ability to increase culturally and linguistically appropriate care and address provider bias, increasing the likelihood that patients will follow treatment plans (Cooper, 2021; Kressin et al., 2016). I developed a patient-relationship-centered care framework incorporating the literature review results to guide this study (see Figure 2). The patient-

relationship-centered model combines the elements of patient-relationship-centered care and social determinants of health, specifying key concepts vital to understanding patient-relationship-centered care.

Patient-Centered Care

“The good physician treats the disease; the great physician treats the patient who has the disease” (Osler, as cited in Centor, 2007).

Attempts to shift provider perspective from "disease" centered to patient-centered and focus on the importance of provider compassion and empathy are not novel. Enid Balint's "medical thinking" contributes to a framework for patient-centered care in the construction of a comprehensive treatment plan (Balint, 1969; Saha et al., 2008). Medical thinking requires the provider to gather in-depth information about the patient, not only identifying the specific pathology of a health condition. The perspective centers on treating the whole person rather than the particular malady or body part. The model supports the development of a comprehensive diagnosis (Balint, 1969). Balint's (1969) model emphasizes that each patient must be seen as a whole and unique human being. Building on Balint's framework, McWhinney's foundational principles of patient-centered care assert, “Practicing the method requires an open-ended inquiry into the patient’s concerns and the patient’s needs for comfort, for information, and for being understood” (Epstein et al., 1993, p. 380).

The determination of being well or unwell, healthy or sick, are social constructs with specific implications related to social roles and obligations. Medical anthropologists and sociologists have developed distinctions between the concepts of illness and disease as social constructs of health. Disease refers to a health condition identified through medically recognized clinical or laboratory tests leading to an established diagnosis by a "qualified" medical

practitioner. "Illness" is the recognition by an individual of not feeling well or right. "Illness" refers to the lived experience of feeling sick either by the individual or by members of society (Aho & Aho, 2008; Germain, 1992; Kato, 2022; Kleinman et al., 1978; McWhinney, 1993). The distinction between disease and illness provides an understanding of the differences between patient- and provider-centered care.

Patient-centered models of care focus on the whole patient and their perception of illness (lived experience) and lie at one extreme of a continuum; the provider-biomedical model lies at the other. The provider-biomedical model focuses on a specific health issue or body part, whereas the patient-centered model centers on treating the patient as a whole and unique individual (Aho & Aho, 2008; Balint, 1969; Pedersen, 2009; McWhinney, 1993). Kleinman and colleagues (1978) posit that the biomedical model and shifts in the health care system increase patient dissatisfaction. The provider-biomedical model focuses on curing the disease and often leads providers to discount a patient's experience of discomfort. The biomedical-provider-centered model increases the number of diagnostic tests ordered, further increasing patient discomfort. Diagnostic tests are expensive and may carry significant risks (McWhinney, 1993). Disregarding patient discomfort often results in poor outcomes due to patients not following treatment plans.

Patient-centered care is proposed as a solution to providers' lack of recognition of the legitimacy of illness, the accompanying increase in patient dissatisfaction and reduction, and the deterioration in the quality of care. Clinical care and research must look at curing disease and healing illness (Kleinman et al., 1978). The value of a patient-relationship-centered care approach is that it considers both biological factors and related social determinants of health. McWhinney states:

There are so many illnesses in which the personal experiences of patients, especially their ability to function in their environment, are as important, if not more important than the clinical diagnosis: for example, chronic disease, chronic symptoms without physical pathology, and problems of the aged. (1993, p. 4)

Patient-centered care depends on a collaborative partnership between provider and patient, provider reflection, collaborative health care decision-making, and trust. Patient-centered care promotes communication and a greater understanding of the specific cultural/linguistic factors, and also recognizes and respects patient agency. Patient-centered care positively impacts health and efficiency of care and potentially reduces lawsuits (Bau et al., 2019; McWhinney, 1993). Stewart and colleagues (2000) report patients' perception of patient-centeredness improves recovery and efficiency of care.

Closely related to patient-centered approaches is relationship-centered care. Relationship-centered care centers on the type and quality of relationships in health care, which go beyond the traditional patient-provider relationship (Beach et al., 2005). The four principles of relationship-centered care identified by Beach and colleagues include recognizing: (a) participants in health care relationships as individuals, (b) the vital role emotion and affect play in these relationships, (c) the bidirectional nature of these relationships, and (d) the creation and sustainability of relationships in health care are "morally valuable" (2005, p. S3).

The increased focus on patient-centered care, relationship-centered care, and social determinants of health is further supported and influenced by the shift in the foundational health care paradigm from a predominantly "sick care" to a prevention focus. The Patient Protection and Affordable Care Act serves as both a catalyst and a partial roadmap for the new paradigm. To support this new paradigm, the Patient-Centered Outcomes Research Institute, a nonprofit

nongovernmental agency, was authorized by Congress in 2012. Their mission is to provide funding and support research to address the lack of actionable research on patient-centered outcomes. The primary goal is to increase the available, relevant information for patients and providers to support collaborative decision-making to promote diversity, equity, and inclusion (Patient-Centered Outcomes Research Institute, n.d.). The paradigm shift necessitates a change in focus in provider training

Patient-Relationship-Centered Care Model

I developed a framework integrating the social and political determinants of health with the basic tenets of patient-centered and relationship-centered care. The patient-relationship-centered care model is based on the results from my literature review and provides an organizational framework for this research project. The patient-relationship-centered model is presented in Figure 2. The figure incorporates key results from the literature review and identifies the corresponding knowledge and skills needed for providers to practice in the new healthcare environment. The framework is the tool I employ to develop the criteria for choosing the digital stories to use in the study. The digital story criteria are described in Chapter 3. The current study focuses on one aspect of this framework, namely investigating how medical residents' experience with digital stories, a humanities-based reflective training, has on their understanding of patient-relationship-centered care constructs. The current study concentrates on the components highlighted in Figure 2.

Figure 2

Patient-Relationship-Centered Care Model

Patient-Relationship-Centered Care Model		
Pillars of Patient-Relationship-Centered Care - Trust - Collaborative health care partnership/relationship between provider and patient - Collaborative healthcare decisions		
Patient-relationship-centered care requires an understanding of and awareness of the importance of these concepts		Patient-relationship-centered care includes these skills and activities
Patient centeredness	- Patient perspective - Patient personal health goals and experiences - View the patient as a whole and unique individual (patient over disease focus) - Patient agency - Shared power - Patient feelings of discomfort - Ethical and moral values of relationships in health care - Relevant social determinants of health and political determinants of health - Patient support system	- Focus on the patient perspective - Identify and demonstrate respect for patient's personal health goals and experiences - Integrate patient health goals and experiences into treatment planning - Provide recognition and check/ control personal bias - Recognize and demonstrate respect for patient agency - Provide culturally and linguistically appropriate services - Identify and, where appropriate, include patient support network - Identify, consider, and discuss assets and barriers to patient's health
Role of bias	- Ethical and moral values of relationships in health care - Cultural and linguistic relevance - Systemic oppression (e.g., racism, sexism, ableism, ageism) - Patient agency - Patient as a whole and unique individual - Shared power - Patient perspective and perception - Social determinants of health - Political determinants of health	- Recognize and check implicit personal bias in provider and staff - Acknowledge and validate emotion and affect - Create and nurture bidirectional relationships - Respect patient perspective, honor and integrate patient health goals and objectives in a health plan - Validate, respect, and work to ensure patient's physical and psychological comfort - Review clinical and organizational policies and procedures to identify and address conditions reinforcing systems of discrimination - Advocate for patients
Emotional/compassionate care	- Cultural humility/relevance - Mutual respect - Bidirectional relationships - Development and maintenance of patient-provider relationships are morally valuable - Provider empathy/ compassion/recognition of shared humanity - Physical comfort of a patient - emotional comfort of the patient - Bidirectional role of emotion and affect in health care - Patient perspective - Impact of all forms of trauma on health outcomes - Patient support system	- Demonstrate interest and build bidirectional relationships with patient - Recognize respect for patient agency - Validate patient experience of discomfort (feeling unwell) - Identify and include patient support network (in conjunction with the patient) - Express validation and address the patient's feelings of discomfort (both physical and emotional) - Practice trauma-informed care - Advocate for patients
Communication/shared information	- Transparency - Effective communication - Co-construction of knowledge and understanding - Linguistic relevance - Health and general literacy levels - Bidirectional communication	- Utilize open-ended inquiry - Transparent and complete communication - Ensure bidirectional communication, utilize components of effective communication - Identify linguistic, cultural, and health literacy requirements for effective communication - Provide necessary interpretation and translation services - Clear, jargon-free communication at the appropriate health literacy level - Active listening
Outcomes of patient-relationship-centered care	- Builds expands upon, and strengthens trust and collaborative partnership - Long-term bidirectional relationships between provider and patient - Increased likelihood that patient will follow the treatment plan	
Impacts of patient-relationship-centered care	- Improved recovery and efficiency of care - Reduced health care costs - Improved health outcomes	

Note. The content of this figure was adapted from the sources presented in the literature review.

Graduate Medical Education

Traditional graduate medical training supports the biomedical-provider-centered model of health care. Achieving the goals and objectives of the new healthcare paradigm of health equity, addressing the social determinants of health, and patient-centered care requires changes in medical education. Despite attention centered on patient-centered care and the social determinants of health in clinical practice, consistent efforts have not been developed to address these training gaps. Graduate medical training on the social determinants of health and patient-centered approaches has been inconsistent (Underman & Hirshfield, 2016).

Professional Socialization

The traditional medical education model socializes medical students to be “concerned and detached” (Becker, 1961; Underman & Hirshfield, 2016). Becker and colleagues’ (1961) analysis of medical students in the late 1950s focuses on the process of emotional socialization. Under the old medical education paradigm, students are encouraged to adopt an impersonal attitude toward their patients (Becker et al., 1961; Hirschfield & Underman, 2017; Smith & Kleinman, 1989; Underman & Hirshfield, 2016). Renee Fox characterizes this aspect of medical education as training for uncertainty and contributes to developing “detached concern” (1957). Her concept of training for uncertainty refers to how medical students learn to deal with the “limitations” of medical practice and knowledge. Developing a sense of “detached concern” ensures future providers learn to manage their emotions and those of their patients. Mastering the concept of detached concern requires medical students to learn how to balance distancing themselves emotionally while simultaneously maintaining the “proper” amount of concern for the well-being of their patients. This facet of medical socialization allegedly teaches future physicians to be “objective” and supports the development of their identity as physicians (Anderson et al., 1990; Fox, 1957; Underman & Hirshfield, 2016).

Underman and Hirshfield (2016) report that certain moments and milestones in medical training are critical to the emotional and professionalization of medical students. Under the traditional model, these crucial moments of their education reinforce their new identity and adopt the aforementioned “concerned yet detached” professional persona. Anderson and colleagues (1990) similarly identify a transformative event for medical students in developing a professional identity, namely their first experiences with cadavers.

The philosophy of medical education at this time, supporting the adoption of the “detached concern” persona, is grounded in the opinion that this helped medical students deal with and control their emotions when working with corpses (Fox, 1957; Underman & Hirshfield, 2016). Medical educators found during these moments medical students learned to take on the emotional temperament expected in clinical practice. Smith and Kleinman (1989) report that much of the emotional socialization of medical students under the old paradigm occurs incidentally through the culture and structure of medical school, not through direct socialization. They argue that although the emotional socialization under this model is not direct, it substantially affects the student. The studies by Becker and colleagues (1961) and Fox (1957) occurred in a very different context from that of a patient-relationship-centered health care model. The two timeframes differ in the structure and culture of clinical practice and the demographic composition of providers and students. New studies on the socialization of healthcare providers and the impact of the “hidden curriculum” in medicine are necessary to assess the environment and current expectations of medical professionals (Hirshfield & Underman, 2017; Underman & Hirshfield, 2016).

New Healthcare Paradigm

The focus, structure, and orientation of clinical practice and medical education have experienced substantial transformations due to groundbreaking events impacting the medical

model beginning in the mid-1990s. During the 1990s, a shift in the practice of medicine from a "medicalization to biomedicalization" model occurred due to revolutionary advances in technology (Beach et al., 2005; Cooper, 2021; Clarke et al., 2003; Epstein et al., 1993; Underman & Hirshfield, 2016). Epstein and colleagues (1993) summarize the impact of the biomedicalization of medicine: "I believe there is also a competition in medicine between words and numbers – and the numbers seem to be winning" (p. 378).

Advances in biomedical technology and clinical research led to new ways of "knowing." The advances in scientific discovery combined with "managed care," renewed patient-led advocacy, and dissatisfaction with biomedical/provider-centered care served as catalysts for change in clinical practice and medical education (Underman & Hirshfield, 2016). More patients began to self-manage their health care, a shift accompanied by a reduction in the trust of physicians and the healthcare system. The dependence on evidence-based medicine led to "standardized" health care decision-making. The standardized health care decision-making process reduced physicians' reliance on their expertise and judgment decisions about care. During this period, a change in medical ethics related to big pharma's ability to market directly to consumers changed the power dynamics of clinical practice. Finally, increases in the gender, racial, and ethnic diversity of medical students underscore the flaws in the old paradigm (Heiser, 2021; Hirshfield & Underman, 2017; McWhinney, 1993; Timmermans & Oh, 2010; Underman & Hirshfield, 2016).

Changes in the healthcare system transformed patient expectations of the culture, structure, and nature of the interactions and relationships between providers and patients. Epstein and colleagues (1993) characterize the objective of communication under the patient-centered care model as "achieving a harmony of understanding" between the provider and patient (p. 377).

The Affordable Care Act and the renewed focus on patient-centered care followed the transformation of the medical landscape in the 1990s, further upsetting the traditional models of clinical care and training. In 2010, President Obama signed the Affordable Care Act into law. The Affordable Care Act is the most comprehensive healthcare reform legislation in the history of the United States. The part the Affordable Care Act has played in shifting the healthcare paradigm cannot be understated, as evidenced by the strong pushback over the last decade (Dawes, 2016, 2020). The Patient-Centered Outcomes Research Institute followed two years after. Together, these two institutions firmly ground the new healthcare model.

Integrating Social and Political Determinants of Health in Training

In the face of nearly three decades of concentrated attention at the federal level and increases in the body of evidence regarding the impact of social determinants of health on health inequities, there has not been simultaneous integration of social determinants of health into medical education. Despite agreement on the critical importance of training providers on social determinants of health and the integration of social determinants of health screening into clinical care, little curricular guidance has been produced on social determinants of health. Medical schools and training centers cannot agree on how to formally integrate social determinants of health training into medical education and training (Doobay-Persaud et al., 2019; Solá & Marquez, 2020). The American College of Physicians developed a series of policies related to social determinants of health in clinical practice, advocacy, and medical education (Daniel et al., 2018). They cite the change in health care priorities from the number of services provided to the quality of services provided as the underlying need for changes in medical education. Medical schools struggle to develop curricular content and evaluation methods for social determinants of health training (Griffiths et al., 2022). Graduate medical education and training programs have begun to include training on social determinants of health. However, most social determinants of

health training and education are focused on raising awareness, not on understanding or developing actionable skills. Social determinants of health training has not been integrated into training consistently across United States residency programs (Schoenberger et al., 2021).

Preparing providers to practice under the new health care model requires a multi-level, socioecological approach combined with a social constructivist frame. This process is necessary to increase provider “understanding” of the specific cultural, systemic, and structural factors impacting patient health (Cooper, 2021). The socio-ecological health model of health and wellness focuses on intersecting micro-macro levels of influence on health from the intrapersonal to the community and societal levels (Rimer & Glanz, 2005). Addressing health equity issues at the health care provider level requires an ability to connect health outcomes with upstream factors (social determinants of health and political determinants of health).

As discussed throughout this chapter, there has been widespread recognition of the importance of social determinants of health, political determinants of health, and patient-centered care to health equity efforts. However, it has been difficult to fully integrate strategies supporting the new paradigm into traditional medical education and training models. Physicians lack adequate training to consider, understand, and address “place” or the upstream factors, middle and macro-level factors impacting patient health. Andress and Purtill (2020) attribute this lack of “competency” to the former health care and medical training paradigm and, as a result, fail to integrate or exclude consideration of the social determinants of health and political determinants of health altogether. Their critique of the traditional graduate education model is well supported, however, Andress and Purtill (2020) emphasize the need for an objective “competency-based evaluation,” indicating that their perspective remains firmly rooted in the traditional medical education paradigm.

Detached Concern to Care

“Stories are large and small instruments of meaning and explanation that we store in our memories” (Lambert, 2010, p. 1).

The provider-biomedical care model focuses on treatment of the disease (Aho & Aho, 2008). Physicians’ lack of recognition of the legitimacy of illness under the old paradigm leads to patient dissatisfaction, negatively impacts the quality of care, and may lead to lawsuits. The solution lies in a modification in the focus; clinical care and research must center on curing disease and healing illness (Kleinman et al., 1978). Provider empathy has replaced the traditional concept of "detached concern" as physicians' acceptable normative emotional state. The shift requires renewed attention to emotional socialization (empathy) in graduate medical education. The new objectives for emotional socialization have been underscored by policy briefs created by professional medical societies. Underman and Hirshfield (2016) identify an increase in emphasis on incorporating empathy and emotional socialization in medical education. Although constructionist frameworks are prevalent in foundational literature on professional socialization, their use has waned over the last three decades. Kleinman and colleagues (1978) propose an alternative framework to the traditional clinical and research models for addressing the crises in health care and health inequities facing the nation over four decades ago. They posit that traditional clinical research could not address the most pressing healthcare system problems: cost, inability to access care, and patient dissatisfaction. They argue the solution potentially lies in translating cultural anthropology frameworks into clinical practice and medical training.

Emotional socialization, combined with the move in provider focus from a disease state to the patient in place, requires an understanding of social constructs developed through human interaction (Andress & Purtill, 2020; Underman & Hirshfield, 2016). Hirshfield and Underman (2017) call for a renewed focus on social science research, utilizing a social constructivist lens to

better understand the process of emotional socialization in clinical environments. They maintain a constructivist framework that enriches the understanding of emotional socialization in medical training. Underman and Hirshfield (2016) highlight early sociological studies' critical contributions to our understanding of the role of emotions and emotional socialization in clinical care. However, despite the increased focus on patient-centered care, social scientists have reduced or abandoned investigating the role of emotions and empathy in medical education, training, and clinical arenas (Underman & Hirshfield, 2016).

The renewed focus on empathy in patient-centered care requires provider education and training on compassion and empathy in clinical practice. Emotional socialization focused on empathy, understood as recognition of shared humanity, is critical to ensure physicians are adequately prepared to practice in the new health care environment (Daniel et al., 2018). Emotional support is a principal construct of patient-centered care, and any effective strategy to integrate social determinants of health considerations in care plans. Yet, the literature on emotional socialization in medical education lacks sufficient qualitative studies or does not adequately investigate the development of empathy or compassion in medical training (Hirshfield & Underman, 2017; Pedersen, 2009; Underman & Hirshfield, 2016). Pedersen (2009) reviewed the literature on empathy in medicine and found that qualitative methods were seldomly used, and empathy rarely defined. The quantitative instruments used in the reviewed studies had a narrow focus and, ironically, neglected to include/gather information (data) on the experiences, emotions, and understanding of providers or patients. Pedersen (2009) found these studies failed to sufficiently examine how medical training and the work environment impact provider empathy in the clinic or patient health. The few studies of empathy in medical training

found by Pedersen (2009) treat empathy as distinct from other aspects of clinical care, namely communication, provider perception, and judgment.

Underman and Hirshfield (2016) indicate that certain moments and milestones in medical training are critical to the emotional and professionalization of medical students. They report there is a marked loss of empathy in medical students by the time reach their third year (Underman & Hirshfield, 2016). Under the former model, critical moments in their education reinforced their new identity and adoption of the “concerned yet detached” professional persona. A defining moment/event in the process of trying on this new medical persona, discussed by Renee Fox (1988) and other social science medical scholars, is the medical student's experience with cadavers. They found that medical students learned to take on the accepted emotional temperament expected in clinical practice during these moments. Hafferty (1988) discusses the role "cadaver stories" played in emotional socialization in medical school and the development of medical identity.

The former medical education model reinforces and justifies the existing system of power relations. New studies on the socialization of health care providers and the impact of the "hidden curriculum" in medicine are necessary to assess the current expectations of medical professionals' demeanor (Underman & Hirshfield, 2016). Based on the changing medical landscape and the gaps in training, key questions come to mind. How do we effectively prepare physicians to shift their modes of practice to the new paradigm? How do we not only impact understanding, but measure that increase in “understanding” rather than develop traditional evaluation methods based upon competency levels?

Potential of a Humanist Arts-Based Approach: Storytelling and Digital Stories

“I contend that the great physicians differ from the good physicians because they understand the entire story. Only when we understand the complete story do we make consistent diagnoses” (Centor, 2007).

Digital stories show promise as part of a comprehensive workforce development strategy to build the capacity of providers to adopt a patient-centered approach and gain a deeper understanding of how to identify the relevant social determinants of health and political determinants of health and their utility in health care planning. Digital stories are brief (3–5 minutes in length) multimedia videos created by individuals (generally non-professionals) centered on a particular issue impacting their lives or communities (Pratt, 2019). Digital stories focus on community members lived experiences. The videos have the potential to increase the residents’ understanding of social determinants of health’s effects on health outcomes. Additionally, digital stories can increase understanding of the skills related to patient-centered care, particularly shifting provider focus to the patient rather than the health condition focus, collaborative care, and empathy.

Patient Perspectives and Storytelling

Physicians do not listen well. Much has been written lately on the importance of listening to the stories that patients have to tell. Often these stories reveal the many facets of pain that could never be revealed by the technological marvels of the laboratory and radiology departments. (Epstein et al., 1993, p. 377)

Increasing attention is being placed on the role of patient perspectives of care to support and promote patient-relationship-centered care. Patient stories and narratives are increasingly used in healthcare professional training to cultivate provider empathy (shared humanity) and improve patient engagement (Hawthornthwaite et al., 2018). Hawthornthwaite and colleagues

(2018) report promising results utilizing patient storytelling sessions as a catalyst for change in clinical nursing practice and patient outcomes. An associated movement in healthcare training over the last few decades advocates for a humanist approach to medical care and training. Despite this shift in medical education priorities, training efforts and evaluation still seem to rely upon developing an “objective” knowledge base rather than the development of “understanding” (or co-construction of knowledge). Sinclair et al. (2021) conducted a systematic review of compassion training in healthcare. Their review identified studies utilizing humanities-based reflective practices relevant to this project. Seven studies focus on the use of storytelling and movies. In all the identified studies, participants were expected to reflect on their experience and knowledge to increase their understanding (Sinclair et al., 2021). Watson (2007) stresses the role patient stories play in improving care and understanding illness in the context of the patient. The constructivist approach to medicine is an approach to understanding the creation of meaning in patient-provider relationships (Watson, 2007). The constructivist perspective of stories as a method of co-construction of meaning is a central tenant of patient-relationship-centered care. Watson (2007) highlights the importance of understanding patient perceptions and experiences in providing adequate care. She describes the tension in clinical care to balance the requirements of evidence-based care (biomedical model) with those of patient-centered care. Practicing physicians have a responsibility to view patients as unique individuals, honor patient stories, and participate with their patients in the co-construction of meaning. Further, they are responsible for modeling this behavior for medical students and residents (Watson, 2007).

Reflection and reflective practice in medical education is rooted in positivism, critical theory, and interpretive theory (Kauffman & Mann, 2013). The reflective practice focuses on an iterative process in which theory and practice have an interactive impact on each other. The

reflective practice model of medical education is closely tied to interpretive theory and hermeneutic phenomenology. Reflective practice emphasizes that a full understanding of a clinical experience or situation depends upon considering both past and present events. Kauffman and Mann (2013) tie reflective practice theory to critical theory in “theory guides or enlightens action and understanding” (p. 12). They discuss the three iterative stages of reflective practices, which are reminiscent of hermeneutic phenomenology: (a) experience, (b) revisiting the experience through reflection, and (c) re-evaluation.

The Promise of Digital Stories

“Within each person lies a story that has the power to change their lives and, if shared, the potential to transform the world of others” (Pratt, 2019, p. 7).

The digital storytelling process was developed in 1994, resulting from a collaborative effort between media artists, designers, and theater producers who shared a vision for "cultural democracy and social change" (Lambert & Hessler, 2020). New technological advances provided innovative tools available to communities at large to create and share powerful personal stories. From these humble beginnings, digital storytelling and storytelling institutes have grown exponentially. The creators of the methodology continue to develop and refine digital storytelling curricula. Digital stories are multi-media short videos (3–5 minutes) created by community members (not media arts professionals) who share their lived experiences. In addition to being a tool for workforce training, digital stories have been used for community advocacy, dissemination of information, and advocacy (Lambert & Hessler, 2020; *StoryCenter*, 2023).

The digital storytelling process and digital stories have been used extensively in the education, public health, and health care education arenas. Yvonne Poitras Pratt (2019) employs the digital storytelling process as a method to decolonize education for indigenous communities

in Canada. Digital storytelling can play a critical role in communities reclaiming their stories and promoting resilience. The history and culture of historically marginalized communities have been co-opted and distorted by those in power. These "traditional" versions of history from the "settlers" point of view reflect biases and reinforce cultural stereotypes in the educational system (Pratt, 2019). These distorted versions of history feed implicit bias and reproduce stratification and racist structures. Just as stories have the power to reinforce inequities, they have the power to promote resilience and confront those structures. Graduate medical training is one arena where digital stories have the potential to deconstruct inequities.

In healthcare education and training, digital stories can increase provider empathy, support humanism in medical education, and improve the clinical experience for patients and providers (Moreau et al., 2018). In their scoping review, Moreau and colleagues (2018) discover a gap in the literature on the use of digital stories in health professions education. They found very few published studies on digital stories in medical education. Out of the 16 digital story-centered studies included in their review, 12 (75%) focused on undergraduate education, three (18.8%) focused on using digital storytelling in continuing healthcare education, and one focused on using digital storytelling in graduate healthcare education. Half of the studies focused on nursing education, while only two focused on medical education.

Mojtahedzadeh and colleagues' (2021) systematic review of the application of digital storytelling in medical education found that the objectives of using digital stories in healthcare education vary widely. They found varied reasons for using digital stories in health professions education. The purposes of the studies run the gamut from using digital stories to promote empathy to honing clinical skills. Their review includes 35 articles on digital storytelling in health professional education. Only three articles focus on digital storytelling in medical

education (Mojtahedzadeh et al., 2021). One of the studies included in the review by D'Alessandro (2004) uses digital stories as a method to overcome the limitations of computer-based patient simulations. D'Alessandro (2004) reports that this method successfully shifts the focus of third-year medical students from a disease to a patient focus.

Conclusion

The literature review identifies two gaps in graduate medical education relevant to this study. First, there is limited training instructing future providers and residents on how to integrate the social determinants of health into health care planning. Secondly, there is little or inconsistent training on patient-relationship-centered approaches in graduate medical training. The new healthcare paradigm focus requires providers to be skilled in patient-centered approaches and social determinants of health. There is ample evidence supporting the positive impact of patient-relationship-centered care on health outcomes, patient satisfaction, and compliance with health care plans. Furthermore, the integration of storytelling into clinical practice and training has demonstrated the ability to promote understanding and skills necessary to provide patient- and relationship-centered care. There are few studies on digital stories' role in promoting patient-centered focus in medical providers. The strong evidence of storytelling supporting increased understanding and skills to practice patient-centeredness, the iterative nature of this practice, and the central role reflection plays in medical education provide support for a study assessing how medical resident's experience of digital stories influence their understanding of the patient-relationship-centered care framework summarized in the patient-relationship-centered care model depicted in Figure 2. The patient-relationship-centered care framework is informed by the results of my literature review and provides a roadmap for this study. Patient-relationship-centered care is a two-part model; the column heading *Requires*

understanding and awareness of the importance of these concepts in Figure 2 lists the key concepts the providers need to understand.

The current study centers on exploring the potential of digital stories to influence medical residents' understanding of the concepts of patient-relationship-centered care described in Figure 2. The patient-relationship-centered care model provides the blueprint for the design of the methods for the current study. The criteria for choosing digital stories are grounded in the tenets listed in the table. Further, in agreement with the basic tenets of hermeneutics, the patient-relationship-centered care model lists my prior knowledge and preconceptions regarding patient-relationship-centered care and provides an initial framework for data collection activities and interpretation. The use of arts-based methods such as digital stories promotes reflection, a critical skill in medical practice. The results of this literature review support the use of digital stories and shape the patient-relationship-centered care model.

CHAPTER THREE: METHODOLOGY

Introduction

“The core lesson is that in our distinctly human desire to wrestle with the complexity of daily life, we can navigate multiple meaning-making pathways into and across the breadth of lived experience” (Ferguson, as cited in Lambert, 2013, p. 6).

This hermeneutic phenomenological study aims to understand how medical residents' experiences with digital stories shape their understanding of the importance of components of patient-relationship-centered care (see Figure 2). This study's results provide insight into digital stories' potential role in medical resident training. Namely, how do digital stories potentially contribute to a comprehensive curriculum preparing physicians to practice under the new healthcare paradigm? During their three-year residencies, medical residents have little time to master the required knowledge and skills. Digital stories have the potential to address this issue, as they pack a big punch (so to say) in a short time and are flexible regarding location and time (Christiansen, 2011; Hardy, 2007; Lambert & Hessler, 2020; Pratt, 2019). The stories can be viewed anywhere and anytime. The training can be administered in person in a group setting or individually. The training method is flexible in that it can be conducted in an individual or group setting in person or online. Digital stories are brief (3–5 minute) videos developed by community members on a specific lived experience. Digital stories combine video and still pictures, personal narration, and music (Christiansen, 2011; Digital Stories, 2017). The power of digital stories and digital storytelling (the process of creating digital stories) in transforming education, supporting advocacy, and making connections between communities and academia cannot be understated (Christiansen, 2011; Hardy, 2007; Lambert & Hessler, 2020, Pratt, 2019). Impactful training methods which fit the limited time and constant movement from one rotation to another are attractive to residents and residency directors trying to balance competing priorities.

Research Questions

- 1) How do healthcare providers experience digital stories in the context of their practice?
 - a) How does the experience influence their understanding of social determinants of health and political determinants of health?
 - b) How does the experience influence their understanding of integrating social determinants of health and the political determinants of health into treatment plans?
 - c) How do their experiences with the digital stories contribute to their understanding of a patient-relationship-centered approach?
- 2) How do health care providers' experiences with digital storytelling shape or inform their interaction and communication with patients?
 - a) How do providers' experiences with digital stories support emotional socialization?
 - b) How do digital stories move providers toward adopting a more patient-relationship-centered practice?

Research Design

Phenomenological research is a search for what it means to be human (van Manen, 1984, p. 38).

The foundational tenets of hermeneutic phenomenology guide the design of this study. The roots of phenomenology lie in the philosophy of Edmund Husserl and Martin Heidegger (Laverty, 2003; van Manen, 1997). Hermeneutic phenomenology centers on uncovering the understanding and meaning of lived experience or “Dasein” and the co-construction of knowledge and understanding (Flood, 2010; Heidegger, 1962; Standing, 2009; van Manen, 1984,

2016). Heidegger (1962) asserts it is impossible to suspend our judgments, biases, and personal experience (fore-conceptions or pre-understanding) or what he coins as “the life world.” This inability to suspend our fore-conceptions and pre-understanding is based on the assumption that human beings are inextricably influenced by their personal experiences, history, and social environment (Flood, 2010; Heidegger, 1962; Standing, 2009). Gadamer (1996) posits that understanding results from the fusion of past experiences/history with the present. “Rather, understanding is always the fusion of these horizons supposedly existing by themselves” (Gadamer, 1989, p. 317). Hermeneutics centers on the essence of experiences and the pivotal role interpretation play in understanding. The foundation of hermeneutics is the assumption that understanding based on real-world experience and instinct is more significant than knowledge grounded in theory (Standing, 2009).

Hermeneutic phenomenological analysis centers on identifying two types of meaning in developing the understanding of a “text.” Flood describes van Manen’s (1997, 2016) definition of the two types of meaning. The first type is “cognitive, the semantic and linguistic meaning makes the social understanding possible” (Flood, 2010, pp. 7-8). The non-cognitive forms of meaning refer to the poetic, suggestive, and transcendent aspects of the “text.” The cognitive and non-cognitive meanings are combined to fully understand life experience (Foster, 2010; van Manen, 1984, 2016). Intentionality, the role of the researcher, is to interpret the experiences to uncover the “essence” of the experience (Foster, 2010; van Manen, 1984, 2016). The process of discovery or “intersubjective understanding” is iterative and uses the “Hermeneutic circle,” which requires interpreting and reinterpreting the experience, which results in a new perspective (Standing, 2009; van Manen, 1984).

A hermeneutic phenomenological approach is a good fit for this study. Patient-relationship-centered care, reflective medical care and training, and phenomenology share basic concepts and principles. The current inquiry centers on understanding medical residents' experience with digital stories and assessing the stories' influence on their understanding of the constructs and characteristics of patient-relationship-centered care, as described in detail in Chapter 2 (see Figure 2). In accordance with a principal tenet of hermeneutics, that it is impossible to suspend our fore-conceptions, the data collection and interpretation processes will include the recognition of my fore-conceptions and that of the co-investigators (participants). Heidegger's hermeneutic circle is a continual process resulting in a new, comprehensive understanding (Creswell & Poth, 2016; Peoples, 2020). The hermeneutic circle provides the foundation for the study design. The inquiry design includes an iterative process of coding, developing themes, and interpreting data to create an understanding of the essence of residents' experiences with digital stories.

Methods

The elements of the patient-relationship-centered care model outlined in Chapter 2 (Figure 2) provide the foundation for the criteria employed to choose two digital stories used in the study. The digital stories were reviewed to assess if they reflected at least one element from each of the four categories listed in the first column in Figure 2 from the reviewer's perspective. I have permission to use the stories from the authors. The reflective practice model is grounded in interpretive theory and hermeneutic phenomenology, which posits that understanding an experience or situation is based on past and present events. Kauffman and Mann (2013), in their description of reflective practice in medical education, present the three iterative stages of reflective practices. The iterative stages of reflective medical practice are reminiscent of hermeneutic phenomenology:

- experience,
- revisiting the experience through reflection, and
- re-evaluation.

Phenomenology is well established as an appropriate method for research in medical education and patient-centered care (Svenaeus, 2001; Toombs, 1992a). The philosophical underpinning of phenomenological inquiry aligns well with patient-relationship-centered care principles, reflective medical training and practice, and digital stories (digital storytelling).

Study Site

The fieldwork site is a college of medicine located in the southwestern United States. The nationally accredited medical residency program is co-administered by Southwestern University College of Medicine and a national nonprofit healthcare system. Founded in the mid-20th century, the Southwestern University College of Medicine mission centers on medical research, innovation, and training of physicians. Southwestern University, in collaboration with the national nonprofit, provides primary, specialty, and hospital care. The Southwestern University College of Medicine was chosen due to its sizeable medical residency program, and recently declared health equity as a priority. The size of the college and its emphasis on health equity and physician training make it a good partner for the study.

Participant Co-Researchers

Participant co-researchers are selected from physicians completing their medical residency training and willing to share their experience with digital stories and how the experience influences their understanding of patient-relationship-centered care. Convenience-criterion sampling is the strategy I employ to identify the medical resident co-researchers. The co-researchers are in a medical residency program at Southwestern University, either in family medicine or participating in a rotation in toxicology (an elective). A convenience sample of

residents who meet these criteria is necessary as there are more than 60 residency and fellowship programs at the College of Medicine. Due to limited time and resources, it would be impossible to expand the opportunity to all the residents at the college. As a result, co-researchers are recruited from the Southwestern University family medicine residency program, and residents from other specialties participating in a toxicology rotation.

The data collection is conducted in person or online to accommodate the residents' schedules. The program director of the family medicine program and the medical director of the toxicology rotation have a deep understanding of the study's purpose and requirements for participation. Both directors support recruiting participant co-researchers from their pool of residents. The recruitment includes 12 medical residents anticipating attrition due to the hectic nature of medical residents' lives. I expect five to nine (no fewer than three) participant co-researchers to complete the study. Determining sample sizes in qualitative research depends on the qualitative methodology and the purpose of the study. In addition to considering the number of participants, qualitative researchers often consider the number of sites (Creswell & Poth, 2016). Creswell and Poth (2016) state that participant sample sizes in phenomenological research can range from a single participant to samples of up to 325 participants. Dukes (1984) emphasizes that phenomenological inquiry requires a comprehensive investigation with a small sample of participants. Dukes (1984) recommends studying one phenomenon and a selection of three to 10 participants to avoid "seeing what we want to see—rather than what is there to be seen—or falling prey to the contingent facts of a particular case" (p. 200).

Participant Recruitment

Given the hectic schedules of the co-researchers, information on the study is provided through a flyer or an in-person presentation describing the purpose of the study, time requirements, and benefits and risks associated with participation. Inviting all 16 current family

medicine residents and all residents completing a rotation in toxicology to participate is part of the sampling plan. Family medicine residents spend three years in their residency program. The potential number of residents in the toxicology rotation is unclear as it is an elective. The residents who choose the toxicology rotation participate in two-week sessions. The residents are predominantly MDs (as opposed to DOs) and come from diverse specialties, including emergency medicine, family medicine, pediatrics, and psychiatry, among other specialties and subspecialties. The residents might find participation in the study useful. The benefits include flexibility of participation and limited time requirements. Medical residents are encouraged to participate in research activities. The study provides an opportunity to collaborate on a research project. Participation in this investigation would allow them to collaborate in research without an extensive time commitment. The flexibility of research modality (virtual or in-person), ability to fit it into their schedules, limited time requirement of the research, and support of the rotation faculty may appeal to these physicians. The advantage of this recruitment site is that it allows for face-to-face recruitment and interviews and the ability to answer any questions quickly.

Residents are not obligated to participate, and there are no consequences for nonparticipation. The residents' participation or nonparticipation in the study and their responses are confidential. They have the option, if they choose, to reveal their involvement if they want to use the experience to fulfill a research requirement. There is minimal risk to participation. Their identities and responses remain confidential, and pseudonyms are assigned to each participant. The co-researchers can discontinue their participation at any point without consequence. The only potential risk is the potential for the content of the digital story to be a psychological trigger. I provide information on counseling resources on campus in this situation. Each participant receives a \$20 gift card to a local coffee shop to thank them for their time.

After agreeing to join the research, the co-researchers review and sign a consent form. The consent form (see Appendix B) describes the research objectives, purpose, risks, and benefits of participating in the research. There is no monetary compensation (other than the gift card) for participating. Taking part in the study potentially increases skills related to patient-relationship-centered care and provides experience participating in action research. The consent form describes the process by which confidentiality will be protected, their estimated time and participation commitment, and their right not to answer questions and withdraw at any time without penalty.

Researcher Role

Phenomenology is meant to enrich our understanding of health in addition to adding to the disease-level analysis is a level of analysis that addresses the questions of how the physiological states are lived as meaningful in an environment. (Svenaus, 2001, p. 87)

I have professional relationships with both the director of the family medicine residency and the medical director of the toxicology programs. We work in health sciences at the same university in different colleges. My work with both directors includes training community health workers, providing traditional workshop presentations, and immersive training experiences for medical residents on the social determinants of health. An example is the “Docs on Bikes” training. Docs on Bikes is an immersive training experience where we conduct a bicycle tour with family medicine residents. The tour is located in the community and served by the medical residents. Before the training, the residents have reading assignments and view digital stories on the social determinants of health. During the tour, the residents are exposed to the barriers as well as the factors protecting the health of members of the community. Docs on Bikes is a popular and well-established training program implemented for six years pre-pandemic. The current study analyzes an additional experiential training building on Docs on Bikes.

My work in public health centers on health equity, community-based participatory research, and action in collaboration with historically marginalized racial and ethnic communities. I teach undergraduate and graduate courses in health promotion sciences. Most of my research and programmatic work focuses on community, women, and maternal and child health. I am the vice president of the National REACH Coalition board of directors. The National REACH Coalition is a national organization that supports the health equity movement in racial and ethnic communities. My responsibilities to the board include health equity advocacy at the national, state, and local levels, and providing technical assistance to communities, nonprofits, and government agencies.

I incorporate digital stories and other arts-based methods in my teaching and research projects. Arts-based projects provide different and unique perspectives. Arts-based methods can overcome linguistic, health literacy, and general literacy barriers between individuals from diverse backgrounds collaborating on research and program development projects. The arts-based methods provide a depth of meaning and insight into the “why and how” of social phenomena, which cannot be obtained through statistical analysis.

The basic tenets of hermeneutics align with the philosophy guiding my work. Everyone is biased, and recognition of bias and reflecting on how it impacts our understanding of phenomena is key to developing an understanding of phenomena. Health is a social construct. The definition of health differs across cultures, between generations, changes over time, and is impacted by economic and technological shifts. My definition of health and understanding of community health has evolved through interaction over time through a process very similar to that of the hermeneutic circle. My experiences and interactions as a patient, educator, and researcher influenced the choice of topic for this study. Hermeneutics, as a constructionist iterative

approach with its emphasis on recognizing rather than attempting to suspend bias, is a good fit for this study.

Data Collection

“Phenomenological research is a poetizing activity” (van Manen, 1997, p. 13).

Consent, Protection of Data, and Identity

After co-researchers agree to take part in the study, the informed consent document is reviewed with them, live in-person or via Zoom. The consent form lists the potential benefits and risks associated with participation in the study. I cover the methods used to protect their identity, information, and responses (see Appendix B). The presentation and consent document emphasize that they can withdraw from the study without penalty. Neither the director of the residency program nor the director of toxicology receives information from me confirming their participation in the study. Upon request, a certificate is provided to the co-researcher if they want to use the experience to fulfill an engagement in research or equity and diversity requirement. Each participant will be assigned a pseudonym, and the data and transcripts are saved on a password-secured laptop and external drive.

The risks related to participation, if any, are minimal. Something presented in the stories may trigger a traumatic or painful memory. A resource list and a direct connection to therapists or counselors available on campus are provided. The interviews will be taped and transcribed. The recordings are securely stored and will be destroyed after analysis per IRB guidelines (see Appendix B). The document linking the participant to their pseudonym will be destroyed per IRB requirements.

Criteria and Process for Choosing Digital Stories

"These are not heroic stories; they are personal narratives of the journey, inspiration, and vulnerability" (Ferguson, as cited in Lambert, 2013, p. 7).

Co-researchers view two digital stories. The digital stories focus on the lived experiences of individuals from historically marginalized communities. The themes of the stories focus on health issues and resilience. The stories were created before this study. The digital stories are chosen from a pool of existing digital stories; some were made during a train-the-trainer workshop sponsored by the National REACH Coalition, conducted by Joe Lambert and Janet Ferguson from the StoryCenter organization, between April 26, 2022, and May 31, 2022. Joe Lambert is the founder of digital storytelling. Other digital stories in the pool were created in past digital storytelling workshops conducted by Creative Narrations (a digital storytelling center) tied to community-based participatory projects with a health equity focus. During each storytelling workshop story, creators complete a consent and release form. The authors of the two stories included in this study gave permission to use their stories. The criteria for choosing the stories are based on the characteristics of patient-relationship-centered care listed in the first column of Figure 2. An advisory board consisting of a community member/patient, a public health professional, and a digital storytelling trainer assessed the stories from the pool. The group recommended which stories to use in the study.

Collection of Data

“If it is assumed that all health-related data are co-created (dialogic), it can be said that the purpose of health research is to ‘see together the phenomena of interest’” (Lang et al., 2020, p. 2).

Flood (2010) describes hermeneutic phenomenology as an interpretive framework that is inductive and descriptive, focusing on the co-construction of meaning. The phenomenological method can be either fluid (seeing where the experience guides the research) or structured (Flood, 2010). Due to the training focus of the study and limited time, the methods employed in the current study are structured. Hermeneutic inquiry requires an iterative process of data

collection to develop a co-construction of meaning. The primary method of hermeneutic data collection is a series of semi-structured interviews to identify fore-conceptions, the essence of the experience, and culminating in a co-construction of the meaning of the experience (Flood, 2010). Seidman (2019) suggests a series of three interviews for phenomenological studies. The first of the three interviews centers on identifying and reflecting on the participant's (co-researchers) life history in the context of the study. The purpose of the second interview is to develop an understanding and uncover the "essence" of "not yet reflected upon" lived experience using a semi-structured interview (Seidman, 2019, p. 23; van Manen, 2016). The third interview focuses on reflecting on the meaning and the co-construction of meaning (Seidman, 2019). Seidman's (2019) structure provides a valuable framework for organizing the data collection while respecting hermeneutic phenomenological inquiry's iterative and organic process.

Using Seidman's framework, this phase of the study consists of three steps: (a) identifying the presuppositions of the participants and contextualizing their experience, (b) discovering the "essence" of the experience, and (c) reflection (Flood, 2010). My research design utilizes a modified version of Seidman's (2019) three-interview series. The design integrates the three interviews with one modification. The first interview will focus on the relevant life history of the participant. While the participant co-researchers view the digital stories (phenomena), I add a data collection step. Participants are asked to jot down one- or two-word responses to portions of the digital stories that resonate with them or elicit an emotional response. These techniques allow for the co-construction of meaning between the participants and me. My pre-conceptions and relevant life history are documented through journaling and field notes. The interviews are audiotaped with permission, transcribed, and supplemented with field notes.

Steps in the Research Process

Once consented, the residents participating in the study schedule a viewing of the digital stories either during their teaching day, individually (face-to-face) or virtually (see Table 1). My data collection procedures are grounded in van Manen's (1984) phenomenological framework and informed by other hermeneutic researchers and studies. Semi-structured interviews are a conventional method in phenomenological research (Lauterbach, 2018). Max van Manen's (1984) methodological framework for conducting phenomenological research. is built upon four basic activities:

1. Focusing on a phenomenon that critically interests us and binds us.
2. Exploring the essence of an experience as we "live it" and not intellectualize it (existential investigation).
3. Reflecting on themes that exemplify the experience.
4. Communicated through phenomenological writing and rewriting.

"Turning to the phenomenon," the first of the concurrent phenomenological activities in the framework includes (a) orienting to the phenomenon, (b) formulating the question, and (c) clarifying assumptions and preunderstandings (Lauterbach, 2018; van Manen, 1984). All interviews will be audiotaped and transcribed. Participants will review the transcripts online and be asked to provide edits, and then again, during the last meeting, they will be asked to review the transcripts and analysis and provide feedback.

I document and reflect on the research throughout the study through field notes and journaling. During the first stage of the research process, I will document my fore-conceptions (pre-understanding) as a necessary foundation for the Hermeneutic Circle (Standing, 2009). The method to identify my relevant lived experience will provide the basis for intersubjective understanding (Koch, 1995; Seidman, 2019; Standing, 2009).

Table 1*Stages of Participant Interviews*

Data Collection Stage	Details	Time Required	Location
Initial meeting post-recruitment.	• consent participant • conduct interview 1 • focus on relevant life history • semi-structured interview	30–40 minutes	In-person or online.
Initial meeting during viewing.	• unstructured • 1–2-word written reactions to digital stories	20 minutes	In-person or online.
Initial meeting immediately after viewing conduct interview 2.	• focus on immediate, not-yet-reflected-upon experience of the digital story • semi-structured interview • concentrate on the details of the experience (essence of the incident)	30–60 minutes	In-person or online.
1–2 weeks post initial meeting.	• Participant review of transcripts • provide feedback	30–45 minutes	Email or in-person.
Second meeting 2–3 weeks post viewing the third interview.	• focus on reflecting on meaning of the experience and co-construction of meaning • semi-structured interview (reflection, hermeneutic circle, fusion of horizons, and co-construction of meaning)	40–60 minutes	In-person or online.
2–3 weeks post second meeting.	• participants review transcripts and analysis (fusion of horizons, co-construction of meaning, hermeneutic circle)	30–40 minutes	Preferably in-person or online. If necessary, via email.

Note. Semi-structured questions for each interview are in Appendix A.

Analysis

“Phenomenological research is a search for what it means to be human” (van Manen, 1997, p. 12).

The participant interviews are recorded and transcribed using Zoom transcription software. The transcripts from the interviews are one of the primary data sources for the study, along with my field notes and journal entries. I collaborate with the co-researchers (participants) in the third interview and review the transcripts and analysis to develop both “intersubjective understanding” and “fusion of horizons” central to all hermeneutic inquiry (Flood, 2016; Lauterbach, 2018; Seidman, 2019; Standing, 2009; van Manen, 1997). The thematic analysis plan utilizes manual checking. The patient-relationship-centered model of care depicted in Figure 2 serves as an organizing framework for the thematic analysis. The categories in the first column of Figure 2 provide a broad category of the patient-relationship-centered care model and, as such, act as an organizing schema for the themes: patient-centeredness, the role of bias, emotional or compassionate care, and communication and shared information.

My thematic analysis strategy aligns with van Manen’s (1984, 1997) methodical structure for human science research:

- Turning to a phenomenon: My previous experience using digital stories in healthcare training and community-based participatory research and action projects fueled my interest in using them to train residents to practice under the new paradigm.
- Existential investigation of the lived experience: this is reflected in the resident’s one- to two-word responses to the digital stories and the transcripts from the first in-depth semi-structured interviews.
- Reflection on the “essential themes” (phenomenological reflection): recorded interviews transcriptions, recurring thematic analysis, review of transcriptions, participant review of transcriptions and analysis, and investigator reflexivity and review of where they fit, if at all, in the organizing categories of patient-relationship-centered care.

- Description of the experience utilizing phenomenological writing: staying true to the iterative nature of the phenomenological inquiry, I write and rewrite the description of the phenomenon.

Write Up

According to van Manen (1984), good phenomenological writing is a depiction of the experience that can evoke the “essence” and structure in a manner that allows the phenomenon to be seen in a new light. This is obtained through reflection, writing, and rewriting.

“Phenomenology is the application of logos (language and thoughtfulness) to the phenomenon (lived experience), to what shows itself” (van Manen, 1984, p. 41). Van Manen’s

phenomenological process begins with paying attention to “the speaking of language,” using multiple examples from the inquiry and writing and rewriting. The write-up for this study will stay true to this process. Van Manen (1984) describes phenomenological writing as an artistic endeavor, “a creative attempt to capture somehow a particular phenomenon of life in a linguistic description that is both holistic and analytical, evocative and precise, unique and universal, powerful and eloquent” (van Manen, 1984, p. 42). My strategy for the write-up of the inquiry includes the elements of van Manen’s phenomenological writing described previously.

Following his direction, my plan is to incorporate anecdotes to highlight and illuminate the themes uncovered by the inquiry (van Manen, 1997). Writing and rewriting in hermeneutics serve to divulge the investigation results and, as a form of reflection, acts as a means of analysis. The iterative process of writing and rewriting requires deep thought, supporting, revealing, and highlighting the phenomenon's essence.

Validity-Trustworthiness

Validity in qualitative inquiry refers to elements of the design of a study that assures the thoroughness and rigor of a study (Creswell & Poth, 2016; Freeman, 2011). Creswell and Poth

(2016) outline validity strategies that align with phenomenology's foundational constructs and tenets. Creswell and Poth (2016) propose five standards for evaluating the validity/quality of a phenomenological inquiry. They encourage the phenomenological researcher to consider the validity of both study design and findings:

1. Is the phenomenon communicated clearly and concisely?
2. Does the investigation reflect an understanding of the basic constructs of phenomenology? Is the study based on the scholarly work on phenomenology?
3. Does the data analysis employ phenomenological techniques?
4. Does the study convey the “essence” of the experience of the participants?
5. Is reflexivity infused throughout the study? (Creswell & Poth, 2016, p. 273).

Polkinghorne (1989) stresses that validity in phenomenological research is critical. Ensuring the research is "valid" provides legitimacy to the study and results in that they can be "trusted" and used to support policy development and justify "action" (p. 57).

Multiple strategies are included in the investigation plan to assess and ensure the validity of the findings and are designed to address Creswell and Poth's (2016) five validity standards. The design of the investigation integrates triangulation into the design. The different data collection methods are designed to ensure the trustworthiness/validity of the results. The data collection activities supporting triangulation include journaling, field notes, member checking, and peer review (Creswell & Poth, 2016; Peoples, 2020). Member checking is essential as it aligns with the basic principles of hermeneutic phenomenology, namely the co-creation of understanding, and is associated with an iterative hermeneutic circle and detailed description.

Both the family medicine and toxicology residency directors are enthusiastic about the study and the potential contribution to developing medical residents' appreciation/understanding

of the importance of reflection and elements of patient-relationship-centered care. The tenets of hermeneutic phenomenology and patient-relationship-centered care are closely aligned.

Hermeneutic inquiry supports the reflective practice and co-construction of phenomena (health-related in this case). The design of the study is flexible and requires a relatively small investment of time from the participant co-researchers. The study's methods and methodology align well with the overall purpose of the inquiry.

CHAPTER FOUR: DATA ANALYSIS AND RESULTS

Introduction

The hermeneutic phenomenological informed design of this study creates a space for the medical residents to reflect on their perceptions of the critical elements of patient-relationship-centered care and its role in clinical practice. Digital stories serve as a tool, sparking reflection on patient-relationship-centered care. The semi-structured interview format constructs a secure place for the residents to contemplate their path to medicine and experiences in residency. Digital stories prompted the residents to consider how they integrate elements of patient- and relationship-centered care in their clinical practice.

The design of this study presented the opportunity for these residents to consider their professional identity and the bidirectional nature of patient-relationship-centered care. The perspective of medicine as a practice more than a science has interesting implications for graduate and professional education, the development of professional identities, and for higher education theory and practice relating to professional and graduate education (Barbarà-i-Molinero et al., 2017; Billett, 2002; Cruess et al., 2018; Fullan & Hargreaves, 2016; Hargreaves, 2016). The study in part addresses a gap in the higher education literature on the development of professional identity in higher education practice and education. Barbarà-i-Molinero and colleagues (2017) report that despite increased interest in professional identity development in the higher education literature the studies fail to provide a full integrated framework. The results of this study have implications for addressing that gap, which are discussed in more detail in Chapter 5.

Two themes emerged from the discussions with the medical residents. First, their responses created a view into the physicians' professional development and an appreciation for the sources of inspiration influencing their professional identity. Second, the role digital stories,

along with the study design, play in the creation of a place for self-reflection and review of their professional development.

Setting

The research is located at Southwestern University College of Medicine located in a large university in the United States southwest border region with a reputable medical residency training program, and the National Healthcare Network, a nonprofit which oversees the provision of healthcare and employs the medical residents. Tensions exist resulting from a clash between the organizational culture of the residency program and that of the healthcare network employing the residents. This partnership is the National Healthcare Network's first foray into academic medicine, and the two systems are still adapting to differences in priorities and mission. This resulted in an unusually long IRB approval process as the study had to be reviewed by Northern Arizona University (Appendix C), Southwestern University (Appendix D), and National Healthcare Network (Appendix E). The research could not take place at the facilities nor leverage any resources belonging to the National Healthcare Network.

The tension between the two systems is apparent and unfolded in the interviews. Physicians throughout the United States are feeling discouraged by our "broken" national healthcare system (Reinhart, 2023). The participating medical residents mirror this sentiment, often expressing their frustration with the healthcare system, health inequities, and the related social and political determinants of health impacting their patients. Despite their exasperation, the residents' responses clearly demonstrate a good understanding of the tenets of patient-relationship-centered care. The residents' knowledge of and integration of the principles of patient-relationship-centered care in their practice results from their path to medicine and experiences with their residency programs.

Health equity is a priority for Southwestern University College of Medicine. This investigation has robust support from the administration and faculty in the college of medicine, receiving approval from both the associate dean for graduate medical education and the vice chair for education for family and community medicine. The study received approval from the interim vice dean for diversity, equity, and inclusion for participants to receive two hours of diversity, equity, and inclusion credit, if they choose, for their collaboration on the study. All faculty and staff at the Southwestern College of Medicine must participate in six hours of diversity, equity, and inclusion training or activity annually. The institutional approval of the study acknowledges the relevance and validates the significance of the research to the college of medicine. The diversity training credit was an effective incentive for the residents going through the toxicology rotation, as they reported having difficulty fitting the training into their hectic schedules. This study provided the opportunity to complete diversity, equity, and inclusion credit hours in their limited free time.

Eight participants agreed to participate in the study from a variety of specialties with high levels of patient interaction. Table 2 presents the characteristics of the resident co-researchers, including their specialty, gender identification, and year in residency. Each resident co-researcher completed both interviews, resulting in 16 hours of interviews, beginning in mid-December of 2022 and finishing in mid-January of 2023. Due to time constraints, not lack of interest, I stopped recruiting in January 2023. Race and ethnicity were not part of the analysis due to the limited number of participants. Racial and ethnic status came up in the meetings, primarily in relation to the participant co-researchers' reports of the need to advocate with and for their patients with limited English proficiency to ensure they received culturally and linguistically appropriate care.

Table 2*Resident Co-Researcher Participant Information*

Resident Name*	Specialty	Gender	Residency Year	Meeting Location
Adam	EM	Male	Fellow	#1 in person, #2 Zoom
Alexa	EM & PED	Female	Third of Five	#1 in person, #2 Zoom
Diane	EM	Female	Second	#1 Zoom, #2 in person
Ginger	FCM	Female	Second	Zoom
Jay	FCM	Gender Fluid	Intern	Zoom
Joe	EM	Male	Second	Zoom
Kelly	PSYCH	Female	Second	Zoom
Nina	FCM	Female	Third	Zoom

Note. EM: emergency medicine; FCM: family and community medicine; PED: pediatrics; PSYCH: psychiatry.

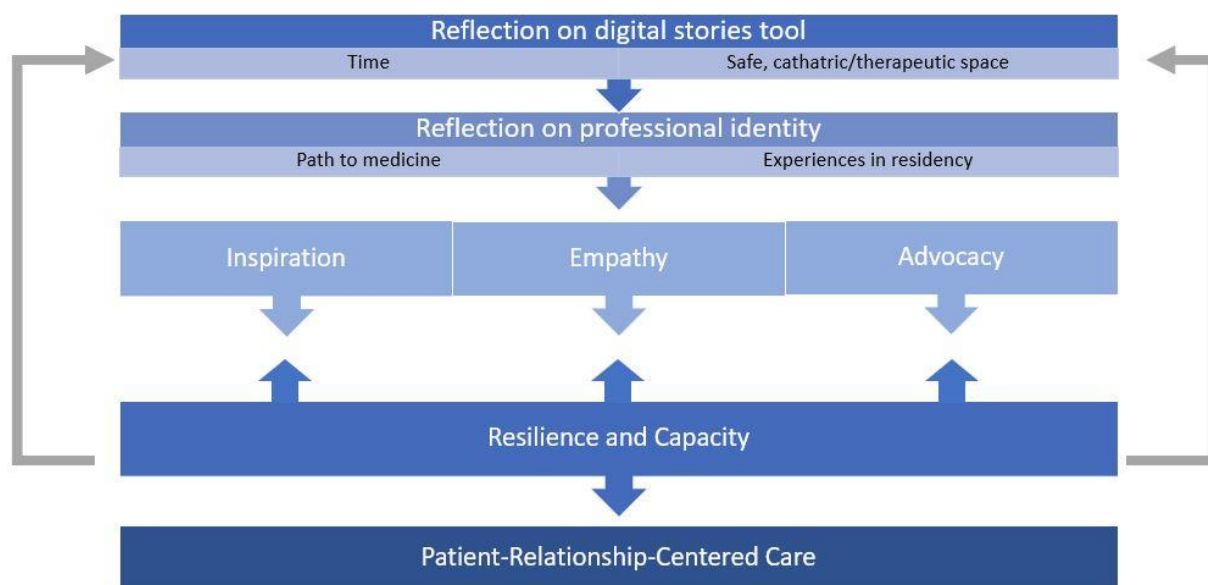
* Names have been changed to protect the confidentiality of the participants.

Reflection is woven through the interview responses, unveiling and connecting the elements of patient-relationship-centered care the residents employ in patient interactions and care planning. Further, the residents shared factors promoting, as well as those inhibiting, reflective practice. The digital stories, in conjunction with time and space, established a supportive environment which encouraged reflection and discussion. During the subsequent conversations, the elements supporting patient-relationship-centered care raised by the residents fell into three broad categories: empathy, advocacy, and inspiration. The data unfolded the interrelationship between the three elements and their influence on each other.

Empathy appeared in the residents' responses to scenes from the digital stories, their personal definition of empathy, and how their definition plays out in their clinical practice and care plans. Further, the residents' consideration of their life experiences and that of their patients promoted reflection on the role of empathy in clinical practice. The residents' definitions of empathy, expectations, and how they integrate empathy in their interactions with patients differed slightly by situation, perceived scope of practice, life experiences, and institutional/systemic factors. Figure 3 demonstrates the factors supporting professional identity and the iterative nature of the process.

Figure 3

Framework Factors Supporting Professional Identity Development



Themes

Two primary themes emerged from the interviews: (a) the results provide an understanding of the residents' professional development and sources of inspiration framing their practice, and (b) digital stories along with the study design create a safe, therapeutic, and cathartic space for reflection and self-assessment of their professional development. This study

centers on the elements of professional identity, specifically on the elements of patient- and relationship-centered care. The two themes relate back to the primary aim of this study, namely how can this investigation contribute to the understanding of how we can prepare physicians to practice under the new medical paradigm.

Professional Identity

Professional identity formation is a critical goal of medical education and training. Professional identity development is the process by which medical students and residents acquire the role of a physician through socialization (Cohen-Scali, 2003; Cruess et al., 2014). The objective of professional identity formation is the internalization of the values, norms and actions-behaviors, and expectations encompassing the role of a physician. Internalization is the assimilation of the new role to the extent that it becomes an individual's identity. Most medical schools don't pay sufficient attention to professional identity development despite the critical function it plays in preparing physicians to practice. Cruess and colleagues (2014) posit that most of the professional identity development in professional medical training is implicit (part of the hidden curriculum), and they advocate for more of an explicit longitudinal approach to: (a) consistently help medical students and residents discover the type of physician they aspire to become, and (b) consider where they are in the process. Utilizing a hermeneutic lens, providing space and time for aspiring and resident physicians to reflect shows promise as a strategy supporting professional identity development. Psychiatry resident Kelly reflects on what she sees as an essential obligation and an intricate part of her professional development, a credo which guides her patient encounters:

My job should be to never give someone a reason not to trust healthcare and be that positive experience where they did feel heard, they did feel trusted. They did feel like

they had a voice in their care plan and try to set a new trajectory, regardless of what the past was. (Kelly, personal communication, January 9, 2023)

Professional Identity Subthemes

Three subthemes of developing professional identities emerge from the discussions: inspiration, empathy, and advocacy. Inspiration includes the values, individuals/role models, and experiences that inform their “ideal” professional identity. Inspiration influences and reinforces the socialization process and the residents’ integration of empathy and advocacy in their clinical encounters. Empathy and advocacy subthemes include values, norms, actions, and behaviors informing the resident’s interactions with patients.

Life history inspiring professional identity. Life history is fundamental to hermeneutic phenomenological inquiry. Aligning with this hermeneutic principle, I asked the residents to share their journey to medicine. The stories of their journeys include aspects of their life histories serving to inspire and shape their professional identities. The original design of the study assumed the digital stories are the experience. Rather, digital stories served as a powerful prompt for reflection, a result of the familiarity and relevance of the stories to the residents. The relevance of digital stories encouraged the residents to recall factors inspiring and inhibiting their ideal concepts of professional identity and patient care. Nina, a third-year family medicine resident, immediately related to the digital story, seeing both her patients and an aspect of her digital story in it. “I like to know the story, [...] the context surrounding their medical problems. And honestly, it’s very similar to what we see day to day in the hospital and at our clinic. So, there’s a lot of resonance” (Nina, personal communication, December 12, 2022).

Residents find inspiration in their cultural backgrounds and values, personal experiences (theirs and their family’s), communities of origin (as well as those they serve), attending physicians, training, and clinical experiences. These motivating factors reinforce integrating the

values and behaviors associated with patient- and relationship-centered practice into their professional identity. Conversely, this aspect of their professional identities is discouraged by interpersonal, institutional, and systemic barriers.

Path to medicine sources of inspiration. Diane, an emergency medicine resident, derives inspiration from her grandfather, a family medicine doctor, and her father, who died due in part to neglect after being labeled a “difficult patient” by the intensive care unit staff. Diane explains:

Dad was probably a “difficult patient” that day. My grandpa put the work ethic in me, and my dad gave me the drive to do better for my patients, the way that he deserved to have someone do better for him. (personal communication, January 19, 2023)

Diane keeps both men in mind when she enters work. Her father and grandfather continue to play central roles in her developing professional identity.

Ginger and Nina (family and community medicine residents) share similar cultural and linguistic backgrounds. Both are immigrants, bilingual in Mandarin and English, and draw inspiration in part from their cultural heritage and family members who are physicians. The two residents revealed that their experiences volunteering in hospitals and in hospice care were transformative, providing a new vision of health care as not merely focusing on healing, but also including end-of-life care as a part of medical practice.

I got to sit in on a hospice conversation between the doctors and a patient ... I think it was the first time where I had really seen the side of medicine that wasn't just all about saving lives and, you know, finding a cure-all. It was really a very human element that there's limits to medicine as well and it's also about being there for the patient, finding the best path forward for the patient. (Ginger, personal communication, December 23, 2022)

The notion of end-of-life care as an inspiration for primary and preventive care at first glance seemed counterintuitive to me. These two physicians find joy in hospice care. Ironically, end-of-life care, focusing solely on the patient's desires and goals, presents itself as an ideal form of patient care. For both, model patient-centered care is one which provides sufficient time and lacks agendas other than that of the patient. Patient care for them means focusing on the patient's health goals and not merely following standard care guidelines or algorithms. Ginger's description provides a deep understanding of how this experience serves as inspiration and influences her developing professional identity. The influence of Nina and Ginger's hospice care experiences on their professional development are supported in the literature. Hojat and colleagues (2020a) found that medical student hospice volunteers with the "No One Dies Alone" project had higher levels of "empathetic orientation" than their peers and more likely to see empathy as an essential part of their professional identities.

Many of the resident co-researchers' inspiration to communicate clearly resulted from suboptimal communications with healthcare providers leading to patients and family members losing trust in healthcare. Medicine has its own language like many professions. Ineffective communication plagues many disciplines, particularly the result of overuse of discipline specific jargon. My work with planners over the years demonstrates this type of communication gap. When working with planners, despite supposedly speaking English, it often mutually sounds like gibberish. The American Association of State Highway and Transportation Officials' *Connecting Transportation and Health: A Guide to Communication and Collaboration* (2019) highlights the universality and magnitude of miscommunication due to overuse of profession-specific terminology. However, the inability of some doctors and other healthcare professionals to use clear language has life threatening consequences.

Experiences in clinical practice and training as sources of inspiration. Effective communication is an essential aspect of all physicians' professional identities. Alexa, a pediatric emergency medicine resident, eliminates medical jargon from her conversations with patients to ensure patients have a clear understanding of their health conditions and can fully collaborate on care plans. Her family's negative experiences with the healthcare system resulting from poor communication by medical providers, as well resources and guidance from her training, serve as inspiration and bolster this aspect of her professional identity. During the interviews she referenced *What Patients Say, What Doctors Hear* by Danielle Ofri, MD, a book documenting communication as the most powerful tool in medicine. Alexa supports the conclusion of the text with examples of her family's encounters with medical jargon:

I think back to my family. These doctors didn't really describe exactly what was going on. You know it's easy to say someone's kidneys are failing, their heart is failing. But realistically, what does that mean when you say these things? Or if you say someone has acute kidney injury, what does that mean? (Alexa, personal communication January 12, 2023)

Kelly is motivated by her personal health experiences and practicing the “medicine of emotions” and an ability to improve people's quality of life. Her personal experiences and support from her attending physicians lend inspiration and motivation to provide patient-relationship-centered care. Specifically, her childhood experiences with emotional swings triggered by an allergy help her to destigmatize mental illness for her patients.

They are the sadness they can't see through it. Being able to use that perspective to break it down and show, no, you are distinct, you are this beautiful thing. Your emotions are something that you experience. And here's how we can process that in a healthy way, so

you can use it to interpret the world, but not be ruled by them. (Kelly, personal communication, January 9, 2023)

In this passage Kelly demonstrated how she uses clear and relatable communication with her patients.

Active listening is key to effective physician-provider communication and to developing trusting therapeutic relationships. Active listening plays a central role in residency training, bolstered by supervising physicians and clinical experience; this and other communication skills are part of the resident coresearchers' professional identities. Jay, a family medicine intern, reached back into their first year of medical school to share a particularly powerful lesson. Their instructor asked them to estimate how many times patients get interrupted by their physicians. "No one knew it, and then we were told once every 18 seconds. We all dropped our jaws a little bit. Some of our eyes went wide ... and that's something that has stuck with me throughout the years" (Jay, personal communication, January 30, 2023).

Both successful and challenging encounters reinforce the internalization of active listening as part of the resident co-researcher professional identities. Ginger shared a story of a patient who fell and hurt her shoulder and disclosed that life was very difficult for her. The encounter, beginning with a discussion of the shoulder, ended with the discovery of a host of factors impacting the patient's mental and physical health. Through active listening and delving further, Ginger discovered a host of stressors facing the patient including social isolation, family conflict, fear of death, and being homebound resulting in feeling overwhelmed.

I think really getting into all of this when the visit started out with, "I fell on my shoulder, and I'm having a lot of pain in my shoulder," and getting into all the other things that are impacting her health that can also be impacting her pain and her chronic

pain. I think these are things that sometimes, when I was first getting started in medical school, you brush over, or you have the 20-minute appointments. People normally don't go into all of this, or they hear it, and they miss it, and they feel a little bit rushed.

(Ginger, personal communication, December 23, 2022)

Effective bidirectional communication between doctors and patients is key to positive health outcomes, patient satisfaction, care planning, and developing strong therapeutic relationships (Roter & Hall, 2022; Ofri, 2017). During our conversations, all the residents identified and discussed factors influencing and reinforcing their clinical communication skills as well as challenges. The primary challenges to communication shared by all the resident co-researchers are time and other limitations of the current structure of healthcare, particularly problematic because communication skills are a fundamental element of their developing professional identities.

The sources of inspiration derived from their life histories support and reinforce socialization into their new roles. The residents' positive interactions with their patients and associated recognition by their attending physicians bolster their confidence to take on their new role. Jay finds inspiration when they can develop strong, trusting, therapeutic relationships with their patients, as do Alexa and Nina. The three frequently reflected on their training and support from their supervising physicians who model patient-relationship-centered care.

Role of Empathy in Professional Identity

Empathy, for the purposes of this study, refers to residents recognizing their shared humanity with their patients. A provider's ability to empathize with their patients influences their understanding of the context influencing the health of their patients and improves communication, trust, and health outcomes (Hojat et al., 2020b). Empathy and effective communication in health care environments are so intricately linked that Ofri (2017) classifies

empathy as a form of communication. Hojat and colleagues (2023) report that the results of the Jefferson project on empathy indicate the benefits of empathy in practice are so great to be considered an “essential” element of professional identity development.

While designing the study I struggled identifying a working definition of empathy, particularly how to differentiate between empathy and sympathy. Many definitions of empathy exist in the literature (Hojat et al., 2020a; Hojat et al., 2020b; Hojat et al., 2023; Neumann et al., 2011). My primary question being, “how can a provider with very different life experiences than their patients be empathetic?” For the purposes of the investigation, I used a definition shared by Yvonne Poitras Pratt, a Canadian indigenous scholar whose work focuses on the decolonization of educational systems. She views empathy as the ability to recognize the shared humanity in another human being (Y.P. Pratt, personal communication, September 22, 2022).

Empathy unfolded organically in the conversations, that is I only asked the medical residents when they mentioned empathy or a related concept. The conversations with the residents revealed deep and varied definitions and understanding and role of empathy, both in their personal definitions and the role of empathy in medicine. The definition and perspectives related to the role of empathy are as diverse as the residents themselves. The definitions ranged from “putting yourself in someone else’s shoes” and “viewing a patient as if they a member of your family,” to more complex perspectives on empathy and its associated roles in health care.

Second-year psychiatric resident Kelly provided an eloquent definition of empathy aligning closely with my understanding. In our conversations, Kelly shares her definitions of empathy and how she leverages this perspective to connect with patients despite significant differences in life experiences:

I think empathy is a recognition of a piece of yourself in someone else. Everyone's experience is so unique, and you're not going to have the exact same situations, no matter how closely aligned your paths are. I feel like everything can be distilled into kind of simpler components to where I've never been in a car accident, but I have felt fear. I've never, you know, lost a child, but I have felt grief. You know, there are these unique circumstances, but they all distill down into kind of common components. And to empathize with them, and to kind of convey that sense of care and compassion, is less about me understanding exactly what they went through, more being able to acknowledge their kind of core feelings and have had those core feelings myself for the human experience. (Kelly, personal communication, January 9, 2023)

In this passage, Kelly reveals her understanding of empathy and its role in patient care. Her definition demystifies and simplifies empathy, indicating its contribution to creating a compassionate, caring relationship with her patients. The residents' differences in their definitions of empathy influence their perceived capacity to be empathetic and view empathy as part of their scope of practice.

During our conversations, the family and community medicine residents shared how empathy helps them understand the context influencing their patients' health (relevant social and political determinants of health). They view empathy as vital to the provision of good medical care, and personally rewarding. Jay, although an intern and just beginning to develop their professional identity, has already developed a reputation for effectively working "difficult patients." Jay shared their perspective of empathy as a live and let live attitude which facilitates bonding and relationships with the patients who are labeled as difficult. Jay's attending physicians and fellow residents recognize their facility working with these patients.

Jay connects their facility with “difficult patients” to their core values, life experiences, and training. Jay’s travels in Papua New Guinea inspired them to, “give people a floor to stand on so they can navigate from that into other parts of their life” (personal communication, December 14, 2022). They attribute their initial lack of language skills early in their time in Papua New Guinea to their approach to understanding their patients’ clinical experiences. Jay emphasized the importance of spending more time listening than speaking to patients. During our conversations Jay shared a sense of joy and accomplishment from their ability to connect with and understand their patients. Although Jay is in the very beginning stages of the development of their professional identity, they have already integrated empathy as a foundational element of their burgeoning professional identity.

The family and community medicine residents shared examples from multiple encounters where empathy contributed to communicating and developing relationships with their patients. Employing an empathetic lens in their practices helps them understand the context (relevant social and political determinants of health) influencing the health of their patients. They see the ability to empathize as central to the provision of good medical care, as well as being personally rewarding. The residents’ accounts of empathy in their practice demonstrate the motivating and reinforcing factors leading to the internalization of empathy as an element of their professional identities.

While all the residents felt that sharing their personal life experiences might be perceived as patronizing or as diminishing the patient’s experiences, a few mentioned situations where sharing their personal life experience facilitated communication and improved patient outcomes. Kelly views empathy as a core value essential to her professional development. During our second conversation, she conveyed an encounter where sharing her personal experiences was

appropriate and supported the creation of a therapeutic environment. She recalled basing decisions to share her personal experiences with patients on the “dynamic” between her and the patient. The patient is an 18- to 19-year-old undergraduate student who attempted suicide after failing an exam who asked Kelly if she had ever failed a test.

I could very much relate to that fear. Talking with that patient about my experiences with getting a bad grade in class, and how to cope with that, really was a breakthrough moment for that patient and let us bond. I felt like they took my recommendations a little more seriously ... having someone who appeared to them as this successful educated medical provider tell them, “Yeah, I have gotten bad grades in classes before, and it gets better” was something meaningful to them. (Kelly, personal communication, January 17, 2023)

Empathy is essential to psychiatric practices. Kelly’s description of her encounters demonstrates an appreciation of empathy as a critical element of their professional identity. During our discussions, Kelly shared how employing an empathic lens informs how to tailor her clinical approach to meet the needs of her patients.

Alexa, as a pediatric emergency medicine physician, bridges the world of primary care and emergency medicine. The duality of her practices gives her a distinct advantage over the other emergency medicine residents to develop an understanding of her patients’ perspectives. The nature of the practice allows her more time and space with her patients, as well as provides the opportunity for Alexa to follow up with the patients she encounters in the emergency room in her clinical pediatric practice outside the frenetic environment of the emergency department. The additional space and time, and dual nature of her practice, act to reinforce the internalization of empathy as part of Alexa’s professional identity.

The other two emergency medicine physicians', Adam and Joe, views of empathy and the role it plays in their practice differ from Alexa's. Although Adam and Joe discussed the role of employing empathy and how it plays in their practices, their perspectives on the use of empathy are more limited than Alexa's. Adam and Joe's professional identities includes a narrower view of empathy, limited to communication. Adam attributed the limited role empathy plays in his practice to differences in his limited life experiences, scope of practice, urgency, time, structure, and institutional constraints.

Advocacy and Professional Identity

In general, physicians' life experiences and understanding of the role empathy plays in their practices provide a foundation for physician advocacy as an element of their professional identities. Luft (2017) maintains that physicians must see beyond the biomedical model, as treatment often requires consideration of the social and political context of the patient. Luft further posits that understanding the context provides the foundation and impetus for physician advocacy and as such is an essential activity for providers.

Physicians have an ethical and moral obligation to advocate for their patients, as well as to engage in public advocacy to address the social and political determinants of health (Earnest et al., 2010; Luft, 2017). Advocacy is fundamental to patient- and relationship-centered care and, as such, is a significant element of professional identity. Earnest and colleagues (2010) highlight national and global medical associations' expressed commitment to physician advocacy as a critical obligation of physician responsibility and a core competency for medical training.

A broad characterization of advocacy emerged from my conversations with the resident co-researchers. The resident co-researchers shared the multiple forms of advocacy they incorporate into their practice. The types of advocacy include: (a) patient empowerment and capacity building; (b) advocating for patients in the primary care setting; (c) confronting and

educating other specialists to ensure patients receive quality, as well as culturally and linguistically appropriate, care; (d) calling out and addressing the bias of specialists, as well as their own; (e) identifying and addressing personal care needs (i.e., food, clothing, shelter); and (f) helping patients navigate multiple healthcare and social services networks.

Our discussions revealed significant differences in the resident co-researchers' perceptions of advocacy as part of their professional identity. All the residents reported engaging in patient advocacy, but none disclosed getting involved in public advocacy despite identifying systemic and structural factors influencing their patients' health. Not engaging in public advocacy could be a function of limited training on advocacy or time and resources. The residents' thoughts and feelings associated with advocacy ran the gamut from affirmation to fatalism.

Advocacy promoting patient agency and empowerment. Patient agency and empowerment as forms of advocacy are essential to patient-relationship-centered care and play a role in all clinical encounters, but especially primary care environments. For Alexa, having a practice which straddles primary care and emergency medicine provides a distinct advantage in her ability to effectively advocate for her patients. The dual nature of Alexa's practice allows her sufficient time, space, and resources to successfully engage in patient advocacy. Alexa's attending physicians in pediatrics provide guidance and serve as role models for patient advocacy. She derives satisfaction from empowering patients, which she finds mutually beneficial. "I think it's great that they're finding these resources and just letting them grow on their own as a patient, too, and seeing what [resources and information] they bring back to the office" (Alexa, personal communication, January 12, 2023). Engaging in patient advocacy bolsters Alexa's confidence and reinforces advocacy as essential to her professional identity.

Patient advocacy to ensure standard and quality of care. Kelly considers advocacy as central to effective psychiatric practice. Her role as a liaison between her patients and other specialists and institutions is particularly important to her. Due to both physician and institutional held bias of people with mental illness and inaccurate diagnosis of physical ailments “masquerading” as mental illness, she finds herself often advocating for patients with other providers. Kelly shared this example of her nuanced approach to patient advocacy utilizing clear communication with other specialists, explaining that she might say to a colleague:

I totally understand why you thought this might look like anxiety. I appreciate you sending the patient to me. After getting to know them ... there are some things I’m seeing that don't fully fit with that picture. I’d like us to be able to work together on how we can investigate this. I’ll be working with the patient on coping strategies, processes ... and see if medication plays a role. While I’m doing that, these are some things that came to mind for me you would probably have more expertise in. Do you think that sounds reasonable? (Kelly, personal communication, January 17, 2023)

Any facility receiving federal funds is required by law to provide culturally and linguistically appropriate services. The residents shared the need to advocate for their patients due to other specialists not abiding by the standards despite being required by law. Culturally and linguistically appropriate services standards require physicians and other medical practitioners to provide interpretation and translation and ensure care is respectful of cultural differences (Think Cultural Health, n.d.). The residents find themselves advocating for their patients to address the bias and the inability of other specialists to understand the social context influencing their patients’ health. Attending physicians successfully advocating for patients serve as role models

for residents, reinforcing the advocacy role as part of their professional identity, as described by Ginger:

The other day [an attending] reached out to the specialists and insisted that they get a translator because they were refusing to see this patient unless we provided a translator, which is ridiculous because [the other specialists] were breaking the law. [The attending] made it very clear to them that she was going to report them if they refused to see this patient. Then the patient got an appointment. (personal communication, January 13, 2023)

The family and community medicine residents share the strong commitment their attending physicians have to patient advocacy. Strong attending role models, mentoring, and demonstrating effective advocacy are considered a best practice for training residents (Lam et al., 2016; Luft, 2017). The discussions included cases of residents' advocacy for culturally and linguistically appropriate care preventing bad outcomes and psychological trauma.

Patient advocacy as supporting coordination of care and navigating the health care system. Family and community medicine residents, due to their role as primary care providers, consider care coordination an essential function of their professional identity. During our conversations, Ginger shared instances of successfully coordinating care and acting as an intermediary for her patients:

Because the family has a hard time explaining it ... a hard time conversing with their doctors. For those of us who can and do see these gaps, being advocates for the patients in these multi-disciplinary meetings where it's the primary care doctor, the specialists, and the social worker having these conversations all together so that it's not just one person. (Ginger, personal communication, January 13, 2023)

Her patients face multiple challenges navigating the healthcare system. Many of her patients come from low socio-economic backgrounds, have low levels of health literacy, limited access to transportation, are uninsured or underinsured, among other challenges.

Challenges to perceptions of advocacy as part of professional identity. The two male emergency medicine physicians (Adam and Joe), unlike their peers, do not see advocacy as part of their professional identities. Adam and Joe mentioned the narrow scope of their practices and the magnitude of the problems facing their patients as factors limiting their ability to engage in advocacy. According to Adam and Joe, their role as emergency medicine physicians is to determine whether to treat, admit, or release patients. Additionally, both Joe and Adam name insufficient institutional and community resources, the hectic nature of the emergency room, and the scarce time they have for each patient as contributing factors.

Adam feels powerless to effectively advocate for the foundational needs of his patients. He views problems he encounters in the emergency room due to the extent and root causes of many of his patient's health issues.

Sometimes you are kind of just putting a band aid on problems. They're temporary solutions and they don't really address the underlying issue, which is they can't get into basic medical services, there's a lot of holes in the cheese. There are a lot of things to figure out. (Adam, personal communication, January 3, 2023)

Adam sees the result of deteriorated social and healthcare safety nets and structural and institutional barriers in his practice: "There's a lack of understanding and a lack of infrastructure. A lack of interest on the majority's part in addressing these situations and most of us complicit with it in one way or another" (personal communication, January 3, 2023). Adam's responses reflect the conditions facing emergency departments across the United States.

Results of our broken healthcare system and societal failures are found in emergency rooms across the nation. Financial pressure to maintain a bottom-line results in overcrowded emergency rooms and other constraints on emergency room physicians. Kelen and colleagues (2021) depict emergency rooms in the United States as akin to the proverbial “canary in the coal mine.” They attribute the causes of overcrowded emergency rooms as not only resulting from department performance, but also from a malfunctioning healthcare system in the United States.

Diane shared a story where she figuratively ran a marathon to advocate for a female patient in her twenties with a headache so severe it caused her to be bedbound. Diane’s continual advocacy for her patient to be admitted was repeatedly disregarded and her patient still had not been admitted at the end of her shift. The following day her attending insisted the patient be admitted. Once the patient was admitted they discovered the cause of the illness and were able to address the cause in less than an hour. The patient spent 24 hours in the emergency room. Diane was vindicated and commended for her advocacy. Despite that, she reported feeling disheartened to the point she declared she would quit and “flip houses” if she didn’t have so much student debt. “ER residents are good at advocating for their patients, which is very patient centered. But it's exhausting ... especially with the lack of respect that we get from people in the hospital that are specialists” (Diane, personal communication, January 25, 2023).

Continual negative reinforcement could lead to residents rejecting advocacy as an essential part of their practice. Diane’s experience is an example of a trend in emergency care referred to as the “tragedy of the commons.” The emergency room is considered a “shared resource,” and the tragedy of the commons is a situation where emergency room staff and administration behave in a manner that protects their own self-interests, in opposition to the “common good,” resulting in dysfunction (Kelen et al., 2021, p. 11).

The original design of the study assumed that residents' experiences with the digital stories would increase their knowledge and awareness of the tenets of patient- and relationship-centered care. However, the discussions with the residents revealed their deep-seated understanding and awareness of the elements of patient-relationship-centered care.

Digital Stories as Therapeutic Tool for Reflection

A shift in the role or reframing of digital stories became apparent in all the conversations with the residents. The relevance of the digital story themes to the residents' patients and clinical experiences changed the role digital stories in the study from an "experience" or phenomena to a prompt, sparking deep reflection on the resident's path to medicine and their experiences in residency. Shifting the focus of the study from raising awareness to a method and a therapeutic/cathartic space for the residents to reflect and assess the progress of internalizing the elements of patient- and relationship-centered care in their burgeoning professional identities.

Digital Stories Spark Reflection

The relevance of digital stories acted as a catalyst for the residents to consider their experiences on their journey into medicine, clinical practice, and professional identity. The resident co-researchers' encounters with the digital stories elicited reflection on their understanding of the tenets of patient-relationship-centered care, and how they integrate the tenets into their clinical practice and professional identity.

I intentionally chose digital stories with universal themes incorporating the creator's lived experiences, without a specific disease focus, to ensure relevance for a diverse group of physicians. The initial responses from the resident co-researchers affirm the relevance of the digital stories to their experiences.

The themes and individuals depicted in the stories are familiar (recognizable) to the physicians despite differences in the physician's type and scope of practice, thus confirming the

ubiquitous nature of the stories. “It was very similar to a lot of stories that I've seen from patients and heard directly. So those are. Oh, it felt very familiar” (Kelly, personal communication, January 9, 2023). The digital stories evoked experiences of sadness, silliness, frustration, joy, patient agency, and inspiration: they immediately prompted reflection on the residents’ experiences. Alexa saw her patients mirrored in the stories: “It makes me feel sad in a lot of ways because you see a lot of patients like this” (personal communication, January 3, 2023). Alexa’s peers’ responses to the digital stories echo hers.

The stories remind Diane of the social determinants of health, the systemic and structural factors negatively impacting her patient’s health and wellbeing.

The whole story ... made me think about a lot of patients we see in the ER, some clearly have a lot of medical problems, and they don't have a doctor, insurance, or the money to get medications and stuff like that. (Diane, personal communication, January 19, 2023)

The digital stories reminded the residents of the structural and systemic factors serving as the context of their patients’ lives and health. One of the stories reminded Diane of the survival strategies patients employ for day-to-day survival.

I think, in the first video when she realizes that the bottle cap is to make his cane slip less was pretty profound, and [...] I see that all the time. Not that specific thing, but people who need to MacGyver their way through getting proper shoes or socks, or whatever equipment they need to be healthy, or to have mobility. (Diane, personal communication, January 9, 2023)

Diane’s responses, and those of other residents’ initial responses to the stories not only revealed their understanding of the context impacting the health of their patients, but the suboptimal means their marginalized patients employ to survive. Their responses to the digital

stories unveil the “essence” of their experiences on their journey to medicine and experiences in residency. The conversations with the residents, following the digital storytelling viewing, created an opportunity for the residents to reflect on their experiences and professional identities.

Reflection in professional identity development and clinical practice. Reflection plays an essential role in the provision of healthcare. Hargreaves (2016), a well-respected scholar in higher education, emphasizes the critical function reflective practice serves, particularly its role in developing professional identity and in patient and patient-relationship-centered care. Providing an opportunity for the residents to reflect on their professional identity development made this study attractive to the vice chair of education for family and community medicine. The vice chair stated that the residents need to spend more time reflecting on their training and practice. Jay’s responses to the digital stories and study design mirror this sentiment.

I think this is cool. I think it's a good way of, I don't know how this is gonna look eventually, this might be a good way of incorporating reflection into the training process. I don't think that's something we do enough of. By training I mean it could be in medical school. It could be in residency. It could be as an attending. That was one of my biggest frustrations with people in medical school. Less now. I think people in this program, at the very least, are reflective, and are always trying to learn. But I found that there were people that I started medical school with who ended medical school in a very similar mindset as when they started. (Jay, personal communication, December 14, 2022)

Jay lamented the inability or unwillingness of their peers in medical school to embrace reflective practice. The importance of reflection to their professional identity derives in part from the nature of medicine as more of a practice than a science. Practice-based professions require a

trial-and-error approach to mastery, which necessitates reflection on successes and to build knowledge, skill, and proficiency. Adam shared his perspective on medical practice:

When you get into medicine, you realize there's not a lot of science, it's more witchcraft than actual science. It's not really an actual science.... A lot of what we do is just anecdotal. Shared experience, right? It's trying things, and it works, if it sticks. There's been a big shift recently to evidence-based medicine, but a lot of it's based on poorly designed statistical models.... This has only happened in the last few decades. Right before that, it was just people trying things, and whatever worked, worked. At some point, it was putting herbs into rooms and in turn it was reaching people's blood. Now, it's distilling things from the earth and giving it to people and see what happens. (Adam, personal communication, January 3, 2023)

Adam's musings on the nature of medical practice underscores residency as a form of apprenticeship, basically learning while doing. Hargreaves and other higher education scholars underscore the function reflective practice serves in facilitating lifelong learning and supporting patient-centered practices (Boud, 2009; Boud & Walker, 1990; Hargreaves, 2016). Reflection is a critical element for quality patient care, molding professional identity, and supporting the immersive educational experiences used in medical residency. However, the residents shared that the hectic nature and the frenetic pace of residency can impede the opportunities for reflection. The phenomenological underpinning of this study promotes reflection, and the study design seemingly sets aside time and creates a safe space for the residents to reflect apart from the dizzying pace and competing priorities of residency.

Digital Stories and Study Design Created a Space for Residents

In our conversations the residents shared their successes, challenges, frustrations, and joys. The time and space to share and ponder their experiences in a safe space allowed them to

consider how their professional identities are unfolding and progressing in a nonjudgmental environment. Nina's motivation to participate in the study derived from her need to find time to reflect on her professional identity, which has been lacking in her journey through medical school and residency.

There, there are so many different goals that I was too busy that I just forgot or else was too busy to even think about "I'm here to make meaningful relationships" with patients, you know there's no time for that. Now that I'm a third year, I'm having a little bit more autonomy. There's more freedom. I now know what I'm doing... Recently in the past couple of months, I got to reconnect to that kind of initial what's the word, motivation? (Nina, personal communication, December 22, 2023)

During the conversations Nina's peers also used the space to ponder their future practices, professional identities, and where they are in the process.

Non-Judgmental, Cathartic, and Therapeutic Space for Self-Assessment

The residents are in the final stage of a grueling, high-stakes training process beginning in medical school and running through their residency programs. The residents exist in a high-pressure environment due not only to rapid pace and competing priorities, but also to continual assessment and evaluation from attending physicians, other specialists, their patients, and their patients' families. Failures have significant consequences for the health of their patients and for their professional careers. The interviews uncovered the emotional effects on the residents and provided a judgement-free space to share and process their feelings (cathartic), vent their frustrations (therapeutic), and consider their problem solving and resilience promoting strategies and supports.

The study's safe environment is evidenced by the residents sharing very personal and potentially damaging information over the course of the discussions. Their limited time,

difficulty finding coverage, and pressure result in some of the residents reporting going to work sick (with fevers). The conversations provide a comprehensive view into their experiences.

Cathartic and therapeutic environment to reflect on the development of their professional identity development. Throughout our conversations, Diane revealed her emotional responses, both positive and negative, stemming from her experiences. She shared her frustration and anger with what she characterized as the dysfunctional nature of academic medicine and overworked, uncooperative residents from other specialties.

Diane's primary motivation for becoming a physician is to ensure her patients receive the quality care that her father deserved and did not receive. She shared the additional stress that this places on her: "I'm always thinking about my dad when I'm at the hospital, I do. I think ... right now I'm in a little bit of a state of a burnout, and so I hadn't really been like studying or reading outside of work for the past couple of months." (Diane, personal communication, January 19, 2023). Diane's memories of her father and grandfather motivate her to work harder and be better, but also add a heavy burden.

Burnout is a common concern, both for the residents themselves and physicians in general. Bynum and colleagues (2021) reference studies in psychology which reveal that shame and burnout can lead to depressive symptoms and impair an individual's capacity to be empathetic. Several studies reveal that empathy declines during medical school and residency, generally during the clinical phase of training. Others found that empathy decline is larger for medical students entering less patient-leaning specialties, and the decline in empathy is associated with the initial heightened interaction with patients in the clinical practice phase of their training (Hojat et al., 2020b; Neumann et al., 2011).

Joe notices a steady erosion in his capacity to empathize with his patients. He expressed his family's concerns about his erosion of empathy and the stressors he experiences at work.

You just can't do that, and it's hard because I feel like you know I've gone home and talked with my family, and they're kind of surprised about my lack of empathy toward people and bad situations. I can only imagine what it's like to go to war and see people actively dying all the time, which we do in the ER. I see people dying and just people's problems that before I would have been more empathetic. Now I just feel like I can't maintain that and maintain my well-being. It's kind of interesting trying to figure that out.

(Joe, personal communication, January 20, 2023)

The pace of the emergency room and magnitude of his patient's problems are additional factors contributing to the steady erosion of his empathy. As Joe worked through the causes and results of his eroding empathy, he ponders how to develop a better work life balance.

Jay shared how developing strong trusting therapeutic relationships with patients provides a sense of joy and accomplishment, and at times can cause them to feel grief and anger. "After a few days [the patient] was telling the other residents, and even my attendings, how much he likes me and that he trusted me. Yeah, I think that is the really cool part" (Jay, personal communication, December 30, 2022). Jay emphasized that they are not into medicine for gratification, as they feel that is too "self-serving," but they derive joy from a sense of "camaraderie" and "kinship" with their patients. Their ability to connect with patients is the "beauty" they find in practicing medicine.

Digital stories and the phenomenological study design provide space and time for self- assessment on their progress toward their professional identity development. The residents shared the factors supporting, as well as impeding, their progress, as well as their

problem solving and other strategies supporting their resilience. They shared the challenges they face and use those as learning opportunities and what keeps them going in the face of barriers.

Being aware of and checking their personal biases, and dealing with the biases, present as challenges and learning opportunities for the resident co-researchers. Fatigue and frustration impede their ability to check bias. Jay shared a situation where exhaustion and irritation influenced their ability to check their bias. One of their patients was experiencing withdrawal symptoms from alcohol dependence and kept requesting attention from Jay due to their anxiety. Jay describes the encounter where they were tired and frustrated and how that impacted their ability to check their bias:

A lot of anxiety, but otherwise he was scoring very, very low on the withdrawal symptoms criteria and I was dismissive towards him because in the ER I wanted to have higher acuity patients.... our frustration with people sometimes I think that contributes to the callousness. I was getting a little frustrated because ... he kept on coming back to this anxiety, and he kept saying that oh, I have tremors, and I... in my mind, I remember thinking at one point: "Is this guy just looking to get opioids from us? Or benzos, or something?" And I really didn't like that. I thought that and I persisted in my mind for a bit. (Jay, personal communication, December 30, 2022)

During our interview, Jay used the time to reflect on this encounter and on bias in healthcare settings. This encounter served as a learning opportunity reminder for Jay for future encounters, specifically Jay pondered how bias against people with substance abuse disorders influences a physician's trust in their patients and can negatively affects patient care.

Ginger also shared an experience with a patient with substance use disorder influencing her subsequent interactions with patients with similar issues. She used our time together to reflect upon how her experiences with past patients inform her interactions with future patients.

I've had a patient that was having such terrible pancreatic pain and his doctors in the beginning were unwilling to give him pain medication for it; perhaps rightfully so. But they also didn't do anything to address the pain... and he turned to buying excessive amounts of opiates on the street, and that's how he handles that pain. What could have just been temporary pain... Now he has chronic pain, he quite honestly now has opiate use disorder because he just buys an excessive amount of it on the streets. (Ginger, personal communication, January 13, 2023)

Ginger used these experiences as a reminder not to be dismissive of patient reports of pain and to consider alternatives to opioids to treat the pain. She fears other patients may be lost to follow up or turn to the streets to resolve their pain. She uses each new encounter with these patients to build her understanding and inform her future encounters.

Family and community medicine residents Alexa and Kelly shared that advocating for their patients serves to bolster their resilience and confidence in their capacity as a resident. Observing their attending physicians successfully advocating for patients motivates them and builds self-efficacy. Successfully engaging in advocacy promotes resilience in that it addresses many of the sources of frustration and builds morale (Croft et al., 2012). During our first conversation, Alexa contemplated the impact even small gestures of advocacy can have on a patient:

I think just accepting that I can't fix everything in the grand scheme of things, but that there are little things you can do to make people's lives a little bit easier and just kind of

taking away some of that extra burden on them in that moment can really allow people a moment to regroup to and just feel less weighed down. (Alexa, personal communication, January 6, 2023)

Alexa shares examples of successful advocacy efforts making a difference in her patients' lives which are within her resources and capacity.

Over the course of the interviews, Diane provided multiple examples of her experiences advocating for patients. Her stories demonstrate her unrelenting efforts advocating for her patients' wellbeing. Despite reporting feelings of dejection and burnout during the interviews as she talked her way through the situations, recognizing the positive outcomes of her efforts changes her attitude. In the latter portion of our last conversation, her morale improved as she reflected on the praise she received from her attending physician for her advocacy, and her upcoming rotation at a community hospital with a reputation for supporting patient advocacy.

Summary

Medical residents have a dual role as working professionals in training and, as such, must adopt self-directed and regulated learning (Hargreaves, 2016). The very nature of medical practice requires self-directed, life-long learning and adopting a practice of self-assessment. Responses from the residents revealed their satisfaction with the process of the study.

Physicians ... have changed their mentality to where they are the teacher and they're less open to sitting and being taught something they think they already know, whereas somebody like something like this, where I was asked to help with providing my expertise to a research project. That very much suits my ego and is an easy thing to say yes to any time. If a doctor is asked to help with something, we like solving problems and sometimes teaching and helping is easier on the ego than being told to come in and learn something. (Kelly, personal communication, January 25, 2023)

Kelly's opinion of the potential appeal of the study as a training method supports the use of hermeneutic phenomenology as a collaborative method, respecting the perspectives and lived experiences of both the investigator and participant co-researchers.

The design of the study shows promise as an effective method to promote reflection and support resilience and the capacity to provide patient-relationship-centered care. The medical residents like the flexibility of the design and their role as co-participants. Other specialists might benefit more from increasing awareness of the social determinants of health and political determinants of health impacting health outcomes rather than the participants in this study due to reported differences in the culture of those subspecialties and differences in the structure of the residency programs.

This shift in the focus of the study provides additional support for the use of hermeneutic phenomenology for the study. My initial assumption was the residents' immersive experiences, with the digital stories serving as an experience, would increase the residents' understanding of the tenets of patient-relationship-centered care. When, in fact, the digital stories served as a tool prompting reflection on the physician's experiences on their path to medicine and in their residency.

CHAPTER FIVE: DISCUSSION AND CONCLUSIONS

Introduction

The central aim of this study is to develop an understanding of how digital stories can contribute to preparing physicians to practice under the new healthcare paradigm. Over the last few decades there has been a shift from a biomedical model, which promotes a “distant yet concerned” approach to patient care, to one emphasizing patient- and relationship-centered care. The original study design, grounded in hermeneutic phenomenology, assumed the medical resident experiences of digital stories and reflection on their experiences would raise their understanding and awareness of the importance of the elements of patient-relationship-centered care. However, from the beginning, my conversations with the residents shifted the focus and direction of the study. The key shifts were: (a) in the role of the digital stories, now serving as a catalyst prompting the residents to reflect on their lived experiences, and (b) the study provided an opportunity for the residents to self-assess the progression of the development of their professional identities.

Rather than functioning as an immersive experience, the digital stories served as a catalyst for reflection on their experiences. “Both [digital stories] had... I don’t know how to describe reflection as a mood” (Jay, personal communication, December 14, 2022). Jay’s initial response (essence) to the digital stories was to reflect. The digital stories and study design provided space and time for the residents to reflect on their experiences. Additionally, the study’s new direction has interesting implications for higher education on the role of reflective practice (Boud, 2009; Boud & Walker, 1998; Hargreaves, 2016) and the process of developing professional identities in graduate and professional education (Barbarà-i-Molinero et al., 2017).

These unanticipated shifts in the focus and direction of the results of the study provided a view of the process of socialization, social, and institutional factors influencing (molding) the

medical resident co-researchers' burgeoning professional identities. The unexpected changes in the study focus provide a broader understanding of how to support the professional development of residents in relation to patient- and relationship-centeredness. Despite increasing interest, a gap exists in the higher education literature on professional identity development in graduate and professional education. Barbarà-i-Molinero and colleagues (2017) report the understanding of professional identity development has too narrowly focused on specific factors or is too discipline specific.

The results contribute to the understanding of: (a) how to support reflective practice and self-assessment throughout medical residents' training, (b) methods for supporting empathy and advocacy in professional medical training, and (c) the factors influencing residents' emerging professional identities. These results are relevant to other health and human services professions and have implications for future research and practice in those fields.

Initial Research Questions

- 1) How do healthcare providers experience digital stories in the context of their practice?
 - a) How does the experience influence their understanding of social determinants of health and political determinants of health?
 - b) How does the experience influence their understanding of integrating social determinants of health and the political determinants of health into treatment plans?
 - c) How do their experiences with the digital stories contribute to their understanding of a patient-relationship-centered approach?
- 2) How do health care providers' experiences with digital storytelling shape or inform their interaction and communication with patients?

- a) How do providers' experiences with digital stories support emotional socialization?
- b) How do digital stories move providers toward adopting a more patient-relationship-centered practice?

The study design is grounded in the principles of hermeneutic phenomenology. Hermeneutic phenomenology seeks to understand the lived experience of individuals ("dasein"), and hermeneutic studies use a collaborative approach to research seeking the co-construction of knowledge and understanding between the investigators and participant co-researchers (van Manen, 1997). The hermeneutic phenomenology methodology acknowledges the bias of both the investigator and participant co-researchers and utilizes an iterative process of interpreting and re-interpreting (hermeneutic circle) to develop an understanding of lived experiences. The end results of hermeneutic inquiry are the "fusion of horizons," where, through reflection, the perspectives of both the investigator and the participants change, leading to a new understanding of the phenomenon in question (Gadamer, 1996).

Discussion

Digital Stories from Phenomena to Catalyst

The residents immediately recognized connections between the life histories of the people in the digital stories and that of their patients. The relevance of the digital stories immediately prompted the residents to reflect on their patients, practice, and professional identities. During our conversations the residents spontaneously pondered the challenges to, and factors supporting, patient-relationship-centered care in their clinical practices. Alexa discussed the similarities between the life experiences of the people in the digital stories and her patients: "It makes me feel sad because you see a lot of patients like this, they come in for one thing and you very quickly and easily see there's more going on in and you want to help them..." (personal

communication, January 6, 2023). Like Alexa, all the resident co-researchers recognized parallels between the themes of digital stories and their patient's experiences.

The shift in the role of digital stories from an immersive experience to a means to promote reflection is significant for two reasons. First, this shift has implications for the use of digital stories, rather than digital storytelling, for training medical residents, physicians, and other health professionals. Digital storytelling is used extensively in health care training in nursing, public health, education, and other human services professions (Christiansen, 2011; Hawthornthwaite et al., 2018; Watson, 2007). Digital storytelling has not been used extensively in undergraduate or graduate medical and professional education. The literature on digital storytelling and medical education reveals that it is primarily used in medical school rather than residency or continuing medical education (Moreau et al., 2018). The limited use of digital storytelling in medical education is due in part to the time and labor-intensive nature of the digital storytelling process.

Digital storytelling is the process of creating digital stories and has proven to be an effective training method for patient centeredness, in part due its nature as a cathartic and therapeutic experience (Hardy, 2007; Hargreaves, 2016; Lambert & Hessler, 2020). Digital storytelling workshops are time and labor intensive, as well as expensive. Due to the financial and time constraints of the study, I decided to use digital stories as a proxy for digital storytelling. My decision to use digital stories rather than digital storytelling, and the resident co-researchers' responses to the digital stories, indicate the potential for a more expansive use of digital stories in professional training.

Digital stories' facility for promoting deep reflection on the medical residents' experiences was a fortunate (albeit unexpected) discovery. Medical residents and other practicing

physicians, unlike medical students, have very little unstructured time outside of their clinical practice to participate in training/continuing medical education. The relevance of the digital stories and study design to their patients and practice, as well as the flexibility (in relation to time requirements and location) of this method to fit into the residents' busy schedules (in comparison with digital story telling) underscore the potential of the use of digital stories in professional and continuing medical education and for professional education in other disciplines. The medical residents' positive reactions to the digital stories in conjunction with the ability of digital stories to convey impactful and diverse perspectives in a short period of time, provide additional support for integrating digital stories in medical training. "Both, I could tell, as soon as they started that they were going to be powerful" (Jay, personal communication, December 14, 2022). The digital stories convey powerful, relevant messages in a short period of time (3–5 minutes each), prompting the residents to consider their encounters with patients and their professional identities.

Recommendations

Shift from Awareness to Reflection

Reflection and reflective practice appeared in each conversation with the residents, serving as a common thread weaving through and connecting the themes and subthemes. Reflection is an essential component of medical training and medical practice. Reflective practice plays a pivotal role in the medical residents' ability to provide quality patient and relationship-centered care. Medicine, as with all practice-based professions, is constantly evolving. Medicine, as a human service occupation requires an ability to adapt care plans to differences in patients' health status and consider the changing social and political contexts influencing their health. Residency is a hectic time, and the resident co-researchers discussed the time constraints and competing priorities that often impede their ability to reflect on their

progress. Furnishing opportunities to reflect during residency supports the integration of reflective practice and lifelong learning, both of which are essential to the professional development of physicians (Hargreaves, 2016). Jay, a family medicine resident shares their disappointment in that many of their peers from medical school have yet to adopt reflective practice. Studies in academic medicine and higher education practice underscore the essential role reflection plays in developing responsive practices in medicine and other professional training in higher education (Gathu, 2022; Hargreaves, 2016).

Implications for Residency and Higher Education Practice

Residency is a stressful time for new physicians: they face multiple competing priorities, hectic schedules, and relatively limited time to master a wide variety of skills and knowledge. The Accreditation Council for Graduate Medical Education in the United States establishes the maximum number of hours a medical resident may work weekly. Residents cannot exceed an average of 80 hours a week over a four-week period. The average number of hours of residents varies by specialty (Accreditation Council for Graduate Medical Education, 2022). Their hours and their schedules may vary depending upon changes in rotations and shifts. Lack of sufficient time to reflect or for assessing progress is not unique to medical training but is an issue facing other practice-based professional training.

All the resident co-researchers reported feeling burnt out, and two specifically reported feeling exploited. This may be akin to Rhoads and Rhoades (2005) discussing the catalysts for the unionization of graduate students nationally. In academic capitalism, graduate students are labeled as “apprentices” to justify long hours and low wages. There is a movement to unionize medical residents to address the long hours, low wages, and difficult working conditions which contribute to burnout. Diane reported that she felt this was a characteristic of academic medicine

which exploits the residents and results in poor outcomes. The working conditions of the emergency medicine residents seems to be the result of a combination of academic and medical capitalism.

Scholars in higher education promote various strategies to integrate reflective practice after the experience (Boud, 2009; Boud et al., 1985; Boud & Walker, 1998). Harvey and colleagues (2016) recommend arts-based approaches, including digital stories, as alternatives to journaling to promote reflective practice in higher education to better prepare students for the workforce. The hermeneutic design of the study and digital stories align with the strategies described in the higher education literature and have potential for use in undergraduate, graduate, and professional education in general.

Healthcare by its very nature is a collaborative enterprise, integrating disciplines such as medicine, nursing, public health, and social work. Higher education scholars suggest incorporating collaborative reflective practice in multi-disciplinary teams as a strategy to optimize outcomes for patients (Boud, 2009; Hargreaves, 2016). During our conversations, the medical residents not only reflect on their experiences in residency but use the time to assess their progress and consider their future practice.

Boud (2009) emphasizes the importance of reflection to the development of “good practice” (professionalism) in workforce and professional education in higher education. He is critical of attempts in graduate and professional education to assess reflective practice utilizing “objective” measures of assessment (rubrics). Boud contends these approaches inhibit reflection and fail to capture the all-encompassing nature of reflective practice. The results of my discussions with the residents demonstrate the study design’s ability to capture the purpose and complexity of reflective practice described by Boud (2009).

As working professionals, the medical residents must adopt a practice of self-regulated learning and assessment. Hargreaves (2016) presents a model of self-directed learning adapted from White and Gruppen (2010). The model stipulates the goal of self-directed learning is to improve performance and is dependent upon the learner's self-motivation, self-efficacy, and self-assessment. The process requires reflection (Hargreaves, 2016; White & Gruppen, 2010). The alignment of their model of self-directed learning with the results of the study suggests the study design could be adapted to integrate reflection and self-assessment opportunities at different stages of the residency program, particularly for those skills that are not amenable to assessment by "objective measures," such as empathy and advocacy.

Cathartic and Therapeutic Space

The study design provides a non-judgmental, cathartic, and therapeutic space. The residents are constantly being assessed by their attending physicians and patients. In addition, medical residents have little time and space to engage in reflection on their developing professional identities, or self-assessment on their progress and skill acquisition. During our discussions the resident co-researchers took the opportunity to reflect on their experiences, vent their frustrations, and work through complex emotions resulting from those frustrations. The residents share the emotions they experience in response to their clinical work, both accomplishments and challenges. They share negative feelings such as "defeated," "frustrated," "irritated," "disheartened," and "demoralized," as well as positive emotions feeling "joy," "honored," "respected," and "trusted." The ability to vent and consider their emotions supports both the process of professional identity development and internalization of roles. The positive emotions reinforce certain behaviors, values, and actions and the negative feelings discourage others.

The residents also take advantage of our conversations to reflect on their capacity to provide patient-relationship-centered care. The results of our conversations reveal both the factors negatively impacting their resilience and strategies they employ to maintain their resilience. Diane shares that she has learned to not be so hard on herself: “I initially went in [to medicine] thinking I'm never going to make mistakes and I'm going to be better than those doctors and nurses, it's slowly become more of “mistakes happen” and I need to be aware of any bias I have” (personal communication, January 19, 2023). The time to reflect allows Diane to be kinder to herself, as well as think through her resilience.

The strategies the residents use to build their capacity within the clinic are varied. Joe engages in extreme sports in the little free time he has. Kelly uses a process of self-reflection to assess her capacity to connect with patients, particularly regarding her “emotional energy” when she is tired or feeling burnt out.

Setting the expectation that if our emotional energy, if our cup is not as full as we'd like it to be... How do we triage? How do I identify who's going to get the most benefit from me pouring extra in. And the patient experiencing psychosis that thinks I'm a witch, and the med students are my coven, is probably going to benefit a little bit less from a prolonged sit-down therapeutic conversation than someone with a little bit more insights, who's more able to engage. (Kelly, personal communication, January 17, 2023)

Kelly reflects on how her experiences and advice from her attending physicians inform her approaches to self-care and help mediate burnout.

Burnout is a common concern, both for the resident co-researchers and physicians in general. Bynum and colleagues (2021) reference studies in psychology which reveal that shame and burnout can lead to depressive symptoms and impair an individual's capacity to be

empathetic. Several studies reveal that empathy declines during medical school and residency, generally during the clinical phase of training. Others found that empathy decline is larger for medical students entering less patient-leaning specialties, and the decline in empathy is associated with the initial heightened interaction with patients in the clinical practice phase of their training (Hojat et al., 2020b; Neumann et al., 2011).

Empathy and Advocacy: Training and Professional Identity

My discussions with the residents revealed multiple definitions of empathy and its role and application in clinical practice. Joe told me he feels a steady decline in his ability to empathize. He fears that if he empathizes with too many of his patients, he will develop post-traumatic stress disorder and be unable to function. Adam attributed his limited capacity to empathize to the scale and social and political root causes of the health issues facing his patients. Despite both Adam and Joe reporting the inability or limited ability to include empathy in their practices, over the course of our conversations they shared encounters with their patients where they clearly use empathy to improve communication or better understand the context of their patients' health.

The other resident co-researchers, including the two female emergency medicine physicians, perceive the ability to be empathetic as critical to the provision of quality care. The differences in perspectives of the role empathy plays in care may be due in part to differences in gender roles and socialization, as Joe and Adam are the only residents in the study identifying as male. Also, the differences may be due in part to gaps in training and lack of clarity regarding the definition of empathy and how to integrate it into clinical practice.

The answer may lie partially in the results of the Jefferson empathy project. Hojat and colleagues (2023) report on a clinical definition of empathy resulting from a comprehensive review of the literature. They differentiate between clinical empathy and emotional empathy.

Clinical empathy is a primarily cognitive function focused on understanding, whereas emotional empathy is equated with sympathy and works as an emotional reaction to a patient's situation.

They found that clinical empathy is more protective against the erosion of empathy. They identify the dimensions of empathy and their role in different aspects of patient- and relationship-centered care, implications from empathy erosion, and potential methods to bolster empathy in residents and medical students. Their results have implications for integrating strategies to prevent the erosion of empathy in medical training, opportunities which consider residents' use of empathy in patient encounters and enhance the use of empathy in clinical practice.

Cantwell and colleagues (2010) conducted an analysis of the members of the Gold Humanism Honor Society at three medical schools (University of Arizona, Rush University, and George Washington University) to identify how the life history and personal characteristics of the awardees can inform how to select students with "humanistic potential" (empathy) and how to promote a humanistic perspective in medical students and their professional identities. Their results have implications for identifying "humanistic potential" (empathy) as part of the admissions process for aspiring medical students as well as integrating "humanism" in medical training.

All the resident co-researchers report engaging in advocacy in collaboration with and for their patients. Again, their perceptions of the role advocacy must play in their practices varies by specialty and gender. The two male emergency medicine residents have a narrower view of advocacy than the other medical residents. Engaging in advocacy is a physician's ethical responsibility, is important to patient outcomes, and promotes physician resilience and morale (Croft et al., 2012). However, as with empathy, despite its recognition as core competency there is a lack of clarity regarding the scope of the competency and few medical schools include

advocacy training in their curricula and residency programs. The Southwestern Medical School's family and community medicine residency program incorporates advocacy training, and attending physicians serve as mentors and role models for the residents. Yet the advocacy seems to focus primarily on patient advocacy. There is a potential to build on their strong foundation through incorporating social advocacy training into their programs to influence system changes to address the root causes of health inequities experienced by the patients and communities served by the medical resident co-researchers.

Implications for Future Research

Implementation With Diverse Range of Specialists

The unexpected reframing of the role of digital stories has implications for its use in the training and promotion of reflective practices and patient-relationship-centered care. This study includes specialties which require high level or more intensive interactions with patients than others; that might account for their strong grasp of the principles of patient-relationship-centered care. Surgeons, urologists, and cardiologists may have very different reactions to digital stories. A follow-up study including a broader range of specialists who don't have the same level of patient interaction may yield different results, they may not be as aware or have as strong a grasp of patient-centered care.

Implementation With Other Health Science Professionals

The design of the study has implications for professional development training in other health sciences and human service professions such as nursing, public health, pharmacy, education, and social work. The successful provision of services in these professions depends on the same elements of patient-relationship-centered care as medicine. Reflective practice and empathy are essential to service quality and client outcomes for these professions.

Improvement of Primary Care Training Through Continuing Education

The flexibility and convenience of the study design make it a good fit for continuing medical education focusing on patient-relationship-centered care. Do practicing physicians understand the elements of patient- and relationship-centered care or would their responses be like those of the residents? Would the digital stories prompt early and midcareer physicians to consider the assets and barriers facing their ability to provide patient-relationship-centered care? The Agency for Healthcare Research and Quality, an agency of the United States Department of Health and Human Services, has launched a new funding initiative supporting research to improve the understanding of primary care to improve health outcomes through including patient-centered care, health equity, and workforce development.

Integration at Different Junctures in Residency

The study design could be modified to address different components of professional identity development. The study design has the potential to provide an opportunity for medical residents and others to assess their professional identity development at key points in their residencies. Utilizing hermeneutic phenomenological methods, digital stories, and other varied art- and humanities-based approaches could prompt reflection and self-assessment of their experiences and progress in the development of their professional identities. Additionally, the study has the potential to support professional identity development for other human service professions, including undergraduate as well as graduate professional training.

Conclusions

The results of this study relate to the original research questions, but rather than raising awareness of the principles of patient-relationship-centered care, the discussions reveal the residents' experiences providing patient-relationship-centered care along with the facilitating factors and associated burdens. The conversations unveil the medical residents' experiences developing their professional identities. The study design creates a safe, cathartic, and

therapeutic space for the residents to consider their resilience and capacity to provide patient-relationship-centered care. The reframing of the digital stories from experience to tool for reflection shifts the focus of the study from raising awareness to identifying strategies supporting and reinforcing reflective practice and providing an opportunity to celebrate successes and vent frustrations.

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APPENDIX A: INTERVIEW QUESTIONS

Interview 1: Fore conceptions and relevant life history

1. Tell me about your path or journey to medicine.
 - **Prompt:** *What personal experiences or experiences with family, friends, school, in your neighborhood, or the health care system influenced your decision to become a physician?*
2. Tell me how your journey has shaped/ influenced how you interact with and care for patients.
 - **Prompt:** *Tell me a story about an interaction with a patient or a typical encounter that has informed how you interact with and care for patients.*

Interview 2: Details of the lived experience (essence, write one- or two-word reactions while they are watching the digital story)

1. Tell me what it was like to watch Juan y La Ficha. What thoughts first came to mind?
 - **Prompt:** *Share your initial reactions (one or two-word reactions). Tell me what it was like to watch Bobby's story. What thoughts first came to mind?*
2. Tell me about/describe how Juan y la Ficha made you feel.
Tell me about/describe how Bobby's story made you feel.
 - **Prompt:** *Describe the feelings generated by each story (not opinion or analysis, just reactions). If they have answered it above, ask if they have anything to add.*
3. Tell me about/describe the moments that stood out to you in Juan y La Ficha.
Tell me about/describe the moments that stood out to you in Bobby's story.

- **Prompt:** *Tell me about(describe) the scenes, comments, ideas, and visuals that left an impression or were particularly powerful, memorable, or moving. If they have answered the question above, ask them if they have anything to add.*

Interview 3: Reflection

We know that our health system is complex, and many factors affect the patient-physician relationship, so I want you to answer the next set of questions as if you are working in a perfect world scenario.

1. Thinking back on what you shared about your journey in our first interview and your experience with digital stories in our second interview, tell me a story that highlights/ describes what you think are the key elements of patient-relationship-centered care. Rooted in/ based on your experiences(personal and with the digital stories) Tell me why those critical elements of patient-relationship-centered care you identified should be integrated into patient interactions and care plans.
 2. Thinking back on what you shared in the first two interviews and what you shared in this interview, describe the role patient life experiences could play in patient interactions and care plans (perfect world scenario).
 4. (Can you tell me a story or provide an example, rooted in your personal experience or the digital stories?
 5. Tell me about/ describe an experience highlighting the factors which support the integration of those critical elements of patient-relationship-centered care in your practice.
 6. Tell me a story highlighting the challenges you face integrating those critical elements of patient-centered and relationship-centered care in your practice.
- **Prompt:** *What structural, policy, relevance, or other factors impede your ability to integrate elements into care, care planning.*

APPENDIX B: CONSENT FORM



Office of Research Compliance

Project Number: 1964063-1
Approval Date: October 15, 2022
This stamp must be on all
consenting documents



Consent to Participate in Research

Study Title: THE POWER IS IN THE TALE; INTEGRATING DIGITAL STORIES IN MEDICAL TRAINING ON DETERMINANTS OF HEALTH AND PATIENT-CENTERED CARE

Principal Investigator: Martha Moore-Monroy

You are being asked to participate in a research study. Your participation in this research study is voluntary, and you do not have to participate. This document contains important information about this study and what to expect if you decide to participate. Please consider the information carefully. Feel free to ask questions before making your decision on whether or not to participate.

Purpose: The study aims to explore the potential of digital stories to influence healthcare providers' understanding of elements of patient-relationship-centered care.

Expected duration and requirements of study participation: You will be asked to view two digital stories and participate in three interviews based on the experience and review the transcripts and analysis for accuracy and input. The estimated time commitment for each participant ranges from three to a little over four hours, spread out over four to six weeks, depending on the length of your responses to the interview questions and the time to review the transcripts and analysis.

Summary of Risks and Benefits: Participation has minimal, if any, risks. The only potential risk is the very low possibility that something presented in the stories triggers a painful memory. Benefits to participation include experience engaging in qualitative research and the potential to fulfill research or diversity requirements. If you choose to use this experience to satisfy a research requirement, you may request a certificate. In this situation, you will receive the certificate. Your participation will not be shared by the PI or anyone affiliated with the research. Additionally, a benefit to participation is an increased understanding of the elements of patient-relationship-centered care with the potential to improve their clinical care skills.

Time Commitment: The estimated time commitment for each participant ranges from three to a little over four hours, spread out over four to six weeks. . Time commitment is dependent upon the length of your responses to the interview questions and time to review the transcripts and analysis

Gift Card: Participants will receive a \$20 gift card to Starbucks to thank them for participating. The participants will receive the gift card after the last interview they complete. The

NAU Adult Consent Non-Federally Funded

Consent Version: 10/15/2022

V Mar 2020

Page 1 of 3



Office of Research Compliance

compensation will be prorated if they don't complete the study, at a prorated value of a \$5 gift card per interview. For Zoom interviews, the participants are on the same campus and I will arrange to either meet them on campus.

Confidentiality of information: You will be assigned a pseudonym. The PI will be the only one with the ability to connect your identity to your pseudonym. Personally, identifiable information will not be shared with anyone. With your permission, I would like to audiotape this interview and create a transcription of the recordings.. Once the transcripts have been validated, the recordings will be erased. Your name will not appear in the transcript, in notes, or in any reports.

Your responses will be stored under your pseudonym. The list connecting your name to this pseudonym will be kept in a password computer the pseudonym list will be stored separately from your responses on an encrypted password-protected computer and encrypted external backup drive in a locked cabinet in a locked private office. Only I, the PI, will have access to the pseudonym file. The pseudonym list will be stored for five years and then destroyed in accordance with NAU policy.

The information that you give in the study will be confidential. Your name will not be linked to your answers.

Because of the nature of the data, it may be possible to deduce your identity; however, there will be no attempt to do so, and your data will be reported in a way that will not identify you.

Information collected about you will not be used or shared for future research studies.

The information that you provide in the study will be handled confidentially. However, there may be circumstances where this information must be released or shared as required by law. The Northern Arizona University Institutional Review Board may review the research records for monitoring purposes.

For questions, concerns, or complaints about the study you may contact *Martha Moore-Monroy* Principal Investigator for this study Office(520)626-8036 or mmonroy@email.arizona.edu.

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact the Human Research Protection Program at 928-523-9551 or online at <http://nau.edu/Research/Compliance/Human-Research/Welcome/>.



AGREEMENT TO PARTICIPATE

I have read (or someone has read to me) this form, and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. I affirm that I am at least 18 years of age and voluntarily agree to participate in this study.

I am not giving up any legal rights by providing my electronic signature/typing my name into this form. I will be **given a copy of this form upon request**

Printed name of subject

Signature of subject

Date

AGREEMENT TO BE AUDIO-RECORDED

Subject Signature: _____ Date: _____

Signature of Investigator/Individual Obtaining Consent:

To the best of my ability, I have explained and discussed the full contents of the study including all of the information contained in this consent form. All questions of the research subject and those of his/her parent or legal guardian have been accurately answered.

Investigator/Person Obtaining Consent: _____

Signature: _____ Date: _____

APPENDIX C: NORTHERN ARIZONA UNIVERSITY IRB APPROVAL



Office of Research Compliance

Institutional Review Board for the
Human Research Protection Program

525 S Beaver St
PO Box: 4062
Flagstaff AZ 86011
928-523-9551
<https://www.nau.edu/IRB>

To: Martha Moore-Monroy
From: NAU IRB Office
Date: November 29, 2022

Project: The Power is in the Tale: Integrating digital stories in medical training on patient-relationship-centered care.

Project Number: 1964063-2
Submission: Response/Follow-Up
Review Level: Administrative Review
Action: ACKNOWLEDGED
Project Status: ACTIVE - OPEN TO ENROLLMENT
New Approval Expiration Date: October 15, 2027
Next Report Date:

This letter is to acknowledge that all conditions with approval have been met.

- Northern Arizona University maintains a Federalwide Assurance with the Office for Human Research Protections (FWA #00000357).

Important

The principal investigator for this study is responsible for obtaining all necessary approvals before commencing research. Please be sure that you have satisfied applicable external and University requirements, for example (but not limited to) data repositories, listserv permission, records request, data use agreement, [conducting University surveys](#), [data security](#), [international](#), [conflicts of interest](#), [biological safety](#), [radiation safety](#), HIPAA, FERPA, FDA, sponsor approval, [clinicaltrials.gov](#), [tribal consultation](#), or [school approval](#). IRB approval does not convey approval to commence research in the event that other requirements have not been satisfied.

APPENDIX D: UNIVERSITY OF ARIZONA IRB APPROVAL



THE UNIVERSITY OF ARIZONA
Research
Innovation & Impact

University of Arizona IRB
845 N Park Ave., Suite 537A
Tucson, AZ 85719
Fax: 520-621-9810
VPR-IRB@arizona.edu

ACKNOWLEDGEMENT OF AN EXTERNAL IRB UPDATE

November 23, 2022

Martha Moore-Monroy

Dear Martha Moore-Monroy:

On 11/23/2022, the IRB Office reviewed the updated information for the following study that is relying on an external IRB as the IRB of record:

Site Information	
Type of Review:	IRB Site
Site Name:	Integrating digital stories in medical training on patient-relationship centered care
IRB Submission ID:	STUDY00002076
Site Investigator:	Martha Moore-Monroy
Additional Site Funding:	None
Site Documents Reviewed:	• Banner Review approval, Category: Institutional Approval; • banner_employee_research_consent_addendum_v2_july_2015 (1).docx, Category: Participant Material; • banner_employee_research_consent_addendum_v2_july_2015 (1).docx, Category: Consent Form; • CBPR Residential Research permission.msg, Category: Other; • Consent formNon-Federally funded consent formNAU Moore-MonroyPsub.doc (stamped).pdf, Category: Consent Form; • Consent formNon-Federally funded consent formNAU Moore-MonroyPsub.doc (stamped).pdf, Category: IRB Protocol;





	• Consent formNon-Federally funded consent formNAU Moore-MonroyPIsub.doc (stamped).pdf, Category: Consent Form; • Data Collection ProtocolMooreMonroyKaryn.docx, Category: Other; • Data Collection ProtocolMooreMonroyKaryn.docx, Category: IRB Protocol; • IRB Protocol, Category: IRB Protocol; • IRBContent for recruitment flyerMooreMonroy91322mjmedits.docx, Category: Recruitment Materials; • IRBContent for recruitment flyerMooreMonroy91322mjmedits.docx, Category: Recruitment Materials; • IRBNetDocument (1).pdf, Category: External Site Authorization; • Martha Monroy_Advisor_Co-PI Attestation Form_(Scott Carvajal).pdf, Category: IRB Protocol; • Martha Monroy_Advisor_Co-PI Attestation Form_(Scott Carvajal).pdf, Category: Other; • Martha Monroy_IRB Department Attestation Approval_(Digital Story Training)_(Z.Chen sig)_10.27.22.pdf, Category: Other; • Martha Monroy_IRB Department Attestation Approval_(Digital Story Training)_(Z.Chen sig)_10.27.22.pdf, Category: IRB Protocol; • Martha Monroy_Scientific_Scholarly Review Attestation Form_(S.Carvajal) (1).pdf, Category: IRB Protocol; • Martha Monroy_Scientific_Scholarly Review Attestation Form_(S.Carvajal).pdf, Category: Other; • Moore-Monroy Biosketch (2022) fall.docx, Category: CV; • Moore-Monroy Biosketch (2022) fall.docx, Category: IRB Protocol; • RE permission to work with Family medicine residents.msg, Category: Other;
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THE UNIVERSITY OF ARIZONA

Research

Innovation & Impact

University of Arizona IRB
845 N Park Ave., Suite 537A
Tucson, AZ 85719
Fax: 520-621-9810
VPR-IRB@arizona.edu

Study Information	
Study Title:	The Power is in the Tale: Integrating digital stories in medical training on patient-relationship-centered care.
IRB Parent Protocol ID:	STUDY00002076
Study Sponsor:	None
Study Prime Sponsor:	None
IND, IDE or HDE:	None

This notification serves to acknowledge the updates you provided for the above listed study. If not already submitted, you may be required to also submit these updates to Northern Arizona University.

The University of Arizona maintains a Federalwide Assurance (FWA) with the Office for Human Research Protections (OHRP) (FWA #00004218). All research procedures should be conducted according to the approved protocol and policies and guidance of the IRB of record. Please refer to [Guidance](#) *Investigators Responsibility after IRB Approval, Reporting New Information, and Single IRB Review*.





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845 N Park Ave., Suite 537A
Tucson, AZ 85719
Fax: 520-621-9810
VPR-IRB@arizona.edu

As a reminder, please promptly notify the local IRB Office upon:

1. Modification in cases of:
 - a. Key personnel changes
 - b. Alteration of Banner required consent language
2. Report any **local** unanticipated problems involving risks to participants or others
3. Notification that Northern Arizona University has renewed its approval at continuing review
4. Closure of the study

We value your feedback and would appreciate you taking the time to complete our survey about your experience with the IRB staff:

https://uarizona.co1.qualtrics.com/jfe/form/SV_ehQ04WxNA06b42i.

If questions arise at any time during your study, please email the general IRB inbox at VPR-IRB@arizona.edu.



APPENDIX E: BANNER RESEARCH PROJECT APPROVAL

Hello Dr. Carvajal & Martha,

Your project has completed Banner Feasibility Review and has been added to the UAHS workflow for Coverage Analysis assignment. An analyst will be assigned to your project by Friday, Nov 18th. *Initial review is typically completed within two weeks of assignment. To help maintain timely and efficient review of projects, incomplete submissions may be withdrawn from the workflow.*

According to your submission documents, your project is not externally funded, so you may now submit your study to the UA IRB via eIRB.

Please include a copy of this feasibility approval email in your eIRB submission.

Kind Regards,
UAHS Research Administration
crc@arizona.edu

Lani Corbett

Research Coordinator, Research Administration
University of Arizona Health Sciences
Office: 520.621.5785



Research Administration

From: Service Hub <svcnowprod@service-now.com>
Sent: Friday, November 18, 2022 12:17 PM
To: VPHS-UAHS-CRC <crc@email.arizona.edu>
Subject: [EXT]Banner Research Request Approved

External Email



Hello,

The Banner Research Project Request, The Power is in the Tale: Integrating digital stories in Medical Training on Patient-Relationship-Centered care, has been reviewed and approved by Banner Research. Please contact Carolyn Elliott if you have any questions related to this project approval.

Number: UAFEAS0001818

Project Title: The Power is in the Tale: Integrating digital stories in Medical Training on Patient-Relationship-Centered care

Department: Public Health

Protocol Number: Power in the Tale

PI Name: Martha Moore-Monroy

Clinical Trial Sr. Manager: Carolyn Elliott

Email: Carolyn.Elliott@bannerhealth.com

Study Coordinator: Martha Moore-Monroy

Approval Date: 11/18/2022

Approval Notes:

No Banner involvement other than access to medical residents as participants. No Banner agreement needed.