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Daniella Arieli

Emek Yezreel Academic College, Israel

Batya Tamir

Emek Yezreel Academic College, Israel

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Cover Page Footnote

We thank all the participants of study for openly sharing their stories with us. We also thank Yitzhak Beja, Galit Ailon, Miriam Hirschfeld and Howard Weinberger for their help, comments and support.

Patients' stories of encounters with doctors: Expectations and anxieties

Daniella Arieli, *Emek Yezreel Academic College, Israel, daniellaa@yvc.ac.il*

Batya Tamir, *Emek Yezreel Academic College, Israel, batyat@yvc.ac.il*

Abstract

The study contributes to the understanding of how patients experience encounters with doctors. The study is based on the gathering and analysis of subjective stories of 'healthy' patients who live in Israel about their encounters with doctors. On the one hand, medical encounters were described as functional ritualistic events, and the doctor was described as an indifferent clerk. On the other hand, and often at the same time, medical encounters were perceived as incredibly meaningful and potentially fateful events, and the doctor as a supreme authority. Four main inter-connected expressions of this were: 1. The encounter as a ritual: A convenient but alarming arrangement; 2. Alone in the struggle to feel well: The unspoken anxiety; 3. Time concerns; 4. Paying for reassurance- Turning to physicians in private practice. The research indicated that the visit to the doctor often raises "healthy" patients' confrontation with existential fears, and that they expect the doctor to be sensitive to their anxieties, and reassuring. Alas, these emotions and expectations often remain unspoken. There is a need for further discussion regarding the different ways patients and doctors perceive medical encounters. Acknowledging potential gaps in meanings and expectations and addressing their implications on patients' experiences is crucial for patients; doctors and policy makers.

Keywords

Patients' experience; medical encounters; anxiety; bureaucracy; healthy people, narrative medicine

Introduction

The narrative approach has become prominent in the research of health. While in the past, information was perceived as authoritative only if it was based on positivist research, nowadays patients' personal stories are becoming an important channel of information.¹⁻⁴ One of the shortcomings in most the narrative research in the area of health is exploring the experiences of illness rather than the experiences of the interaction with their doctors. This study aims to fill some of these gaps by focusing on the analysis of stories from patients regarding how they experienced their interaction with their doctors.

The extensive research on the patient-doctor encounter has, to a large extent, focused on a positivistic perspective. There are numerous examples for this, including a study that developed a 'warmth thermometer' that measures patients' perceptions of their doctor's empathy and warmth⁵, or an observational study that focused on the measuring of periods of computer use by doctors during the clinical encounters.⁶ In spite of the great contributions of this large body of research, there is a growing recognition that the complexity of this encounter challenge the attempt to capture it through positivistic means of research and there is a need for finding other methodologies that will provide more understanding of these interactions^{7,8} and of "the processes underlying these interactions".⁹

The use of a narrative research approach is a way of addressing the above challenge as it relates holistically to the experiences of the people telling the stories, rather than trying to identify separate objective elements.¹⁰ The emphasis in a narrative research is on the story of the narrator, both what, and how, it is narrated. Narratives can be used to convey other types of information that go beyond traditional presentations of factual, disease-based information, such as experiential information.¹¹ A narrative research of patients' experiences has the potential for receiving information that is not currently part of the specific clinical interaction, but which can influence the overall patient experience by including references to past experiences, inner fears, and expectations. An additional advantage is the potential of narrative research to bring to the surface issues that are often silenced, such as criticism and hard feelings towards the doctor.¹²

'Narrative medicine' as a medical approach was developed as a way of addressing patients' stories about their health and life. Narrative medicine aims to address the relational and psychological dimensions that occur in tandem with physical illness, and to validate the experience of the patient.¹³ Nevertheless, research on narrative medicine has shown the tendency of patients to censor themselves and, in particular, to censure details that they assume are not clinically relevant, such as their emotions.^{14,15} One result of this censorship is that patients do not express their objection to the doctor's authority or voice any criticism

they have.¹⁶ This self-censorship means that the patient's story about his or her doctor's visit is often a silenced narrative. Positivistic research based on surveys often fails to reveal these unspoken experiences. According to Schlesinger and his colleagues¹⁷ a quarter of the American patients who top-rated their provider on closed-ended questions, nonetheless describe one or more serious problems with care in their comments.

While 'classic' narrative research usually deals with life stories and biographical narratives¹⁸ there is growing interest in the study of 'small stories' which focus on anecdotal events and moments.¹⁹ Studying 'small stories' in the field of healthcare has been noted as a way of understanding the complexity of the experiences related to issues of health and illness.²⁰ This research belongs to this genre - it is based on descriptions of anecdotal events that occurred in the lives of our interviewees: their meetings with physicians.

Polanyi²¹ distinguishes between a report - a relatively short answer that supplies information - and a story - an answer that contains meaning and has a message about the narrator's reality. Unlike reports, stories have the potential to reveal intimate aspects that often remain hidden, and demonstrate the interconnectedness of topics or events that are apparently different and separate.⁴ Telling a story is a way of creating a meaning.¹⁰ The narrative/ story do not reflect a concrete positivistic reality but rather the reality is, to a large extent, created as the story of what is told.²² In this study we relate to the stories of patients as a source of important knowledge regarding patients' subjective experiences of the medical encounter, without assuming that their stories constitute precise factual accounts of what actually happened.

In order to focus on experiences of interaction rather than on experiences of illness, we chose to focus on the experiences of 'healthy people'. Clearly, categorizing people as "healthy" or "sick" is, at least to some extent, subjective, relative, and open to interpretation.²³ In this study the term "healthy people" refers to people who define themselves as generally healthy, and who do not suffer from an illness that significantly impacts their daily life. They are people for whom a visit to the doctor is not overshadowed by serious illness, but is related to periodic examinations, incidents of a temporary illness, or bureaucratic concerns. Armstrong²³ used the term "Surveillance medicine" to argue that health care interventions no longer focus almost exclusively on the body of the patient in the hospital bed, but penetrate into the lives of the wider population, through preventive care or through numerous expressions of the medicalization of everyday life and its "internalization by all the population".^{23, p.400} The result of "the extension of a medical eye over all the population"^{23, p.401} is that everyone

is a patient, including people who see themselves as healthy.

The context: Patient-Doctor encounters in Israel

The participants of this study are citizens of Israel. Since the implementation of the National Health Insurance Law in 1995, Myers-JDC-Brookdale Institute has been performing a series of bi-annual public opinion surveys/polls regarding performance of the healthcare system. The 2014 survey was the first to include questions concerning patients' experiences with physicians.²⁴ The findings indicated high satisfaction with the doctor-patient encounter, especially regarding encounters with family physicians. However, other studies that examined various aspects of medical encounters in Israel present a more complex picture. We will give just a few examples.

Stashefsky and her colleagues reported that doctors' sessions are largely devoted to typing or reading from the computer, and that doctors tended to look at the screen precisely when patients expressed feelings or spoke about the socio-psychological aspects of their problem.⁶ Greenfield and colleagues point out that physicians described patients who wanted to exercise their right to receive a second opinion as disappointing.²⁵ Karnieli-Miller and Eisikovits²⁶ argued that doctors often use different sources of power and rely on hierarchical authority in order to persuade patients to agree with their preferred treatment choice. Keidar points out that due to burnout caused by overload in receiving patients and administrative assignments, Israeli patients often complain and feel disappointment.²⁷

The National Health Act ensures a broad range of services and high accessibility to primary care physicians and specialists, at low cost. However, about a quarter of the respondents of the national Brookdale's survey conducted in 2014²⁴, stated they had met with a private physician in the three months preceding the survey. All of this indicates that surveys do not provide a sufficient understanding and there is need for further research on Israeli patients' perspectives regarding the patient-doctor encounter.

Methodology

In this preliminary study we were interested in the stories that a group of random interviewees would choose to tell about their experiences, and not on stories that relate to a specific doctor or even a certain type of doctor (e.g. GP, specialist etc.). We expressed our interest in interviewing people who met these criteria through various social networks. We interviewed the first twenty men and women (twelve women and eight men) who volunteered, and who have defined themselves as usually healthy and met two additional criteria: age and social status. We chose the age group of 40 to 65, since we wanted to listen to

patients who had a history of visits to doctors but were not so elderly that they would have had severe health problems. Second, in order to ensure that the stories would be influenced as little as possible by gaps in education, socioeconomic status or difficulties related to access to healthcare, we chose to interview professional people with an academic education (engineers, marketing executives, academics, schoolteachers, architects, etc.). All participants lived in the center of the country, an area whose demographic is characterized by high levels of accessibility to health services.

We stopped at 20 interviews to have a manageable amount of information that wasn't repetitive. However, we subsequently continued to encounter people who heard about our interest and wished to share their experiences with doctors, with us. We did not include these additional stories in this study, but they strengthened our confidence that the findings collected in this preliminary study might at least, to some extent, provide some insights into how people in this social group experience their encounters with doctors.

In order not to direct the respondents to tell a particular kind of story, each interview was opened by asking about the most recent encounter with a doctor. After this, and usually without any further request, the interviewee shared more stories of other encounters. We received a flow of stories about numerous interactions with various doctors over the course of interviewee's life. The interviews lasted between one and two hours.

The analysis consisted of four main stages. First, the interviews were coded separately by each of the researchers. This stage yielded a variety of issues and themes. Secondly, we read the interviews together and discussed the main issues and themes in each one of the stories. In the third stage we focused on identifying the recurrent issues and themes that were typical of the overall body of interviews. The fourth stage was dedicated to choosing the examples that would best express the main themes and organizing them for writing a report. According to the qualitative grounded theory approach²⁸ our analysis and main arguments were not based on previous models and concepts, but on our findings.

Ethical considerations: The research aim was explained to all interviewees. The interviewees freely agreed to participate in the research and could end the interview at any moment. In order to maintain their privacy we have used pseudonyms and omitted any identifying details that could reveal their identity. The research has been approved by the Emek Yizrael College Ethics Committee.

Findings

Each of the interviewees had many stories he/she wanted to share with us. The stories were diverse; they related to different kinds of needs (e.g. treatment, counseling, obtaining prescriptions), and they involved different kinds of doctors (e.g. general practitioners and specialized doctors). The stories can be categorized into 'positive' / 'negative' / 'indifferent' interactions. The 'indifferent' stories were fewer and usually shorter and described the interaction as 'a matter of fact' event with no emotional impact. In the 'positive' category, a sense of mutual respect, trust and even friendship was described between patient and doctor. Many of the stories and the most detailed ones were in the 'negative' category. They described disappointment and even a sense of being assaulted by the doctor. Some of these stories were even described as a traumatic and collectively played an important role in the overall body of stories of each of the interviewees.

In spite of the same interviewee speaking with much appreciation about some of the doctors that he/she met on various occasions, the visits that were experienced as negative and stressful had a lot of impact on the ways the patient felt towards doctors and clinical encounters in general. This was true also in cases where the "negative" or "traumatic" story related to an encounter that occurred many years ago. The great impact of these stories was evident by the very fact that our interviewees chose to speak about those past events, even though we had asked them to only relate to their last visit to the doctor. Some of them even chose to start answering us by reflecting on a past negative experience first, and only then went on to speak about the more recent encounters. The negative stories were often told in an emotional and passionate way. In some cases it seemed that asking the interviewee about his/her experiences with doctors led to a release of an emotional load that was waiting to be expressed.

The analysis of the stories, and in particular those that were so emotionally loaded, points to the existence of a tension between two contradictory ways of viewing the medical encounter, and the doctor. On the one hand, the medical encounter was described as a functional ritualistic event with the doctor described as an indifferent clerk. On the other hand, and often at the same time, the medical encounter was perceived as an incredibly meaningful and potentially fateful event which the doctor was expected to be a supreme authority and a source of support in the face of deep anxiety. We found that in spite of the interviewees being healthy and that many of their medical appointments were not related to health problems, the doctor's visit surfaced much anxiety among them. The stories also revealed that this anxiety was not part of the spoken dialogue at the doctor's office.

What follows are short verbatim descriptions taken from some of the narratives which illustrate the four main interconnected expressions of the tension between the two contradictory perceptions of the medical encounter: 1. The encounter as a ritual: A convenient but alarming arrangement; 2. Alone in the struggle to feel well: Unspoken anxiety; 3. Time concerns; 4. Paying for reassurance- turning to physicians in private practice.

1. *The encounter as a ritual: A convenient but alarming arrangement*

In many stories, interviewees described themselves as knowing exactly what they wanted of the doctor. Their requests included issues such as prescriptions for medications, medical test referrals, or doctor's signature on a form. It seems that the respondents did not perceive such requests as involving professional discretion. But, as the following verbatim will show, this perception went along with anxiety. The following description is taken from Gil's story of his last visit to the doctor:

"There's a family doctor that I go to and he is actually more of a clerk than a doctor. He's pleasant, he signs the note, but I don't rely on him. There are all kinds of things that you have to keep track of; my brother had a melanoma... On the one hand it's convenient, I call him and say I need medication, sleeping pills for a flight abroad; I tell his secretary, and I come and collect it... So actually I'm managing it, and I'm not sure I'm managing it well."

Gil describes the role of the doctor as that of a clerk and it seems convenient for him that the doctor automatically fulfills his requests. At the same time, this kind of relationship with the doctor is a source of anxiety because, Gil has worries regarding his health and seeing the doctor as a clerk makes him feel that he is carrying the weight of responsibility for managing his health risks alone which he might not be managing well. This story expresses the ambivalence that is related to contradictory perceptions of the medical encounter seeing it, on the one hand as a ritualistic event that follows predetermined rules, where the result is known in advance both to the patient and to the doctor while at the same time seeing it as an important encounter that deals with life and death.

The next example is taken from the story of Lila regarding her last visit to the doctor. This was a relatively "casual" story, one that was not told in an emotional way. The visit was related to her being concerned about her husband's snoring, and their wish to get a referral for tests for him. The way she described the interaction between them and the doctor shows that she knew exactly what needed testing, and described the meeting with the doctor, who was the specialist in this case, as nothing more than a formal event:

"The conversation was that he asked questions he had to ask, and got the answers he had to receive ... it was clear to us that he was

acting as nothing more than a clerk... he did not have to show his skills as a doctor ... he also showed no frustration of doing this clerical work... I was frustrated, because we waited so long for those five minutes, knowing what they are going to be like. "

There is cynicism and criticism in the way Lila describes the interaction. She presents herself as well aware of what referral is needed as well as the bureaucratic mechanism involved in providing it. In her view, the doctor's role was not supposed to involve any medical and professional discretion and she interprets the doctor's emotions, saying he seemed not frustrated in his role as a clerk. Nevertheless, seeing the procedure as a merely ritualistic encounter was also a source for frustration for her, since it increased Lila's annoyance for having to wait a long time for this appointment.

2. *Alone in the struggle to feel well: Unspoken anxiety*

In the next example the visit was not intended to be bureaucratic, since Adina, the patient, went to the general practitioner (GP) due to a general feeling of weakness and fatigue in the previous few weeks. She described herself as telling the doctor about a family crisis that had led to her weakness, and about her symptoms, and this is how she described how the doctor acted during the interaction:

"...while he was speaking with me he was of course looking at the screen and not at my eyes, and then suddenly says to me – have you had a mammogram? Do you know you should do an occult blood test? Now, just before that I had celebrated my fiftieth birthday, and this was difficult enough to digest ... and this doctor- I had come to see him in a low emotional and physical state, asking for help, and what does he give me? He's pointing to the risks that I should expect, colon cancer, breast cancer... it shocked me. So insensitive... I took my things and left. I decided that I will lift myself on my own".

Adina described the doctor as alienated to start with, looking at the screen rather than at her, while she is speaking of her difficulties. Previous research has pointed out that doctors tend to look at the screen for a great part of the medical encounter including, and perhaps in particular, when patients speak about themselves.⁶ This example provides a description of patients' experience of this tendency. Her cynical way of saying that she has experienced this before, was saying "of course".

This story also shows that offering periodical preventive tests that are recommended by the Ministry of Health (MOH) might be interpreted as insensitivity towards the patient's anxieties. Adina did not expect this. What she wanted of the doctor was reassurance, support and sympathy. Instead, she felt that the doctor was rigidly following his protocol and was not sensitive to her feelings. She kept her emotions to herself and left the doctor's office feeling disappointed and stressed. Adina ended the story with the conclusion- that she has to rely

on herself, and not on the doctor, to deal with her difficulties.

Another stressful story was also related to referrals for medical tests. Marco, aged 50, wished to obtain a signature on a medical certificate. He went to the doctor to receive that, but describes himself annoyed and anxious as a result of the interaction:

"About a month ago, to obtain a scooter license, I needed to sign a medical form. He (the doctor) wrote that everything was fine, and then recommended to me, at my age, to do a stool test... That annoyed me. At first I was worried that maybe he was telling me that something was wrong with me... I'm a little anxious about these things, tests etc...I don't have time to die (laughs)... And then I realized that it is something you do at fifty... There was something aggressive about this... it came without any preparation... I felt that it was very cold, that he doesn't really care about me... I felt as if he was trying to sell me something... I said to him forget it, and left"

This extract demonstrates the gap between what is said in the room and what the patient experiences. The referral that was probably seen by the doctor as part of his medical duty, as well as part of a bureaucratic procedure he is obliged to fulfill, was experienced in a different way by the patient. Marco heard it as a reminder of the great threats of being ill and of the possibility of dying. He felt unprepared for that and he felt angry at the doctor because he did not express any empathy or consideration of his fears, describing the doctor as cold, insensitive, and acting as a salesman. But all this was not spoken of at the encounter. The explicit interaction was minimal but it uncovered an implicit layer of emotions and anxieties.

3. Time concerns

In the tension between seeing the medical encounter as a ritual or as a fateful event, time played an important role. The stories revealed that the experience of patients was greatly influenced by the patient's constant awareness of the limited time slot of the meeting. This was accepted as a bureaucratic constraint, but was a source of great anxiety.

Rachel's story provides an example. She went with her adolescent son to get medical clearance for intensive sport training. The son had had a spirometry test (assessment of lung function), and they returned to the doctor to receive and discuss the results. From the expression on the face of the doctor, Rachel inferred that the results were not good. She became worried and asked questions in order to understand what the problem was. She did not understand the explanations the doctor gave, but refrained from asking again. This is how she described the interaction:

"I felt as if he (the doctor) is talking yet not talking to me. That disturbed me- what do you want to tell us? Maybe he thought it wasn't my business, or maybe he just wanted to see his next patient... I did ask what was the matter...He did not volunteer too much information, and I did not want to dwell on it ... I think I felt

uncomfortable to take his time because I knew there were other people waiting who he had to see".

Rachel left this appointment anxious. The doctor actually did not say that anything was wrong but she felt he thought something with the son's test didn't go well enough. But she didn't ask all the questions she wanted because she was worried her appointment time was over. Self-censorship was a recurrent motif in various stories. Many were of situations where patients tried to avoid "disturbing" the doctor with more questions, in spite of feeling worried about something and wanting more answers. The interviewees used phrases such as "I did not want to be pushy", "I did not want to bother the doctor", "I did not want to waste his /her time." It seems that many patients have internalized the constraints of bureaucracy and take upon themselves the responsibility to guard the schedule, without actually being asked by the doctor to do so. But the result is that they often end up feeling that their questions – whether spoken or censored - did not get sufficient answers.

A somewhat amusing example of the way patients try to negotiate with bureaucracy and "buy more time" with the doctor, was narrated by Dan. Dan, in his sixties, began his account with praising his family doctor. He said that himself, as well as his wife, have been seeing this GP for many years. He described her as being very knowledgeable and expressed a lot of trust and appreciation for her professional judgment, and for always speaking with him "at eye level". However, he noted, he often felt uneasy with her busy schedule. Then Dan said that lately, in order to have sufficient time to discuss with her some health issues that concerns him, when calling the doctor's office he asked for two sequential appointments, one for himself and one for his wife. He then came to the doctor's office with the two membership cards, his and his wife's, and handed both to her:

"I told her, I know you have only ten minutes for me. So here - take the two cards, I made two appointments, and give me twenty minutes."

Dan said that the doctor refused to take his wife's card and told him that she will give him as much time as he needed. He left her office satisfied and got all the information he needed, but his story exemplifies the stress of time in patients' experience, and how some patients try to manipulate the bureaucracy in order to create a less stressful experience in the medical encounter.

4. Paying for reassurance - turning to private physicians

Almost all the interviewees included in their stories encounters that took place in private clinics. The data suggest that the main motivations for this fairly expensive choice were the desire to experience the doctor as reassuring. The interviewees did not describe the 'private

encounter' as more effective in terms of addressing their medical concerns but as a more satisfactory experience in terms of meeting their emotional needs.

In most cases, recounting their experience with the private practice followed a story of disappointment in the public system. For example, Ruth, in her forties, spoke of herself as looking for what she termed as "a corrective experience". She described herself as going to a doctor in the public system due to digestive problems, and feeling that the GP was insufficiently attentive to finding the cause of her problems. The disappointment brought her decision to look for a private clinic:

"I told him ... Listen, I'm here because I need a corrective experience... And all the time I was there even when he did not find answers, he always expressed a kind of reassurance. "Don't worry, we'll look, if not that, then it will be another reason... exactly the opposite of the way she (relating to the public GP she had gone to see before) was... It felt good even if there wasn't a solution, he still expressed sympathy."

Although at the time this story was told, the cause of the problem and a cure had not been found, Ruth experienced having the doctor 'on her side' and that made the difference.

In another interview, Rose spoke about going to a private doctor with her teenage daughter, who is a dancer and suffer from knee pain. Here too the private doctor did not find a better solution than did the doctor in the public system, nevertheless her experience was better:

"...we saw that it doesn't go anywhere with public medicine, so ... we went to a private physician... He showed her pictures including a skeletal image and sat with us for half an hour in a very relaxed atmosphere. We paid 1500 shekels (equivalent to 350 Euro) and received reimbursement from the insurance. He had all the time in the world for us ... the secretary opened a file and gave us a drink. We felt respected."

The aching knee problem was not solved but the experience of the encounter was more relaxing. They received more attention, more explanations, and that was described as "respect". The cost of the meeting and the reimbursement by the insurance for was an important part of the story, since it expressed their ability to choose. It seems that the choice to turn to private clinics is, at least to some extent, an expression of middle class people's desire, in the face of uncertainty, anxiety and stress, to experience themselves as having the ability to choose a more assuring medical encounter.

Discussion

This study focused on healthy people's narratives of encounters with doctors. The participants described the

medical encounter as a ritualistic event but at the same time as a fateful interaction. The stories and the emotional manner, in which many of them were told, indicate that the medical encounter brought health anxieties that were not necessarily connected to their current physical condition, to the surface. The stories also revealed that the participants were expecting the doctors to be sensitive to their anxieties, even though these anxieties and expectations were often not spoken of during the interaction.

The first examples showed the ambivalence that was related to seeing the medical encounter as a ritualistic event. The stories showed that seeing the doctor as a 'compliant' clerk was convenient but at the same time, this kind of relationship with the doctor was a source of frustration and anxiety. The subsequent examples showed how medical encounters sometimes turned into an experience which was alarming and annoying to the patient. The expectations of patients that the doctor would act in a very different way to what actually happening are illustrated. These examples also showed that these expectations and feelings of anxiety and frustration were often unspoken during the encounter, and that the result was a sense disappointment of being left alone. Time played a central role in the third category of examples. They illustrated that patients are aware of the time limits of the appointment, and feel that they need to refrain from asking too many questions. This often increases their uncertainty and anxiety. The fourth and last group of stories related to the choice of turning to private clinics. The findings of this study showed that the motivation to turn to private practice is, to a large extent, based on the desire to obtain a sense of assurance and empathy from the doctor.

In the opening section of "Illness as Metaphor", Sontag describes the existential universal fear of crossing the border, from the 'kingdom of the healthy' to the 'kingdom of the sick'.²⁹ The findings of this study show that for many 'healthy people', meeting the doctor, regardless of the issue at hand, is perceived as a threat, as it often confronts them with the acknowledgement of the frightening possibility of crossing the border to the "kingdom of the sick".

Although all the interviewees were generally healthy middle class people, and are not what is usually considered as "vulnerable patients"³⁰, their stories reveal their sense of vulnerability regarding medical encounters.

Following this, we suggest differentiating between two layers of medical encounters: (i). Explicit, namely the spoken dialogue, and (ii). Implicit, namely the emotions and expectations that are present, but remain unexpressed. The full meaning of the encounter for patients is not expressed in the explicit interaction. What it often fails to

address is that the visit to the doctor, even for 'technical' matters, often induces existential fears and that patients expect that the doctor will be sensitive to these emotions.

Asking the interviewees to tell their stories gave them an opportunity to speak of things which they did not express to the doctor. Some of them had told some of their stories before, to friends and family; most of them said they never spoke about these experiences and emotions before, and for some of them the interview was a unique opportunity to reflect upon and verbally express experiences that had an emotional impact on them. We interpret the fact that the interviews included so many stories of 'negative' experiences not as an indication of a statistical truth of the interviewees having mostly 'negative' experiences, but rather as an indication of the impact these experiences had on them.

Today, more than ever, patients' narratives are becoming popular among decision aid developers¹¹, and "an accumulated, accessible bank of patient narrative" is considered as a way of helping policymakers detect systemic shortfalls in health system performance.^{17, p.678} Even if the stories that were collected in this study cannot be considered as representative of all patients' experiences, we think that they provide some insight into how people from the "healthy" population experience medical encounters, and therefore are an important source of knowledge for doctors, educators, policy makers and researchers. The great importance of patients' experiences requires using a variety of research methods, including the more traditional positivistic methods that are useful tools in their own right, and also qualitative tools such as those used in this research. Used together these methods provide a rounded view of patient experience.

This study has several limitations. First, it is based on a small number of participants, and the participants represent a particular socio-economic status, religion and nationality. As is always the case in qualitative research of this sort, generalizing from this study to other contexts is problematic. Additional research should be carried out on other social, ethnic and national groups, in order to learn the extent to which this study's findings are related to the organizational context or the cultural background of the participants, and whether they are also relevant to people from other groups and other health systems. Second, this study represents only the patients' perspectives and does not capture the perspectives of doctors. There is a need for further research to deal with doctors' stories of interaction.

Conclusion

There is a need for a deep discussion regarding the different ways patients and doctors perceive the meaning of the medical encounter. Acknowledging potential gaps in

meanings and expectations and addressing the implications of this on patients' experiences is crucial for patients, doctors and policy makers to improve the outcome of the patient-doctor encounter.

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