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# Health Care Agency: Statewide Awareness of Patient-Centered Care in Maine's Mental Health Care Facilities

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**Abstract**

        This research project focuses on patient-centered care (PCC) in the context of inpatient acute psychiatric units. Hospitals have been claiming their renewed outlooks on health-care via PCC. It has become an increasingly popular term to use on hospital websites and in presidential statements. The technologies and practices surrounding psychiatric care have evolved in such a way that patients are more welcomed to have an input in their care. This project discusses the discourse around PCC at Mental Health Care Facilities in Maine. There is no consensus on the definition; the meanings ascribed to it are derived from the individual institutions. This project asks: *In what ways has the PCC initiative impacted facility understandings and practices of care?* This project uses official document analysis, interviews, and surveys to develop the full range of data needed to construct the conversation around PCC. Patients received a preexisting survey to evaluate patient satisfaction. Psychiatrists of the acute psychiatric unit where surveys are collected have been interviewed. A comprehensive definition of PCC would allow for more fluid discourse between institutions. Moving forward all U.S acute psychiatric unit mission, vision, and value statements should be evaluated. More data from interviews should be collected and analyzed to determine the social implications of PCC and doctor- centered care. An analysis comparing how many acute wards use each method must be done to see how mainstream each method is. We must determine if PCC is the best method of care.

**Introduction**

The term patient-centered care (PCC) was coined by Enid Balint in the late 1960's. It was used primarily in the treatment of psychosomatic disorders (psychological disorders that have physical symptoms) (Tanenbaum 273). This approach to care now extends to other areas of medicine. Since the late 1980's, PCC has been recommended by the office of the U.S Surgeon General as the best form of treatment in all medical treatment settings ("Patient and Family Centered Care"). The recommendation came as a response to the patient dissatisfaction with the United States health care system.

This research project focuses on PCC in the context of acute inpatient psychiatric units. Maine defines psychiatric units as "a unit within a general hospital that meets the needs of a person with mental illness." ("Medical Facilities Hospital Types"). Inpatient implies that the patient is admitted and stays for longer than 24 hours. Acute in mental health facilities means that the patient is an eminent danger to themselves or someone else. Typically they are classified as suicidal or homicidal. Their status is typical noted as having suicidal ideation (s.i) or homicidal ideation (h.i). Psychiatric units deal specifically with patients who have mental health disorders. This is not to say patients do not have other health issues. The patient is in the unit, because they are struggling with their mental health. Most patients are voluntary, meaning they can be discharged, even against medical advice, at any point. Some patients are involuntary or "blue-papered". "The form that is used to request that someone be involuntarily admitted to a psychiatric hospitalis commonly referred to as the "Blue Paper" " ("Rights and Legal Issues: FAQs"). These patients have been court ordered by the government to stay at an acute inpatient psychiatric unit for 72 hours unless otherwise stated. They lose the right to refuse medication and may be restrained if necessary.

Demographics of the patients in these facilities are important to note, "a combination of poverty, psychotropic medication, and limited access to physical health care contributes to high rates of chronic illness and premature death among mentally ill people" (Parks). Those who suffer from mental illness often have other health needs, which is why the integration of PCC is essential to this population.

Treatment options must be explicitly explained in a way that the patient can understand (Falzer ET AL.). "Differences between public and professional beliefs can affect the action people take if they develop a mental disorder" (Jorm 234). All of the options must be examined by the patient and/or caregiver. Having knowledge of the terminology around mental health allows for patients to be more active in care decisions (Jorm 231). There is a movement to improve mental health literacy in the general public. Patients have the right to know what evidence-based care treatments work and type of help they can receive (Jorm 233).

The vast growth of medicalization in mental health settings has allowed patients more autonomy (Hale). With this growth in medicalization, there are benefits and costs. Hospitals now have the uncanny ability to " transform their healthcare by considering every aspect of the healthcare experience from the perspective of their patients and reconnecting staff to their passion for caring for others" ( Griffin Hospital). At the same time, it can seem like an easier solution to pull out the prescription pad to treat a patient than to listen to the patient concerns and develop an integrated treatment. Doctors have incentives from pharmaceutical companies to dispense psychotherapeutic drugs, further incentivizing prescriptions (Gaudiano 814). This allows them to get to more patients in less time, with lower quality care (Kuosamen)

Creating a treatment plan that a patient understands may involve assistance from a guardian or family member. A patient is multidimensional with regards their social, economic

and family circumstances (Anderson). The patient may not agree with the medical

recommendations, but must be educated about their options for care (Robinson). This allows

them to feel empowered in vulnerable circumstances (Kanerva). It is important that doctors keep

in mind the realistic options for care the patients have access to (Anderson).

The technologies and practices surrounding psychiatric care have evolved in such a way

that patients are more welcomed to have an input in their care. Electronic medical records and

email reminders are a platform by which doctors can communicate with their patients (Adams).

Patients have the internet to search the medicines their doctors prescribe, and they have access to

many more medicines to treat their mental health disorders (Light).

Patients must be involved in the decision making of their care. Hospitals have been

claiming their renewed outlooks on health-care via PCC. It has become an increasingly popular

term to use on hospital websites and in presidential statements "we are expanding that patient-

centered care experience" (Daly, Shelia) by "providing unique programs that address specific

needs" (RIH). Providers try to find common ground with their patients so that both the patient

and provider are satisfied with the steps moving forward. The patients' questions and concerns

are acknowledged. "They feel they are being treated with dignity, respect, and compassion"

(Griffin Hospital). Some hospitals offer "integrated treatment and prevention through residential,

outpatient, and community-based programs" (RIH). There a wide variety of locations for

treatments that meet the specific needs of patients. This allows the patient to feel they are being

heard. "We don't want you to simply be cared for, but of equal importance, feel cared for as

well" (Daly, Shelia). Daly's emphasis on care is something to notice. Health care facilities are

constantly claiming their care is caring.

Historically doctor- centered care has been the approach to treating patients in acute inpatient psychiatric facilities. This has partly to do with professional dominance within the health care setting. There is status and hierarchy built into the capital of a provider. Society allocates this capital with an understanding that "you (the provider) will serve patients' needs first and behave in an altruistic manner" (Light). This is a slippery slope built on trust and assumptions. "By virtue of their professional license to practice, (providers) accept the responsibility of providing the best care possible for their patients" (Melnyk). Providers are given the responsibility, the power of providing care. This care has to be the best for patients. Providers have social standings that allow them to dispense care. The economic and political gains providers get from their position make it so "business…is often based more on staff convenience than patient comfort" (Griffin Hospital). A social hierarchy is created in which the doctor is the one with the power and control over the patient's health. They are making the decisions. The patient is not typically included in the decision making of care. It is assumed that the doctor knows the best course of action.

A doctor- centered care approach looks at the patient as a consumer of a product. This patient may have few resources and opportunities for choice based on their social location (Tanenbaum). The doctors are the seller of the said product, mental healthcare. They do not look at the patient in terms of their whole being. Doctor-centered care focuses on the medical issue at hand, and works to solve the said problem. The other needs a patient may have are not considered. There is a culture around health-care that promotes capitalism, which leads to health-care inequality (Anderson) and reinforces doctor-centered care.

PCC aims to be a medical treatment that is of the person, for the person, by the person and with the person (Miles). Why would this matter to patients? With this course of action

patients are given options around future treatment plans. The treatments allow patients to gain knowledge and understanding of their diagnosis and further options. They have the ability to decide who their providers are, which may allow them to feel more in control of their health outcomes. This builds trust, safety and credibility between the patient and their provider.

This paper will discuss the discourse around PCC. There is no consensus on the definition. The meanings ascribed to it are derived from the individual institutions. Research for PCC is difficult to conduct when discourse is ignored (Robinson). I have done a pilot-study examining an acute psychiatric ward's statements and observed practices of PCC. This paper is a comparative analysis of the discourse around PCC. There is one question that this project will address to relate statements made by the hospitals analyzed to PCC: *In what ways has the PCC initiative impacted facility understandings and practices of care?*

**Background**
*PCC Defined*

There is a great deal of research on the benefits of PCC, but definitions vary. Some claim the patient and family is one unit of study, while others focus on the individual patient and all the aspects of their life (Bell). The four assessments that must be done, according to Stewart, to ensure PCC are; "1. Patient feelings about illness 2. Their ideas about what is wrong 3. The impact of the problem on their daily functioning 4. Their expectations of what should be done" (Stewart 796). When this assessment is done properly, the data shows that there is a significant reduction in diagnostic testing and greater patient satisfaction. "Patient-centered care is associated with improved patient health and efficiency of care" (Stewart 799).

Another way that PCC is defined is by the wholeness of the patient. The biopsychosocial model allows for this by looking at all factors. According to the Institute for Medicine, "care that is respectful of and responsive to individual patient preferences, needs and values" This model

incorporates a patient's preferences, needs and values. The biopsychosocial model is especially

applicable to medical diagnoses and care (Tanenbaum 275). It illustrates how there are many

factors that contribute to a patient's medical state and treatment options. The model compliments

PCC.

*Historical Context of Mental Illness*

In *The Great Confinement,* Foucault explores the origin of hospitals. The police were in

charge of confinement within the hospitals. They were created as a government tactic during the

wars. Those who were forced into confinement suffered from inhumane working conditions.

They lost their liberty. "Houses of correction" were another way in which the government tried

to regulate society. It was a way to "control costs and absorb unemployment" (*Foucault Reader

135).* A hierarchy developed within the institution of correctional facilities and hospitals through

the segregation of powers of labor. These institutes became the moral institute for punishment

(*Foucault Reader 137).* These morals were determined via written and unwritten sanctions.

*The Birth of the Clinic* focuses specifically on the clinic. This helped organizations to

become localized. Having designated areas for dealing with the mentally ill was critical to their

stigma. The ways by which the Clinic developed was conducive to how diagnosis and treatment

functioning developed. Disease was viewed as one dimensional. The person was not viewed as a

disease per say. They were punished and confined in such a manner. The different parts of a

person were magnified in order to gain a greater understanding of the whole. This evolved to the

medical gaze.

Foucault continues on to talk about communication and its role in health care. He dissects

different relationship patterns. Having open communication was extremely subjective according

to Foucault, "a space of free communication in which the relationship of the parts to the whole

was always transposable and reversible" (*Birth of the Clinic* 38). The parts worked in conjunction with the whole, but only within the context of the disorder. A dictatorship of privileged knowledge arose, hurting the ability for transparent communication.

Themes of repression and assistance for the poor dispersed the structure of the clinic. The clinic was unable to meet the needs of those stigmatized by society (*Birth of the Clinic* 44). "Quacks" and doctors with little to no knowledge were allowed the ability to treat oppressed patients. Holding the poor and sick drained the system, which led to less qualified professionals giving less than professional treatments (*Birth of a Clinic* 66). This lowered patient morale and satisfaction. More mistakes were made.

In Foucault's *Birth of the Asylum*, he references the stigmas associated around mental illnesses. The segregation of mentally ill people is rooted in religion. This alienation of people with mental health disorders, has created a safeguard within sanity. Over the years, there has been debate about whether a person can be cured of their mental illness. This influences the sorts of treatments they receive. Foucault notes that madness (people with mental health disorders) and punishment are linked. He states that the harsh rules of religion contribute to the madness.

There are different ways that providers of mental health care have approached treatment. These approaches are as follows:

- Silent treatment: creating humiliation to create social change. The patient is "prisoner of nothing but himself" (*Foucault Reader* 151).

- Recognition by mirror: making the person realize they are crazy by only reflection of themselves.

- Perpetual Judgment: This is repression, because the person realizes they are in a social world which judges them. They come realize the stigmas imposed on them via their behavior.

- Medical Personage: This is based on the doctor and patient interactions. The doctors act as the gatekeepers to confinement, but are not in an authoritative position necessarily. They determine the criteria for being confined. The doctors need all the facts and use their observations to determine how severe a patient is.

With all of these approaches in place medicalization evolved. It became the doctors' responsibility to determine who qualified for care. Doctors had the power to cure, which supports the present day hierarchies. This is where patient submissiveness emerges. The patients start to "self-surrender" (*Foucault Reader* 163).

*Mental Health Care Today*

Today care can start before the doctor knows what the patient has. Initial care can determine the course of the treatment and how the patient will feel. There are some key things that can be done to help with mental health first aid. The following are elements that contribute to good initial care: approach the person, assess the situation, assist with any crises, listen nonjudgmentally, offer support, offer information, encourage the person to get professional help, and encourage other support options (Jorm 237). Health professionals can use these use in varying degrees to establish trust and communication with their patients.

Despite a greater emphasis on communication between providers and patients via PCC, there is no standard definition. Hospitals each have aspirations that often include communication via teamwork, as noted by Mclean Hospital values. What a hospital claims and what a hospital does can be very different.  Communication is proven to improve safety within acute inpatient

psychiatric units, so it needs to be a top priority at these institutions. This communication needs to extend beyond the health-care providers. Patients must be heard and their opinions must be acknowledged. This allows for the relationships between provider and patient to develop in a way that is conducive to successful treatment (Kanerva). Successful treatments "emphasize the synthesis of empirical evidence and clinical expertise with patient values and preferences" (McHugh 595). There is a teamwork approach incorporating both the scientific and social aspects of care.

*How PCC is Being Taught*

Medical students are still struggling with adhering to PCC protocols, partly because they don't have consistent discourse around it. The other reason is that there is such a delay in the time by which proven evidence based treatments are moved from research settings to clinical setting (Melnyk). Standards of care have evolved, and different cultures assert different ideals on the institution of the hospital. Listening is a critical piece to the doctor and patient's relationship. Foucault states to "make yourself master of your patients and their affections; assuage their pains… command their will" (*Birth of the Clinic* 88). It includes both verbal and nonverbal cues. Being able to acquire good listening skills increases patient satisfaction and clinical outcomes. It allows the doctor to make more accurate diagnoses, especially in mental health, develops a good doctor-patient working relationship, and acts as a healing method for patients (Jagosh). The data shows that more patients are receiving psychotherapeutic drugs despite asking for therapy (McHugh 599).

Medical schools are requiring social based courses such as introduction to sociology and introduction to psychology (MCAT). This is the rebirth of a concept long discovered. According to Foucault, good bedside manner and morals were highly valued early on in the clinic. Doctors

taught their students these standards: "religious, humane, and compassionate" (*Birth of a Clinic* 84). Somewhere along the way this got lost as the desire for instant gratification increased.

*PCC Emphasis*

Patient safety is one of the top concerns of the staff in inpatient psychiatric units. There are several dangers that present themselves, in the best of circumstances. Violence in the units lowers patient satisfaction and trust with health-care providers. The incidents can be unnerving for everyone involved, including staff (Omerov). How staff reacts to violence is an essential precursor to how patients feel about the incidents. When staff takes the violence personally and get angry, it perpetuates a negative environment and experience for other patients. As stated earlier, communication is a way to reduce violence. If psychiatric units are able to have maximum communication that incorporates the patients, their patient satisfaction rates will rise.

Hospital funding has started to revolve around the patient experience. There are a few policies in place that work to satisfy both the patient and the hospital. One of them is Medicare's, Value-Based Purchasing which is reimbursements based on value of care given to patients. The other policy is under the Affordable Care Act via the public/private sphere of Patient- Centered Outcomes Research Institute. This organization uses patient satisfaction surveys as a measurement of patient-centered care and aims to have research on patient-centered care (Tanenbaum).

*PCC Structure and Implementation*

This project focuses on how patient-centered care is constructed via the accessible discourse, information communicated via text (Massengill 28), found on websites of inpatient psychiatric units in Maine, staff interviews, and surveys given to patients at one hospital in Maine. Language is the basis of the structure of a hospital/clinic (*Birth of the Clinic* 96). The

statements and surveys act as the data sets for patient-centered care evaluation. What a person says compared with what is said about an institution can be different (*The Birth of the Clinic* 121). This study focuses specifically on patient-centered care in the context of mental health care settings.

The structural pieces of the discourse allow for action regarding care. "One cannot expect a profession to behave much differently than the institutional and cultural framework in which it works" (Light). The discourse analyzed is the framework by which the mental health care providers are situating their treatment. Providers should be able to explore the practices, so that they can have a better understanding of what is working for patients and what is not (Melnyk). Having evidence-based practices helps providers sustain their work. "An organization that desires to build this type of culture and environment so that its clinicians can consistently implement evidence-based care must have a philosophy, mission and commitment... (that is) visible throughout the organization" (Melnyk). I am looking at the visibility of these statements in practice.

A pilot study looking at the practice of patient-centered care has already been conducted. I observed the practices and compared them to the values to a Maine hospital. Survey questions were developed to help guide the interview process of patients, nurses, doctors and social workers. Each patient and their providers were interviewed. The patient population was 29 patients over the course of one month. The examined unit had 30 beds total including low and high acuity. All of the interviews were confidential. The interviews posed little to no risk for the patients' safety. They were given the option to decline being interviewed or could decide to stop the interview at any time. All identifying features of the providers and patients were erased. I interviewed participants in patient rooms, interview rooms, and the large and small nursing

stations of the unit. People were interviewed without the presence of other providers, except for

the nurses. This is because of their on-call basis making it difficult to interview without

interruption. The analysis found that patients and providers often have good intentions, but there

is often miscommunication. This pilot study showed further investigation of PCC is necessary.

**Methodology**

Six Maine mental health facilities are evaluated via a range of methodological practices.

Both qualitative and quantitative data is collected to enhance the results. This paper uses content

analysis (qualitative and quantitative), interviews, and surveys to develop the full range of data

needed to construct the conversation around patient-centered care.

The discourse used in each of the facilities' missions, visions, values, and patient-

centered care definitions are analyzed and compared. Discourse is any practice by which people

assert meaning to their reality (Ruiz). I am interesting in the meanings of words and how often

they are used.  This is so I can better understand the patterns of use and relate that to the broader

social context (Ruiz). Foucault has three concepts surrounding discourse that relate to the clinic

and its implications for society:

1. The alternation of spoken language and perceived stages in an observation

2.  define a statutory form of correlation between gaze and language

3. Ideal of exhaustive description

The following quote states explicitly why content analysis via discourse is important for this

project:

"If we bear in mind that the social universe is largely a space of shared meaning,

then discursive practices are clearly important for our knowledge and

understanding of social reality. Discourse analysis as a social research method is

therefore grounded in two basic assumptions: 1) the knowledge of social

intersubjectivity provides us with indirect knowledge about the social order

because intersubjectivity is a product of it and because the social order is formed

and functions through this social intersubjectivity; 2) discourse analysis allows us

to understand social intersubjectivity because discourses contain it and because

social intersubjectivity is produced through discursive practices" (Lozano).

Distinctions between mission, vision, values, and patient-centered care are made. The

mission statements for each hospital express the beliefs they hold true. Each hospital has a

vision, which can be interpreted as a goal. This vision guides the type of care patients receive.

The values are the expectations the hospitals have to maintain their mission and obtain their

vision. These could be considered the rules or sanctions the hospitals utilize. This study also

notes the presence of PCC statements on the websites. The wording around PCC is also

observed. Commonly used words are discussed and the meaning around them interpreted.

This paper pulls out the words that draw on central ideas of PCC. Content analysis is

used because it takes statements and fragments them into pieces for interpretation. The meaning

is not inherently there, but given to the phrases. These words are interpreted and examined

within the context of the statements. The discourse around PCC will be evaluated.

The program Dedoose is used to codify the categories of words. To determine the

categories the theoretical framework of Foucault is used to ground the research. Foucault's

works of the Asylum, The Birth of a Clinic, and Confinement are used. Developing these

categories based on theory allows for the norms around PCC to emerge and be interpreted. A

caveat to the norms and categories produced by the research is that any interpretations made

must keep the subjects of the data at the forefront (Ruiz). How the patients and health-care

providers subjectively view PCC is critical. Social discourse will vary, according to Bourdieu, by both social position and the social value given to the discourse.

An annual report of a preexisting survey to evaluate their treatment and involvement in care was collected. These surveys were completely on a voluntary basis. They were distributed to patients at one hospital in Maine just prior to discharge. The surveys evaluate patient satisfaction and treatment. This is how patient viewpoints are incorporated into the data.

Seven psychiatrists of the acute psychiatric unit where surveys were collected are interviewed. These interviews took place in their respective offices. The interviews have been transcribed. The transcriptions include both verbal and nonverbal communication/signals. What someone says and what they mean can be two different things and the transcription process will help clear up those distinctions (Ruiz). When conducting interviews it is incredibly important to avoid bias responses. The responses can become biased by how questions are framed or how the research is described (Massengill 27). The structure of the interview is critical. To get at the heart of patient-centered care understanding, I have taken a less structured approach to the interview. The interview guide can be found in the appendix.

This adds to the clinical perception of what patient-centered care is, and how to achieve it efficiently. The interview focuses on the particular experiences health-care providers have with PCC and how they engage with patients. The surveys will evaluate the effectiveness of the policies in place for patient-centered care.

**Results**

Based on the transcriptions of the interviews and the common threads that many of the interviews had, it makes sense to analyze the interviews as Foucault would have using the following as ways psychiatric patients are evaluated: silence, recognition by mirror,

perpetual judgment, and medical personage. In the discussion section I note how each theme falls into these categories or creates a new one that Foucault did not account for.

- **Silent treatment:** Using the silent treatment is a way for the provider to minimize the mental illness. The silence acts to refuse the patient the attention of deviant thoughts and ideas they have. They become limited to normalcy. Lack of acknowledgement by the providers makes **t**he patient a "prisoner of nothing but himself" (*Foucault Reader* 151).

- **Recognition by mirror:** making the person realize they are crazy by only reflection of themselves.

- **Perpetual Judgment:** This is repression, because the person realizes they are in a social world which judges them. They come realize the stigmas imposed on them via their behavior.

- **Medical Personage:** The doctors act as the gatekeepers to confinement, but are not in an authoritative position necessarily. The relationship between the doctor and patient corresponds to the link between medical thought and insanity (*Foucault Reader* 158). They determine the criteria for being confined. The doctors need all the facts and use their observations to determine how severe a patient is. They carefully listen for all symptoms (*Foucault Reader* 159), so that they are able to come to a diagnosis. This gives the practitioner a sense of authority.
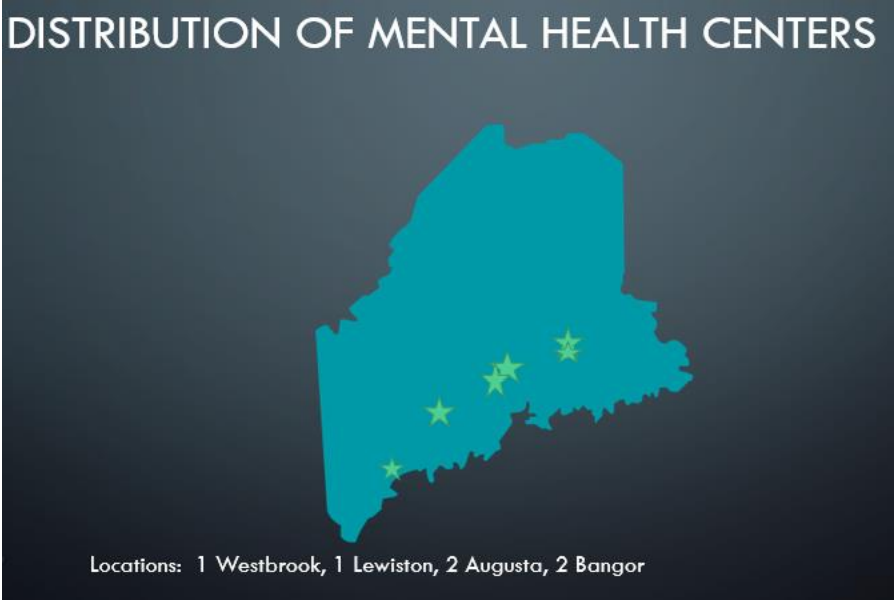
*Figure 1:* Distribution of Mental Health Centers
This shows how Mental Health Facilities are distributed across the state. There is a huge gap in distribution for Northern and Western Maine. People in those areas have to travel to one of the Southern or Eastern locations to receive care.
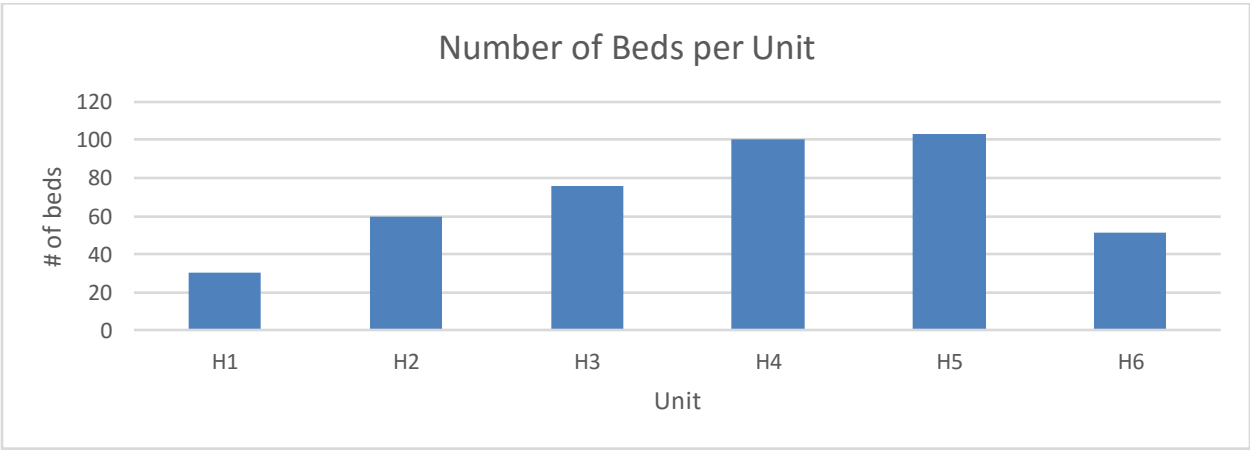


*Graph 1.* Number of Hospital Beds per Unit
There is a bed crisis across the nation, but specifically in Maine. Looking at the facilities at most there are just over 100 beds in a unit. All of these beds are expected to serve the entire state of Maine

## Statement Results

The Number of Hospitals That Have Various Types of Statements on Their Websites (n=6).

*Graph 2.* Number of Hospitals with Official Documents of their websites



*Figure 2:* Packed Code Cloud of Statements

## Interview Results

| Most Common Word | 2nd Most Common | 3rd Most Common |
|---|---|---|
| **patient (34)** | **you know (24)** | diagnosis (21) |
| **patient (54)** | culture (38) | we (18) |
| who (40) | medication (26) | psychiatry (23) |
| **patient (28)** | **PCC (12)** | long pause (11) |
| **patient (41)** | **you know (21)** | very (21) |
| **patient (21)** | **collaborative care (17)** | more (14) |
| **patient (25)** | asking (22) | **patient centered (20)** |

*Table 1:* Most Common Codes in Interviews

## Survey Results
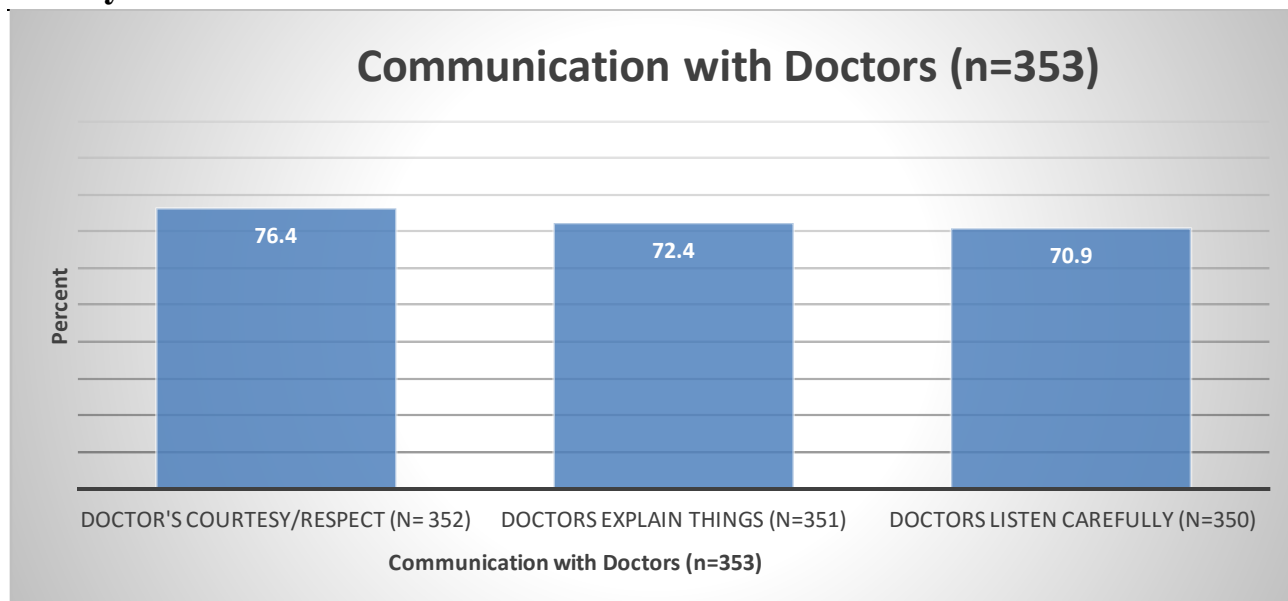


*Graph 2:* Survey Results Communication with Doctors
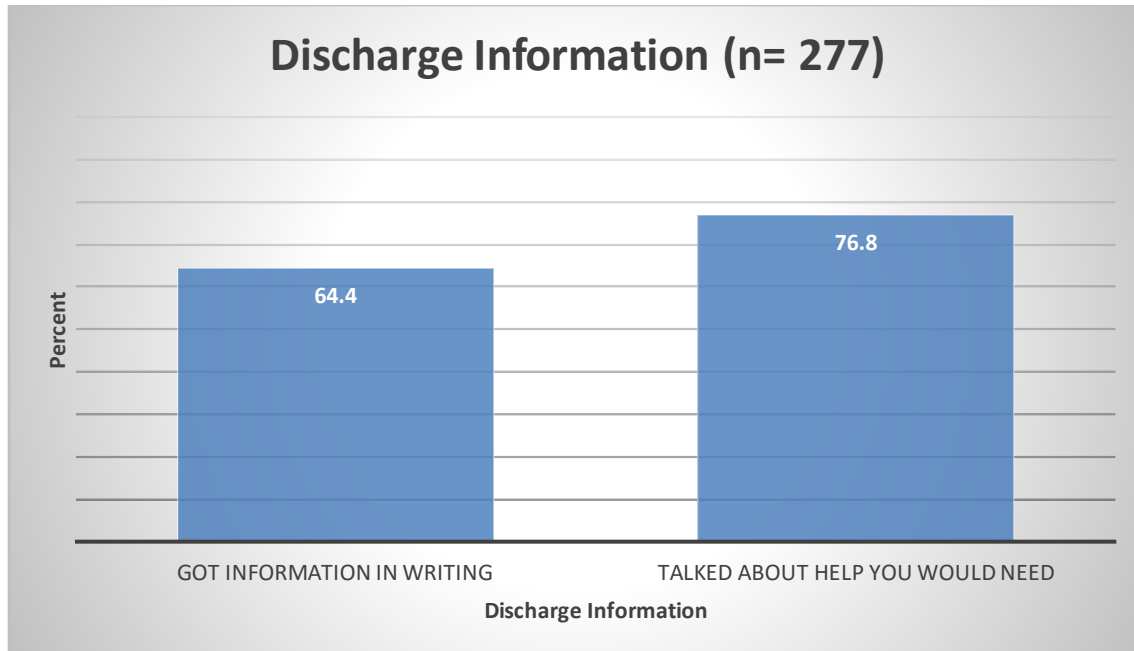
*Graph 3*: Survey Results Discharge Information

**Discussion**

Official Document Analysis

The mission, vision, and values work together to structure each of the institutions. Each hospital

is in charge of taking care of patients with mental illness in their acute psychiatric wards. Though

these six hospitals are in Maine they have noticeable differences in what they give meaning to

and what they view as important. This directly influences the patient experience. Graph 2

indicates that 5 facilities have both value and mission statements, 4 have vision statements and 3

have PCC statements. Keeping the frequency of these statements in mind, it is important to

examine what the statements are actually saying. In the packed cloud figure "who" is the largest

with other words such as respect, community, care, and religion popping up.

*Mission:*

 In Richardson Hospital's[1] mission there was an emphasis on improvement all of the time. They

want to "enhance, every day, the health of people". Karol Valley Hospital and Kendal Hospital

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[1] All names of institutions have been changed for confidentiality

discussed how they do so via their facilities. Karol Valley Hospital has "high quality, cost effective services" and Kendal Center has "state-of-the art care". Another way to create improvement of care is with relationships. Freeman Psychiatric Center "collaborates with individuals"… "in the least restrictive environment", while St. Edward's Hospital uses "Jesus as healer" and pays "special attention to those who are poor and vulnerable". They claim to give "spiritually centered holistic care". All of these statements from the missions connect to Foucault's theoretical framework.

*Vision:*

It is important to note that two of the facilities Karol Valley and Ellin hospital did not have vision statements. Visions are important in seeing goals, so not having explicit goals is important to note. The vision statements that are present have very specific goals to be the "leading community health care system" through "clinical excellence, customer satisfaction, and financial stability" Richardson Hospital. These are related to the capitalistic gains framework. St. Edwards has less of a focus on finances and more of a focus on religion with Catholic being mentioned twice in the vision. Kendal Center desires to "collaborate with the community" as opposed to Freeman Psychiatric Center which claimed in their mission to focus on the individual. Freeman's vision is also individualistic focusing on "challenging people to use their strengths".

*Values:*

Only Ellin Hospital did not list their values. The other facilities all stated what they find important in care. Richardson Hospital focuses on "hold(ing) each other accountable" while "project(ing) a positive image of the institution through actions, words and appearance". There is little to no mention of patients. Their values appear limited to their institution. St. Edwards focuses on religion through the "joy of ministry" and "service (of) the poor". They value charity

and use religious terms like ministry and service. Karol Valley Hospital focus on the standards they uphold through " service excellence" as if there is a product they are selling, "doing the correct thing for the right reasons" implying morality, and "collaboration and teamwork" with communication. Kendal Center is the only place that says anything about the patients. Their values are simple, "patients first". Freeman Psychiatric Center attempts to uphold the institution by "exceed(ing) expectations and "respect(ing) boundaries". Again there is no focus on the patient.

*PCC:*

Three organizations have explicit statements on PCC. Richardson Hospital claims to get "improved patient outcomes" by "includ(ing) the voices of patients". Voice is an important factor of PCC to Richardson Hospital. St. Edwards Hospital believes "a patient is an individual to be cared for not a medical condition". This individualism limits the care to the patient and ignores other factors that may impact care. The Hospital claims that "each staff member is a caregiver" so they have the power to give care. This is built into the hierarchy of care. Kendal Center has a different approach to PCC by examining "dignity of each patient as a whole" and acknowledging "his/her status".

Surveys

The surveys had a lot of information, but the pieces critical to better understanding PCC were under these categories: Discharge information and Communication with Doctors. The categories were divided based on the questions asked. Communication with Doctors included information about doctor's courtesy/respect, doctor explains things, and doctor's listen carefully (*Graph 2*). 76.4% of patients claimed that their doctor's showed courtesy and respect. While 72.4% said their doctors explained things and only 70.9% said their doctor's listened carefully. Discharge information included getting information in writing and talking about help you (the patient)

would need (*Graph 3*). 64.4% of patients claimed they got information in writing and 76.8% claimed they talked with someone about the help they would need. This addresses both verbal and nonverbal communication surrounding discharge. These are the pieces of information the institution finds valuable when examining patient satisfaction.

Interviews

Once the interviews were collected I looked for emerging themes and what language providers[2] used when talking with me. 6 of the 7 providers had "patients" as the most common code, while "you know?" and "PCC" fell to the second and third most common (Table 1. Most Common Codes in Interviews). In terms of themes that surfaced, I found that most of them fit into the Foucault framework, with a few exceptions. The themes I saw are as follows: Models of Health, PCC Defined, Communication with Patients, Stories, Listening, Provider Perceptions of Patients, Studer/$, Access to Resources, Hierarchy, Credentials, Lying to Patients, Recognition by Mirror, Standards Rules and Regulations, and Government Mandates. Each of these themes is explained explicitly below, then linked to the conceptual framework:

**Models of Health**

Throughout many of the interviews providers referenced the psychoanalytic model of health and the biopsychosocial model of health. Some providers were trained with the psychoanalytic model, developed by Freud. Dr. Everest looks back at the model in reflection: "I think we had the nice combination of developing a relationship with patients understanding their emotional space or their emotional status as well as addressing the biology of their mental illness". This model looked at biological factors at play and emotions. The patient had an understanding of how and why they were feeling the way they were. There were many critiques to this model

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[2] Note all names of providers and institutions have been changed to ensure confidentiality

including sexism and lack of social understanding. This model is no longer in popular use and has been replaced with the biopsychosocial model.

The biopsychosocial model is most popular among providers in today's practices of care. Dr. Sedge notes that "we like to look at biopsychosocial". This is because the care looks at the mental illness as multidimensional. Dr. Everest chose this type of medicine for this reason. Mental health is so important to every aspect of a person's well-being "I was really just more interested in sort of integrated care. Sort of this notion that mental health issues have a very impact on people's physical health as well." He claims that mental health effects physical health too.

With this newer model in place patients can have expectations about provider results. A provider cannot necessarily cure a patient even if they are looking at new dynamics that other providers have not considered. Dr. Everest emphasizes that "the chances of me finding some biological cure for them (the patient) that no else has been able to find is very, very slim and I might be able to do them a lot more benefit by helping them come to terms with that." It may not be the solution the patient was looking for, but it may help the patient deal with other parts of their life. This being said Dr. Everest claims "one of the most important things you can do as a psychiatrists is take a look at the medications and trim down the list." These biological treatments could be doing more harm than good. By lower the amount of medications a patient is on, the patient experiences less side effects, according to Dr. Everest.

**PCC defined**
During the interviews each of the providers were asked what words they thought of when they thought of PCC and were asked if they felt they had an adequate definition of it. Dr. Pell made the comment that "a lot of physicians are obsessive-compulsive enough that they would have a very definite idea what PCC is". This statement says a couple of interesting things. One that

many providers are obsessive-compulsive, which could act as a stereotype. And two that as a result of the obsessive compulsive behavior they have an understanding of the definition of PCC. Dr. Harris emphasized autonomy in each of this statements relating to PCC. He said "It's all about the patient" and that "I *give* them a lot of control and *autonomy*". The focus is on the patient and the provider is the one who has the power to give out the control and autonomy. He reemphasizes his power in autonomy when goes on to say "when we are at the end we formulate their case and talk about the plan. Usually I *give* a lot of *autonomy*". He goes on to make specific claims about the United States culture of PCC "here (United States) *autonomy* is most important than anything else which means the patient will make the decision for themselves when that have the capacity." Again the provider determines if the patient has the capacity to make their own decisions and if so they grant the patient autonomy.

Dr. Sedge also puts power on herself by claiming she is the provider and identifies needs. She says "we have to provide the best care and identify a patient's needs". The care has to be to perfection, at its best, and the provider has to know what the patient needs. She goes on to say that the provider is obliged to be kind and sympathetic, "you have to be kind and sympathetic to your patient". There is a standard incorporated into this, a rule that one must act a certain way toward patients.

Not all providers whether they know about PCC or not practice it. Dr. Karr reminds us of that when he says, "I think not everybody practices collaborative care… I think older physicians have more of a risk of being more authoritarian. Younger people seem to be much more collaborative". Age in his mind is a factor. Younger doctors are more collaborative with care, which he interchanges with PCC and older doctors are more authoritarian. These statements are also quite sweeping when thinking about the implementation of PCC. Dr. Greenwood makes the

point that not all providers buy into PCC, because it has become a catch all term. He says "They (conservative providers) do understand that there is a lot of flash. There's a lot of things that come out that don't pan out over time, so I think they are cautious more than anything else". All of the attention PCC gets may not be because it is a good treatment, but because it is a popular one.

Dr. Everest is already looking into ways to improve this trendy treatment. He thinks providers need to always have it on their mind and have reminders about it. He wants there to be "more of a daily focus on it… really make use of the things we already have in place…whiteboards in the patient rooms…I've been finding as I look around that they are not be used as actively as they could be". He also wants to have the care be customized to the patient. He tries to "tailor the intervention with what seems most appropriate for people". He is again the judge of what exactly appropriate means and for who the treatment qualifies. When Dr. Greenwood discusses improvement he contradicts himself in the interview. Early he states that "I think that we aren't *proactive*. We are not preventative" within the next few minutes he is found saying "we have a very *proactive* way with which we look at all aspects of the center". He emphasizes the importance of proactivity, yet cannot get it straight whether or not his institution is proactive. This goes to show the lack of understanding of PCC and its definition, despite Dr. Pell's earlier assumptions.

**Family**

The family is a crucial contributor to a person's health, so having their input can be incredibly helpful. I was curious about how often the family or guardian were mentioned in the interviews, because only one of the mission statements mentioned family within the context of PCC. During the intake process the family can act as a source on information. Dr. Harris states during his interview "most of them (the patients) will name a family member and definitely that is a big

source of information". This is especially helpful if the patient is not able to give information about themselves. Dr. Everest states the importance of family when he says "I want to get…a family member to participate in assessment." Having family as part of the patient makes sense because the family influences the patient. Another way in which the family is involved is during the intake when asking the patient about "Their relationship with people around them, family, friends" Dr. Sedge.

Family involvement varies across cultures. Dr. Harris notes how in some communities the "family will need to process that take care of the patient without telling them. Which reflects also it's not the autonomy of the patient it's the family". This is a particularly striking statement. It discusses how unaware the patient is about their condition and where the autonomy is placed. In U.S culture the patient is the one with autonomy, according to Dr. Harris.

Patient autonomy is not always maintained, despite PCC efforts. In the case of guardians, which often hold the same weight as family for patients who can't speak for themselves they become the ones in control. Dr. Harris states that patients may communicate that they do not want a particular treatment, but that guardians have the ultimate say "The patient might refuse and that is why they have a guardian to make the decision for them."

This can create conflict between the patient and the provider, because the provider is obliged to do as the guardian says. According to Dr. Karr "it can be very tricky when there's a guardian involved because you have to be collaborative with the guardian" which further complicates the patient/provider relationship.

**Communication with Patients**

Communication between providers and their patients is verbal and nonverbal. Dr. Markus said very bluntly "I talk" when asked how he communicates with his patients. Other providers gave

more insight into what happens during that talking. Dr. Pell and Dr. Karr used similar wording with the language they use to talk to patients "I speak in *common* language and I say I observe *honestly* what I say what I see" Dr. Pell. Dr. Karr used the word "*simple*". This implies easy to understand words that the patient can comprehend. Dr. Pell and Dr. Greenwood both emphasize honesty. Honesty, simplicity and commonality allow for a fluid exchange.

When trying to get information from patients it is important to keep the above principles in mind. Dr. Sedge attempts to get information by comforting the patient and speaking honestly about the confidentiality of the situation. She says that she "assure(s) the patient that this information is going to be confidential and the more information we have the better we are able to help them." She conveys the importance of the information while trying to manage the patient's confidence in her. Dr. Karr tries to find a balance "by sacrific(ing) some of the information by being more gentle and being more patient with the interview". Keeping things simple, honest and common make this more doable.

Relating to the patients is another huge component of communication. Dr. Pell speaks with his patients with their own jargon to get them to give information. He says that "people will own being pissed off because it's said in those terms". He opposes this to anger. Pissed off and angry mean the same thing according to him, so if he can get patients to admit they are pissed off, when they are claiming they are not angry, he knows they are angry. Another way to relate to a patient is to create a long standing relationship with them Dr. Greenwood says "The way I communicate with people is through the duration of the relationship." If a patient knows their provider Dr. Greenwood claims they will feel more comfortable communicating with the provider. Relating to patients can be difficult when a provider does not use the same language or know the patient. Dr. Karr claims that by "mak(ing) some simple goals and see whether we have

goals in common" the patient has a better communication with the provider. Even if the goals are

different, the provider and patient can at least acknowledge each other's goals. Dr. Karr

mentioned again simplicity in the above statement. Relations with patients need to be simple,

honest and common.

**Provider perceptions of patients**

How providers communicate with their patients is influenced by their own personal biases about

the patients. Several providers discusses how they could not understand where their patients were

coming from, "It's when they (the patients) don't value their health or can't value their health

that I struggle… that's the group that it doesn't matter what they look like you know, they are

destroying, they are destructive of themselves. I don't quite understand, so I struggle most with

that" Dr. Greenwood. He goes on to state why he has such a hard time with these patients. His

morals get in the way of treating the patient as someone who needs his help. He says "My values

are clear on that you help yourself and you figure it out and so how do you see patients and care

for patients who don't care or can't care?" Dr. Greenwood. This puts the blame on the patient. It

is their fault that they do not care or can't care about themselves.

Some providers feel the patients actually want the diagnoses they have "I think there's a large

acceptance of psychiatric disorders….that patients collect" Dr. Pell. It makes it sound like the

patients are trying to get as many disorders as possible. From a common sense point of view this

doesn't make sense because of the discrimination and stigma associated with mental illness, but

Dr. Pell points out that "they (the patients) are trying to convince me that they are really

sick…they don't feel stigmatized by it they feel justified."

Others make assumptions with striking implications about how those assumptions should be

addressed. Dr. Pell stated, "I think they (the mentally ill) should be allowed to be segregated

from the community. Mentally ill people are victims of the community more than they are a

danger." He assumes that his patients are mentally ill, which is an assumption in itself about who the patient is. Dr. Sedge does something similar in her interview when she says on two occasions that "I'm not going to confront a patient who is psychotic, paranoid, or irritable".   It reduces the patients to a disease. It does not consider the complexities of human beings. Dr. Pell states that these people should not be in the community. He says it's for their own good. The word segregation has historical implications which make me think of the separate but equal rights movements around race. Those movements acted to further marginalize blacks. By separating the mentally ill from society they will face many of the same discriminations.

These discriminations are reinforced by societal norms. In an extreme case Dr. Pell states that "it's a social assumption that somebody walking naked in the public is either a danger to themselves or a danger to others. And I don't think that that's explicit. My personal beliefs are that people should be allowed to walk naked in public". There is nothing inherently dangerous about a person walking naked in public. They are not putting themselves or anyone else at risk for death. Despite this society assumes this person must be institutionalized. There are norms around who and when someone should be controlled. Dr. Pell says he thinks people should be allowed to walk around naked, yet he would always commit them, because society has placed those norms on his role as a provider. This is a case where his opinion does not matter. The social institutions in place control him and he controls the patients.

The provider perceptions influence communication between the provider and patient. Dr. Everest says that when the patient knows what they want out of the communication that they are actually harder to control the patient, "In some ways the most difficult problem is when patients have an idea off what they want…which to me is not in their best interest…that sounds somewhat patriarchal and I think it is to some degree". The provider's perception of what is best for the

patient may not be what the patient feels is best for them. This can create conflict. He goes on to say that change is hard, "I think very often I have a healthy respect for how difficult it is to get patients to change their way of looking at data." The patient may be presented with information by the provider that does not align with their beliefs or ideas for care. Controlling the patient becomes essential at this point. The provider must negotiate that space. They have to carry that "health respect for how difficult" change is.

**Story**

In of the interviews six of the seven providers mentioned people as having stories. These stories were the part that mattered and should be listened to. Dr. Pell puts a high emphasis on people's stories. He says that "I believe in stories instead of diagnoses. I believe in people instead of diagnoses. And I don't that I give high value to diagnoses… I think they are a necessary evil." His values line up with stories, not diagnoses. He even goes so far as to claim that diagnoses are a necessary evil. Diagnoses are for categories. Stories are for people.

 Diagnoses often get in the way of a person disclosing critical information. Dr. Pell believes diagnoses cannot do stories justice. He says "it was an issue of discussing diagnoses…addressing the nature of diagnoses and how superficial they are. How they are based on superficial criteria…it isn't a substitute for a patient's story" The diagnosis lacks depth, according to Dr. Pell. The stories carry the substance, not the diagnosis.

Dr. Everest felt the same way when deciding to go into psychiatry instead of surgery, "I enjoyed getting to know patients more than just getting to know gallbladders". There is a human connection supposedly made by this act of story-telling. Providers are interested in what the patient's perspective is and they can get this through the stories. Dr. Pell says he "tries earnestly to understand their story so that they know, so that they feel understood." Effort is put in to get to an understanding. This is the understanding of the story. By creating this connection providers

feel their patients disclose even more of their story. Patient's gain autonomy through story telling because their own words are being used to describe their circumstances. According to Dr. Harris, "if you say I am here for depression I will use your words. I will not use different words."

Dr. Karr and Dr. Greenwood had a different take on story-telling in relation to diagnoses. They feel that it directs how the diagnosis gets made. By having the stories, it can help the provider to make decisions about the diagnosis. Dr. Karr says that "people may have various disorders which they are not talking about and you don't know that until you start asking some questions." By getting at a person's story, the provider may be able to make a more accurate diagnosis.

Dr. Markus believes that everyone has a story and wants to share it. He passively listens as he "sits back" and lets them share. This is not encouraging for the patient who may need reassurance and comfort while telling their story. The story may take time to emerge, but according the Dr. Greenwood within "the first 3 to 5 minutes is the patient telling me their story". Dr. Harris accounts this willingness to talk so openly about their story to cultural expectations. He claims that "people are open to being with a therapist in this culture. Sit with somebody to talk with." Therapy is often thought of as sitting down and talking. There is an emphasis on talking as a way of communication.

**Listening**
In the provider interviews there was a huge emphasis on listening. This listening was done in a silencing way. Dr. Karr and Dr. Greenwood both said they try to be quiet as they can while they listen. It is the provider's responsibility, in their mind, to figure out what the patient wants out of the interaction. They feel by listening they are able to better understand. Dr. Karr exemplifies this in his interview when he states "you have to find out what's the patient's agenda and see whether you have agreement about that agenda". This agenda represents the terms that the patient and provider agree to. Dr. Karr goes on to state the importance of collaboration via

listening. He states providers cannot be authoritarian, because patients will not cooperate. "I

think it has to do with the authoritarian doctors telling patients what they are supposed to think...

and collaborative doctors like me asking the patient where they are at and listening." By listening

the provider can get a better understanding where their patients are at and what they are willing

to do. Providers can gauge how much control they can have over their patient.

The listening has to be genuine for the provider to reap the benefits. Dr. Harris discusses how

well patients pick up on providers who actually care. He states "the patients are smart enough to

recognize they are connected and their being listened to and heard by the provider". The listening

allows for a connection. The connection allows for control. Dr. Karr reinforces this when he talks

about what patients are willing to deal with. They are more cooperative if they feel heard. They

desire a sense of autonomy and respect. It is unclear whether providers feign this or simply

convince patients that they are trustworthy of collaboration. Dr. Karr claims that "people want

more autonomy and they want more respect and they're not willing to put up with. And there's

the internet so people have researched these medications. They don't expect you just to tell them

to take the little green pills". This statement shows that patients are more involved in their care

than ever before and their expectations are higher. They anticipate a provider who listens and

also explains. The passivity of the listening that many providers discussed in their interviews,

could hurt the patient/ provider relationship. Patients expect to be treated with respect, have

autonomy, and be treated by active participants.

**$/ Studer**
Studer is an organization that helps institutions create and maintain their image. Organizations

can promote themselves, providers can attend conferences and workshops, and patients can be

told they are receiving a certain type of care. Dr. Markus is the only provider who talked about

Studer in his interview. He states "I don't know how much they pay Studer for all this stuff but

they are basically outsourcing their jobs". He cannot stand what Studer represents. This company essentially makes hospitals look good for their own benefit. He says "I was really disgusted by what I read and what I heard (from Studer). They basically tell people to lie to patients". Patients are getting a glossed over version of what the institution is actually capable of, according to Dr. Markus. This all goes back to money and the capitalist economy.

There was a lot of terminology with capitalist undertones. Dr. Everest used subcontract when discussing who does what parts of the initial evaluation "*subcontract out* the medical evaluation". Dr. Sedge uses "more *efficient*, *productive*" when referring to how PCC can be improved. Dr. Everest even brought up insurance companies when talking about the sorts of treatments providers prescribe to their patients "Over time the *insurance companies* and the emphasis is on psychiatrists is doing medication management and little in the way of psychotherapeutic and really is the detriment in some ways." He believes this has a negative impact on care.

Some psychiatrists identify themselves within the realms of capitalism. Dr. Everest views himself as part of a product he is selling. He says "I'm getting *paid* to do this…You are *paying* me as the patient. You are *paying* me to see me…you have the right to expect a professional product" He uses the word pay 3 times and the word product one time in that statement. Dr. Everest continues to use the word pay when he talks about how he helps patients "we are there to understand… what kinds of problems they want to *pay* me to help them overcome". Dr. Pell reinforces this with his identity. He says "I'm not an authority. I'm a *consultant*". It sounds much like a financial consultant. He goes on to claim that he does not have personal ties to this job. "This is my job, I am trying to do my job the best I can, but I am not *invested*". Whether a person

is emotionally, physically or financially invested it represents a commitment. This is a commitment Dr. Pell openly admits he has not made.

**Hierarchy**

There is a hierarchy built into the medical community between providers and their patients. Some discussed how the hierarchy influences their communication with other providers "I feel like communications are open above and below me" Dr. Pell. As Dr. Sedge confirms "We are (of) all levels". There are multiple levels built into the system. This allows for control over each of the levels. Providers lower in the hierarchy often feel insecure with their status and need reassurance. In Dr. Sedge's interview she kept stating that "I want to know what other people said". She was hesitant to answer questions "incorrectly". She did not want to say anything that conflicted with what other providers said. This made her authority feel less credible. She discussed her avoidance on confrontation with patients. By doing so she is unable to sustain the medical personage.

The hierarchy maintains the medical personage, by allowing for management of the institution and those within it. Dr. Harris exemplifies this control when he discusses how patients react to him as a provider "because I present authority…I'm creating boundaries. I'm creating rule and they are struggling with that." He has authority as opposed to Dr. Sedge. This authority allows him to create boundaries within the provider/patient relationship. Patients have a hard time with this because of the limits he sets. Dr. Harris goes on to further talk about the power he has over his patients "I will give control…tell me what you (the patient) want me to do." Control is something to be given not taken. The provider has ownership over the control. It is the provider's currency.

It is important to know where on the hierarchy patients place their providers. How providers interact with patients can change how patients perceive their providers. Dr. Markus brings up a

great example of this when talking about medical students, "patients…identify with them (medical students) as a treating physician when really technically they're not." How they represented themselves allows them to have status, giving them control over the situation. Status seeped into many of the provider interviews. Status acts to validate credentials.

**Accessing Resources**
The patients are often depleted of the resources the providers can provide because they lack access. When talking about treatments for mental illness Dr. Sedge states that she has "several patients who have stopped medications because they cannot, they have no means of paying that…the treatment is not effective because the patient does not have cannot buy medications." The mental illness is not effectively treated because despite there being a resource it is not available to the person who needs it. The patient may be making tough financial decisions, in which case the medication does not make the cut. Dr. Sedge warns against the dangers of this, because the treatment is no longer effective when not used on a consistent basis.

Patient autonomy is dependent on access to resources. Often times these are financial resources that lead to health care resources. Dr. Sedge talked repeatedly about how resources are important for both the patients and their providers. The providers can give resources and be a resource for their patient's if the institute they work under has supports in place. Dr. Sedge says "it depends on how accommodating the facility is for the provider". The facility is the institution in control of resource allocation and the provider is the one seeking out the resources. This statement shows the control the institute has over the provider. The provider is dependent on the facility, in order to create and maintain resources.

**Credentials**
Three providers mentioned credentials in one way or another during their interviews. This maintains the medical personage and reinforces status. The institution and other providers

support the credentials created. For example, Dr. Markus claims that those lower in the hierarchy are expected to exaggerate the credentials of their coworkers to make the institute look good. He says "if you're a phlebotomist they want you to go in and say (jumps in their chair) Dr. X has ordered some blood work. He's the *best* psychiatrist anywhere!" This emphasis keeps the control within the institution.

Dr. Greenwood and Dr. Sedge view credentials as a vital part of PCC and communication. When asked about what factors to consider when looking for a provider Dr. Sedge responded with "credentials, reviews, and experience". Credentials are at the top of the list. Reviews and experience show the credentials that Dr. Sedge looks for. Dr. Greenwood states that without credentials a provider will not be successful. He talks about it in the context of competency: "if you (the provider) are not competent people know very quickly know that you are not and that will destroy a relationship sooner than anything else." To get the relationship to a place where the patient feels trust in the provider Dr. Markus claims there are three things that the patient must feel about the provider, "they have confidence that you are listening, that you do understand and have some idea of what you are doing". Listening, understanding, and knowledge confirm credentials credibility.

**Lying to Patients**
Dr. Markus and Dr. Karr both made explicit statements about coercion and lying to their patients. These statements displayed the provider authority and hierarchy while also diminishing the patient's autonomy. Dr. Markus was straight forward claiming, "in some way or another and sometimes we have to coerce them (the patients)". The word choice is interesting because he states "we have to" as if there is no other choice. Dr. Karr uses the same language when talking about deception saying "there are some situations that are very difficult and you do sometimes do what *you have* to do to try to aim for the person's best welfare". He makes it sound like he is

doing it for the patient. Yet, Dr. Karr admits other factors are at play such as guardians. "I don't like to do deceitful things to patients, like just changing their meds, because their guardian said to do that." In that case the guardian has the autonomy. The power shifts from the patient to the guardian to the provider. This controls the patient by limiting their understanding of what is happening to them.

### Recognition by Mirror

Two of the providers interviewed discussed the importance of making sure they understood what the patient was saying. Their ways of making sure they get is going on are not unlike Foucault's recognition by mirror concept. Dr. Everest claims that he has his patients "repeat back to me what I've talked about as far as an intervention." This ensures that information is being transferred as it is intended. Repetition can be viewed as mockery which keeps the patient below the provider in the hierarchy. This is essential for the management of the patient.

Mirroring is visible in the ways providers respond to patients. In Dr. Pell's interview he claims that providers must "Express concern about the way they (the patient) feel and tell them that you know that they're upset and express an understanding about the situation they are going through" in order to establish trust. Telling a person that you understand they are upset is mirroring back their emotions. Again, this can be seen as mockery. If a provider does not legitamitely understand, then making this claim will place the patient in a marginalized space. Unless a provider has gone through the same exact situation, it is impossible for them to express as Dr. Pell claims "an understanding about the situation".

### Standards, Rules, Regulations

When asked about what happens during the first evaluation of a patient Dr. Pell, Dr. Markus, Dr. Karr, and Dr. Harris all explicated stated that there was a "standard outline that most of us follow". This outline tries to ensure that every part of the patient's life is explored. Dr. Harris

makes the bold statement that "we check, we assess everything". Everything is a lot and things can get missed. It is important to providers that they do not miss anything, because they need to know as much about the mental illness and the person as they can. Dr. Harris notes that "each piece of information will help us (the providers) connect it to the symptoms". These symptoms are part of a diagnosis. It allows for categorization and subjective connections to be made by the providers. Not all providers agree with the diagnostic model. Dr. Pell, for example, claims that "diagnoses are a carry-over of a medical model that doesn't very well apply to psychiatry." Mental health cannot be reduced to a diagnosis, according to Dr. Pell. The diagnosis is part of the medical-model which aims to fix a problem systematically. From Dr. Pell's experience this is not effective.

Other types of standards exist around care. Institutions are regulated by criteria that the government and society put on them. According to Dr. Pell this criteria is for care that institutions are expected to uphold is simply too strict. He believes "there is too much criteria established… it in order to minimize risks at all costs." Minimizing risk is the stake that the government and society have in these institutions. By minimizing risk there are a greater number of patients who are not patients. There are people in need of care that don't receive it. Dr. Pell says that "they won't lower their standards so that they'll be more beds available." With more beds available more people could receive care. Dr. Pell understands that the care may not be as high quality, but that at least people would be getting care. He believes that "if there was a certain amount of acceptance of failure… built into the system where everybody was a little bit more tolerant about it" then society would be better, as a whole. More people could receive care. And the bed crises would be lowered. Dr. Pell is stating here that failure is not accepted in a way,

shape or form. Perfection is the goal, and he wants us not to strive for perfection when it comes to mental health care.

**Government Mandates**

There are two clear examples where government mandates control the facilities. One is in reference to Maine Care patients and their service plans. The other is mandates surrounding commitment to these institutions.

Dr. Markus addresses the Maine Care patients in his interview. He is the only provider to bring up the government mandate that existed on Maine Care patients. This mandate is no longer in place. The mandate insisted that "Maine Care patients had to have an individual service plan. The goal all had to be quotes from the patient and we were supposed to just work towards the patient's goals." Dr. Markus. The patient was put in complete control of the goals of treatment. This was problematic for providers Dr. Markus explained because some patients did not understand the gravity of their illness and could not make decisions for themselves. Some patients would make unrealistic goals like getting off medications or being cured. Without the guidance of the provider linked with the authority of the provider, patients were making decisions deemed bad for their health.

Several providers brought up patients who have been committed to the institutions when discussing difficult times to implement PCC. Dr. Greenwood said what many of the other providers would not say explicitly, it's important that the "patient wants to be there, that the patient's not being mandated there." A patient who wants to be at a facility is more likely to cooperate and be active in their treatment.

When a patient is mandated into the institution there are specific rules and regulations that follow. Leading to patient loss in autonomy and the provider feeling helpless. There are circumstances that patients must be committed. Dr. Markus recalls one of these times in a

nonchalant tone "I had a patient here that wanted to kill himself. I took him to court and got him committed". If a patient is an imminent danger to themselves, they get committed. It is part of the routine. The process as he explains it is very straightforward, "there are outside experts that come in and examine the patient, render an opinion, and eventually you have a hearing…the judge decides whether the patient meets criteria for and involuntary stay". The expert does the evaluation that is not associated with the institute, the judge makes the decision, and the patient is controlled into an "involuntary stay". The judge, not the expert, makes the ultimate decision. Sometimes patients try bargaining with their providers saying they didn't really mean it or that it isn't relevant now, because they feel better. Dr. Pell reflects on one of these times and the reasons why he must follow the mandate, "These are medical legal issues (commitment laws). It doesn't matter that you at this point in time feel it is unfair. It doesn't matter. This is the routine here, I have to do this like this." There is a routine and the provider cannot stray from it no matter their personal beliefs. Dr. Pell claims he "can't put myself at risk." If something happens to the patient that could have been prevented the responsibility falls back on the provider. Dr. Pell does not agree with these mandates, in a lot of cases. He understands them to be social expectations that he must uphold to keep the institute in control. The institution does not have the patient at their center, therefore the provider does not. Dr. Pell states "I don't think commitment is primarily a therapeutic job. It's a social expectation laid upon a person because of my knowledge base. Not because of my mission." This means that commitment should be a therapeutic experience, yet it is not. Dr. Pell acknowledge his status as a provider with knowledge forces him into implementing commitments.

**Conclusion**

How Do the Results Connect Theory?

- *Silent Treatment:* Listening, Stories, Standards Rules and Regulations, Government

  Mandates and Family act as silencing treatment. Standards Rules and Regulations,

  Government Mandates and Family diminish the patient's rights and how the providers

  interact with patients through passive listening to their stories only furthering silence. The

  surveys also note this through the communication tactics of the providers with patients.

  Communication with Doctors and Discharge Information, both indicate silencing

  measures. The patients don't feel as connect with providers as they could and don't feel

  they understand their care. This silencing acts as a way to marginalize patients. In the

  official documents patients are further marginalized by how they are identified: "those

  with severe and persistent mental illness", "poor", and "vulnerable". This also falls into

  the category of Perpetual Judgment, because it influences how others treat them. As a

  result of their status they are unable to have their voice heard, which is emphasized in

  many of the documents. Their voices get reduced by the dehumanizing treatment they get

  through the documents.

- *Recognition by Mirror:* Communication with Patients and Recognition by Mirror both

  gave examples of how providers repeat back to patients what patients are saying. Patients

  are aware they are being evaluated. The patient is the subject. In the interviews the most

  common word was "patient" which shows how the conversation mirrored back on the

  patients. "PCC" was also very common, which indicates the providers need to keep

  repeating it to make sure it was being said. In the official documents on one statement

  from Richardson Hospital stood as mirroring treat others "the way you would want to be

  treated". This falls into morality as well, but here you can see how a provider sets an

example that the patient is expected to follow. The patient is to see the mirror and
understand that they are to do as they are told.

- *Perceptual Judgment:* Provider Perceptions of Patients and Lying to Patients act as
  perceptual judgments about what the patient is capable of handling and how they are
  treated in relation to discrimination and stigma. The providers often cannot relate to the
  patients, so they pass their own judgments onto the patient. Many of the official
  documents reference the patients in marginalizing ways such as: "those with severe and
  persistent mental illness", "poor", and "vulnerable". This oppresses the patient. In
  addition to the oppression the patient faces from their provider they face oppression
  through the institutions morality. Some examples of moralistic tones in the documents
  include: "Jesus as healer" "Catholic health ministry", treat others "the way you'd like to
  be treated", and "we serve". When they make those judgements they end up coercing or
  lying to their patients. If the patient is not equipped with the information they need, then
  they are unable to make their own judgments about what is best for them.
  "You know?" was used on several occasions during the interviews, implying a common
  judgment to be made. The providers assumed I knew things about the patients,
  treatments, diagnoses, and procedures. This was an inaccurate judgment. The point of the
  interview was to gain further understanding not to be told I know things I do not.
- *Medical Personage:* Hierarchy, Credentials and Models of Health all work to keep the
  medical personage. The hierarchy keeps control while the credentials maintain the
  hierarchy. These are in line with the overall models of health that psychiatric units adhere
  to. The medical personage exemplifies how structures have control over bodies.

- *Capitalistic Gains:* Studer/$ falls under this additional category. It works to maintain the image of the institute, while commodifying care. The official documents mention this image they try to sustain through the language they use such as "financial stability", "enhance", "customer service", "positive image of the institution", "service", "performance", etc. The distribution of Mental Health Care Facilities and the number of beds available support commodification of care. It is much like the race to the bottom. How few beds can be allotted to care without an overflow? What is the minimal number of facilities absolutely necessary for care? Looking at where the facilities are located, it is clear they are near areas of capital gain. They are in Maine cities mostly, or areas of wealth.

A comprehensive definition of PCC would allow for more fluid discourse between institutions. There are many notable differences between the hospitals analyzed. Their discourse and their definitions vary. Some websites do not cite PCC as part of their discourse. Others explicitly state their stance on PCC and its importance. Family-centered care is only briefly mentioned on one of the hospital websites. Family can impact PCC greatly, yet it is rarely discussed in depth.

Examining the themes that emerged from the interviews and how the Foucault framework incorporates most of them, I claim that PCC is really not that much different from previous care. If sociological framework from the origins of hospitals still hold true, that says a lot about the lack of progress.

Despite the PCC initiative, facilities have been unable to improve their care in ways that are progressive. The research question "*In what ways has the PCC initiative impacted facility understandings and practices of care"* can now be answered with evidence from the discussion

question. PCC reflects many of the concepts it claims to combat such as silencing. Care may have shifted from Doctor-Centered to Patient-Centered, but patients are still being oppressed. The focus has gone from the doctor to the patient, but not without consequence. Who gets to be a patient and have a say in their care is still determined by the provider. The provider still has the ultimate control.  Doctors may claim they are giving patients autonomy and listening to them, but the survey shows that patients do not feel as strongly.

**Limitations**

This study only looked at only 6 psychiatric facilities. The conclusions made can only be applied to the acute inpatient psychiatric wards in Maine, not nation-wide. Having data from the pilot study of one of the hospitals may have made the researcher able to make more solid claims, because they had experience within the hospital setting. Another limitation is that by only analyzing language, application is not viewed in its entirety. Though the surveys and interview act as ways to measure patient satisfaction, they were only done at one hospital.

By evaluating the meaning of words, the researcher is subjectively adding their own meaning into the syntax used. Looking at the data through the eyes of the patients and health-care providers was hard, because so much was left up for interpretation. The researcher is a white, female, low income, Colby College student, who has suffered from mental disorders. These demographics are all important to note, because it gives the angle at the researcher was able to analyze the data.  The researcher has been a mental health worker at one of the facilities, which may bias the results to favor one hospital over another.

**Moving Forward**

Moving forward all U.S acute psychiatric unit mission, vision, and value statements should be evaluated. Then more data from interviews should be collected and analyzed to

determine the social implications of patient-centered care and doctor- centered care. An analysis comparing how many acute wards use each method must be done to see how mainstream each method is. We must learn what the best type of care is and how to implement it effectively. Further research must be done on health outcomes in relation to PCC.

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Appendix

Appendix 1. Interview Guide

1. *I would like to explore what your initial motivations for getting into this sort of medical practice. Could you recall the story of how you became a practitioner at this institution?*

2. *Can you walk me through a typical first evaluation of a patient? What is the process? What sorts of questions do you ask? What are you looking to find out about the patient?*

3. *When treating a patient in what ways do you feel you communicate effectively with them? How do you know?*

4. *What would you say are the three most important aspects of a successful doctor-patient relationship? How do you build x? Example of a time when you used x? How do you build y? Example of a time when you used y? How do you build z? Example of a time why used z?*

5. *What are the first words that come to mind when you hear the phrase patient-centered care? What is important about those words to you?*

6. *Do you feel you have an adequate definition of patient-centered care? How do you feel your definition of patient-centered care differs from that of your colleagues? In what ways is it the same?*

7. *Can you explain circumstances under where it is difficult to implement not to use patient-centered care as it's defined in your institution? What about those circumstances would make patient-centered care hard?*

8. *If a person that you know was searching for an institution that provided patient-centered care, what would you tell them are the most important factors when considering where to go?*

9. *Can you tell me about a time when your use of patient-centered care was particularly effective?*

10. *If you had to change something about how patient-centered care operates at your institution what would it be?*