

# Chapter 5

## When the Doctor-Patient Divide Is a Chasm



### 5.1 Understanding Multiply-Disadvantaged Patients

In 2011, Atul Gawande, noted surgeon and author, changed the consciousness of the healthcare system, particularly those studying healthcare costs, when he first reported on the work of Dr. Jeffrey Brenner in Camden, N. J. In his article, “The Hotspotters” in *The New Yorker* [1], he described the interactions between Brenner and some of his patients in the most disadvantaged areas of Camden. The data about such patients had been well documented [2], but Gawande told the individual stories of these patients in a way that made sense of their dilemmas and their costs. “The Hotspotters” gave people names and life stories who otherwise are called “complex,” “high-utilizing,” “multimorbid,” “low-income,” “minority” patients. Giving the story of individuals who were extremely high utilizers added an element that the data often fails to convey: hope. His stories described the kind of care that made a substantial difference in their lives in addition to a difference in their costs to the healthcare system.

Perhaps one reason that the patients that Gawande described and that Brenner treated seemed so underrepresented in the literature was that they were described in different literatures under different categories. There was a literature on high-utilizing patients and another on multimorbid patients, particularly those with both behavioral health and medical diagnoses, who are often brought together under the label of “complex” patients. There was a literature on low-income patients and their interactions with the health system. There was another literature on the treatment of patients from minority or immigrant groups by the health system. Each literature tended to focus on people defined by the category that it studied. Few studies were careful about how else their group had been defined in other literatures. This practice tended and still tends to underplay the fact that patients in one studied group are also members of other groups studied in other literatures.

There is one more group description that commonly can be applied to Dr. Brenner’s patients: trauma victims. In a study done by Brenner’s team [39] that

involved in-depth interviews with many of these patients, the high-utilizing, multimorbid, complex, low-income, mostly minority patients his team interviewed in depth had high scores on a measure of adverse childhood experiences [3]. They had experienced abuse and/or chaotic home lives of an intensity that has been shown to correlate with greatly increased risk of mental and physical problems in later life.

Not every patient who fits one of these groups (disadvantaged, complex, trauma victim) belongs in the others. It doesn't take a lot of time to find an example of a patient who only fits in one or two of them. Still, the overlap is much more substantial and much more common than is represented in any of the literatures on any of the groups (see [Appendix](#)). In this chapter, we will look at what is known about the relationship of high-cost, high-morbidity patients (complex patients), low-income patients with low educational attainment (disadvantaged patients), and patients with histories of trauma. Patterns of behavior or problems that may seem unexplained, when a patient is considered in one group, will begin to make better sense when they are considered as a member of a second or third. All of this is done so that healthcare procedures and methods that have been shown to be helpful to one group can be brought to bear for patients recognized as members of others. This should make the case for a synthesis of current approaches to providing care for these groups and for a new approach to building partnerships with them.

## 5.2 Complex Patients

There are a number of published systems for designating “complex” patients [4–10]. In addition, it is common for individual health systems or even individual primary care practices to create their own approaches to designating patients as “complex.” All of the systems have in common an attempt to identify a subgroup of patients for additional monitoring and services. Most focus on the confluence of high medical cost and multiple chronic illness [11]. After eliminating the “high utilizers we can't do anything about,” e.g., cancer patients needing a bone marrow transplant, we are left with the high utilizers described here [12]. Many use the addition of a psychiatric diagnosis as a heavily weighted element because of the great increase in cost that is associated with the comorbidity of a chronic illness and anxiety or depression [13, 14]. They try to meet a dual goal of designating patients who are likely to derive significant health benefits and to require less costly overall healthcare when the additional monitoring and support services of a program for complex patients are brought to bear.

When high-utilizing patients are studied, they prove to be more likely to have psychiatric or substance use problems in addition to the chronic illnesses with which they are coping. When they are compared with moderate utilizers with the same acuity of chronic illness, the high utilizers are younger, and they have higher burdens of anxiety, depression, and substance use [15]. This is a finding from a study that controlled for the effects of medical morbidity, adverse events, age, race,

gender, employment status, and health insurance coverage. An anxiety diagnosis contributed the most to identifying high-utilizing patients, and a diagnosis of anxiety, depression, or substance use correlated most powerfully with patients with medical illness complexity and utilization.

The question of how to identify complex patients, when considered in more detail, can be addressed with another question, “Complex to whom?” One approach is to specify types of complexity. Consider the categories used by Frankel, Bourgeois, and Erdberg [16] of clinical complexity, presenting with conditions that are difficult to identify and treat; operational complexity, the difficulty in coordinating the multiple health professionals needed to deliver optimal treatment; and management complexity, the difficulty a patient presents as health professionals try to exert influence on their health behavior and adherence. In this model, and others like it, the complexity is in the experience of the healthcare team. Their job of providing care is complex.

Perhaps a more sophisticated definition of complexity at this writing is the Patient Centered Assessment Method (PCAM) [17]. It is an example of the way a good deal of research, wisdom, and experience can be condensed into a one-page assessment of a patient’s complexity that grew out of work in Minnesota [18]. In this model, the complexity is seen as in the patient’s social, health system, and medical circumstances. The task of the team is not just to assess the numbers of medical diagnoses but to “understand that proportion of the patient’s despair, demoralization, discouragement, and withdrawal that is related to ‘complexity’ derived from non-medical factors that inhibit quality of life and can block improvement from routing medical or mental health care” ([4], p. 302). In the rest of this volume, calling a patient “complex” will signify a patient coping with medical, behavioral health and social circumstances that complicate their interaction with the health system and make usual medical or mental healthcare likely to be ineffective or less effective than would be expected of patients with their medical diagnoses alone.

The PCAM is filled out by a health profession about the patient. It asks about 4 general areas of a person’s health situation using 12 questions. The PCAM assesses current health and well-being by asking about the physical health needs that should be investigated, physical problems impacting mental well-being, problems with lifestyle behaviors, and other concerns about the patient’s mental well-being. It assesses social environment by asking about the safety and stability of the person’s home environment, about the impact on their well-being of their daily activities, about their social network, and about their financial resources. It assesses the person’s health literacy and communication with their health professionals by asking how well they understand their health situation and how well they engage in conversations with their health professionals. And finally, it asks about service coordination by asking for a rating of other needed services and how well-coordinated current services are.

The PCAM is much more sophisticated than might appear on the surface, allowing a clinician with no access to health cost data about a patient, to make reliable decisions about which patients to consider complex and how to assess levels of

complexity. It is remarkably accurate in predicting patterns of a patient's interaction with the health system such as length of stay in the hospital [19]. Perhaps more importantly, it can guide a health team on where to put efforts and resources in making care more successful for complex patients.

### 5.3 Disadvantaged Patients

Asking about finances is important for understanding a patient's relationship with the health system, not to assess their ability to pay their medical bills but because income correlates with health. Findings in the USA and other industrialized countries indicate a monotonic relationship between income and a number of health outcomes such as birth outcomes, life expectancy, chronic disease rates, quality of life ratings, and mortality [20]. In other words, the poorer you are, the sicker you are, and the shorter your life will be. Barnett and her colleagues put the relationship of socioeconomic status (SES) to health in their study in a particularly vivid way, "Young and middle-aged adults living in the most deprived areas had rates of multimorbidity equivalent to those aged 10–15 years older in the most affluent areas." Their review of ten studies showed a 24% higher rate of multimorbidity in the most deprived areas over the most affluent. While the most powerful predictor of multimorbidity is age, for all ages lower than 85, patients in more deprived areas had higher levels of multimorbidity than those in more affluent areas. In the more deprived areas, the likelihood that a person with multimorbidity had a mental health as well as a physical diagnosis was more than double the likelihood in the more affluent areas. And having a mental health disorder was strongly associated with having more physical disorders. Income seems to determine how likely a person would be classified as complex in the way of grouping patients described above.

Low income and low education on one hand and race and ethnicity on another intersect in recursive and reciprocal ways [21] in influencing health risk, morbidity, and mortality. Much of the literature comparing socioeconomic status with health outcomes does not distinguish between racial and ethnic groups. Because certain racial and ethnic groups are overrepresented among low-income populations, research on the health burdens of low SES on one hand and race/ethnicity on the other is describing many of the same people. It does seem clear, however, that additional disadvantage for many is attributable to discrimination and racism leading to additional stressful life experiences and psychological distress. These populations show a greater likelihood of reacting with hostility, anxiety, depression, and hopelessness [22]. In studies that have controlled for income, African Americans have a higher likelihood of high allostatic load scores at all ages but particularly at ages 35–64. African American women had higher scores than their male counterparts [23]. Allostatic load is the wear and tear on the body caused by chronic exposure to stressful experiences or situations. When situations are experienced as dangerous or unsettling, the "fight-or-flight" response can stay chronically activated leading to changes in the functioning of the immune system which over time can cause organ

damage, impaired response to new dangers, and heightened vulnerability to disease. High allostatic load is a feature of people who have experienced multiple traumatic events as well as people who live with high levels of stress on a day-to-day basis.

However the research is grouped; people in lower SES groups and certain racial and ethnic minorities appear to face both higher rates of traumatic events and higher levels of stress [22]. Interviews with a number of young adults who grew up in low-income neighborhoods in a major American city (Philadelphia) showed levels of adverse childhood experiences at rates much higher than the national average. Nationally 45% of adults report one or more adverse childhood experiences, as defined by the ACE screen, before the age of 18 [24]. A sample of low-income, mostly minority adults (African American, Hispanic and Native American) in an urban environment reported adverse childhood experiences at extremely high levels [25]. Their reports included the items on the ACE screen and additional adverse experiences such as single-parent homes; lack of parental love, support, and guidance; death of family members; exposure to violence; criminal behavior; economic hardship; personal victimization; and discrimination. Of the 119 adults interviewed, 511 adverse experiences of those on the ACE screen or the list above were reported [25].

A term used in some of the research on this group that brings together the concept of a person's comparative income and social status as impacts on their options and stresses in life is "disadvantaged." And the impact to trauma greatly increases that disadvantage.

## 5.4 Trauma Victims

Traumatic events, particularly occurring in childhood, have a powerful impact on future physical and mental health. The study of the impact of trauma brings together neurobiological, immunological, and genetic evidence on one hand and epidemiological evidence on the other [33] for a picture that forms a plausible "back story" for the patients that are being designated as "complex." The impact of trauma has been brought into focus through the use of a measure of adverse childhood experiences [3]. The "ACE" measure asks about patients' history of abuse (emotional, physical, and sexual), witnessing domestic violence and parental marital discord, and growing up with mentally ill, substance-abusing, or criminal household members [26]. The use of the ACE measure has shown a dose-response relationship between the number of types of adverse experiences remembered and a varied array of illnesses and dysfunction as adults. The list of the problems and conditions that increase in likelihood as the number of adverse childhood experiences goes up is long and varied. Early trauma impacts such basic elements of development as the size and function of several areas of the brain [27–29] and the expression of the genome [30]. These impact the function of the immune system leading to hyperarousal and increased stress response to events and relationships [31]. People with higher adverse childhood experiences have correspondingly higher psychiatric

disorders, substance use disorders, psychosocial disturbances, and physical illnesses. They show higher depression, anxiety, panic, suicide attempts, PTSD, hallucinations, dissociative disorders, and borderline personality disorders [33]. ACE scores correlate with substance abuse: smoking, alcohol use, illicit drug use, and injection drug use [33]. The same correlation exists with psychosocial disturbances such as difficulty controlling anger, intimate partner violence, difficulty with long-term attachment, likelihood of stormy interpersonal relationships, problems regulating mood, early intercourse, and high lifetime number of sexual partners [33]. ACE scores correlate with cognitive problems such as memory for events. The number of adverse childhood events correlates with physical illnesses such as cardiovascular disease, hypertension, hyperlipidemia, asthma, metabolic abnormalities, diabetes, obesity, infection, and other physical disorders with or without corresponding medical findings [3, 32]. Finally, many of the elements are additional traumas in themselves, while others contribute to a life of continual disadvantage. They include poor work performance, financial stress, adolescent pregnancy, risk of sexual violence, risk of intimate partner violence, and poor academic achievement.

The habit of Western science to dichotomize the mind and body is one reason that the observations of the impacts of trauma have only recently begun to coalesce. The study of the impacts of trauma has been a pivotal part of the converging of the study of “psychiatric” and “medical” illness. In fact, it is reasonable to reconceptualize the types of impacts listed above (neurobiological and genetic, immune system functioning, psychiatric illnesses, psychosocial difficulties, and physical illnesses) as different points of observation on what is one long-term, highly complex process. And, while the argument against attributing causation to patterns of correlation is always important to consider, Anda and his colleagues [33] argue that the massive quantity of evidence about the impact of trauma meets Sir Bradford Hill’s nine criteria for establishing an argument for causation [34]. But one does not need to make a case for causation in order to make a case for the likelihood of a trauma history among patients designated as “complex” by standards of multimorbidity or high utilization.

Clinicians have observed the confluence of psychiatric, psychosocial, and physical problems for years, often without a theory of what could explain this pattern. They observed that some patients were more disabled by their illnesses than others who had similar clinical pictures. They saw that some patients came to medical care much more often than others who were equally sick. They saw that some patients with chronic illness were more likely to also have depression or anxiety or to be using substances. In each case, it was not common for clinicians to inquire about a trauma history as the factor that united these observations [35]. It is probably fair to say that the level of awareness of the impact of trauma in many quarters has changed only marginally in the last 20 years.

Patients who tend to be what the British term “frequent attenders,” who seem, despite their higher levels of care and attention, to be more disabled by their illnesses than their peers, can be frustrating to clinicians. This is particularly true

because many of these patients who come so often do not reliably follow the treatment plans offered to them or they go to multiple medical settings so their treatments are not coordinated. One telling name for this group is patients who are “overserved and underserved” [36]. Another is a description of the patients as identified by their doctor’s reaction to seeing their names on the schedule for the day, calling them “heartsink” patients [37].

While there has not been a lot of research aimed at studying the impact of a trauma history on socioeconomic status (SES), it is reasonable to put together some of the factors that are associated with childhood trauma to support the suspicion that there is a correlation between the two. Factors such as a higher likelihood of disability, higher burdens of medical and psychiatric illness, higher probability of substance use disorders, problems with anger management, and interpersonal relationships, a higher likelihood of illness due to immune system dysregulation, difficulties with long-term relationships, and higher likelihood of homelessness lead to a picture of a population that has significantly increased challenges in getting and keeping employment adequate to maintain a reasonable standard of living. Studies that elaborate the difference in health status of higher- and lower-income people, including different rates of obesity, mental health problems, unsafe neighborhoods, and access to care, often fail to include differing rates of traumatic experiences [38]. These increased rates of trauma reciprocally potentiate impact of the other elements cited in these inventories.

As we consider the lives of these three overlapping groups of patients, the term “multiply-disadvantaged” seems an appropriate description. It is a term that can bring together patients otherwise termed “low-income,” “low-education,” “complex,” “high-utilizing,” “underserved,” or “trauma” survivors. These are patients who are likely to wear their disadvantage physically and functionally, in their immune system, in their psychological challenges, in the conditions of their day-to-day lives, and in their burden of illness. Keeping in mind the full resonance of the term can also give access to noticing how much a patient has accomplished in spite of their challenges, the strengths they have developed, the relationships they have maintained, and their contributions to other people. Those are distinctions that will be needed when we come to talking about how to make partnerships with multiply-disadvantaged patients.

## 5.5 The Health System and Multiply-Disadvantaged Patients

“Multiply-disadvantaged” is a fitting term for the patients that Atul Gawande described in *The New Yorker* article mentioned earlier. His term, “hotspotters,” is a term from the perspective of the health system, one that was very important because it helped the medical world and the public to conceptualize patterns of high utilization and high cost that previously were not widely recognized. Mautner and her colleagues [39] offer a picture of the interaction of these same

multiply-disadvantaged patients with the health system from the patients' perspective. Over half of the patients interviewed reported interactions with the healthcare system that they found upsetting, disrespectful, or demeaning. These patients were likely to report that their subsequent interactions with the health system were influenced by these experiences. They were less likely to follow the treatment suggestions they were given and sometimes less likely return for care. Many reported trying to change providers, though that was probably not something that was easy in their situation.

Just as their negative interaction with the health system tended to impact their health behavior, positive experiences made a difference in their health behavior in the opposite direction. Those who reported feeling "cared for," despite the likelihood that their functioning would deteriorate because of their diabetes, hypertension, and depression, said that they felt better over time. Their health status improved. These patients particularly focused on their interactions with the care management team in Brenner's program for the outreach and relationships offered more than for specific services.

Caruso [40] interviewed very-low SES patients at a rural health center in New England about their experience with the health system. She isolated six themes in their experiences with physicians that seem to be an elaboration of the themes found by Mautner. She found that her respondents experienced the power asymmetry between themselves and their physicians as reminiscent of previous experiences that they had experienced as oppressive or stigmatizing. They sometimes avoided future visits after an unpleasant medical encounter. Their emotional reactions to unpleasant interactions in an environment of power asymmetry contributed to their being less likely in the future to ask for needed information or express their opinions. They commonly chose not to make some disclosures that they felt were too dangerous to make to authority figures such as their physicians. And, as with Mautner's interviewees, physicians who were personable increased patients' comfort with care, and physicians who asked about patients' dissatisfaction or other possible ruptures in the doctor-patient relationship tended to ultimately strengthen the relationship with accompanying likelihood of improvement of the effectiveness of their care.

When Bernheim and her colleagues [41] interviewed physicians who treated multiply-disadvantaged patients, they found the same patterns in mirror image. The physicians tended to characterize patients as "stoic," "guarded," and "distrustful," though some physicians described them as "appreciative." The physicians, half of whom were of racial minority background, reported that when they made adaptations in their usual care patterns with these patients, they did it for the patients' benefit. They were likely to prescribe fewer and less expensive medications, make fewer specialty referrals, try to get more done in one visit (and thereby seem more hurried), and postpone testing when possible. They altered their usual routines to try to adapt to what they expected about the patients, that because of their low incomes, they needed costs kept to a minimum; that because



of their low education levels, they would have difficulty understanding their treatment regimen, or that because of their chaotic lives, multiple visits for care would be especially difficult.

All of these changes in care have been named in research into the disparities in healthcare afforded to disadvantaged patients and racial or ethnic minorities [42]. The expectation of lower education, lack of interest in their health, or lack of adherence becomes embodied in medical practice in ways that have been demonstrated in the studies. This leads to the finding that physicians encountering patients of lower income or education are commonly less patient-centered than with more affluent patients [43, 44]. They are more directive and use less relationship-building approaches such as counseling, empathy, or talk of emotions [45]. In a study by Garrison and his colleagues [46], it was found that pediatricians working with the parents of Medicaid patients in sites in less affluent areas elicited and answered fewer questions about children's psychosocial issues from parents than in sites in which most patients had private insurance. They were also quicker to refer these patients to mental health services for problems that they addressed and managed in their practices for families in more affluent suburban practices.

In the case of medical services for multiply-disadvantaged patients, the difference in income and education can become a daily fact of life for doctors and for patients. It becomes an assumption about the relationship, not something to notice occasionally when it happens to occur. But what is experienced as an asymmetry of knowledge by the doctor is often experienced as an asymmetry of power by the patient. Over time, this asymmetry can lead to a lack of trust that influences both doctors and patients.

Some patients come from ethnic communities that have experienced domination and/or oppression by other groups. For these patients the reminder involved in the stark contrast of knowledge and income (power) can be even more sinister. Whether people are cued toward being passive in the face of a perceived authority or assume mal-intent in interactions in which they are not confident of their doctor's motives, this cuing is an unacknowledged part of many medical visits. Doctors who choose to serve in low-income or underserved communities can find many of their patients reacting in ways that are openly wary of them or feigning cooperation to get what the patients think they need. For those patients, the doctor's expertise is sometimes useful, but his or her motives are not trusted. In these situations, patients can express beliefs about doctors "just being in it for the money" or colluding with each other against them; "they all talk to each other."

Healthcare providers and multiply-disadvantaged patients, presumably doing their best in the situation as they each understand it, can be said to engage in a reciprocal and mutually reinforcing pattern; they "cooperate" to make care less effective. Multiply-disadvantaged patients who are less healthy are also less likely to engage actively in a visit. They are more likely to internalize stigma about themselves and their knowledge of health information. They need more experiences

of support and positive relating than more advantaged patients to receive the intended benefit from their care. Yet they commonly receive more directive and less supportive care from providers. Health professionals mistakenly assume that these patients are less active in visits because they want less information and care less about their health than more affluent patients. The reciprocal interaction pattern that leads to physician/patient relationship being less patient-centered and more directive is often exacerbated in the case of minority patients such as African Americans [47].

Nurses, medical assistants, and administrative staff observe and sometimes amplify the pattern of mutual frustration between doctors and multiply-disadvantaged patients. This has been shown in the case of patients who come to their primary care site with problems like substance abuse and multiple chronic illnesses that are due in part to their own poor health behaviors. They are more likely to smoke, to be obese, to abuse substances, and to be poor at following a medical regimen, each of which will contribute to the impact of their diabetes, asthma, heart disease, and other illnesses. The judgment that “it is their own fault” can be part of a cooler or more perfunctory interaction style by nurses and medical assistants as well as doctors [48, 49]. Patients who use illicit drugs are likely to be expecting discrimination, and for those who do experience discrimination, it correlates with poorer physical and mental health [48].

## 5.6 Taking Stock

The usual divide between doctors and their patients in their different perspectives on health and healthcare and in their different purposes during a medical visit makes the goal of creating a partnership with patients in their healthcare a significant challenge. How much more challenging, then, is the chasm between doctors and multiply-disadvantaged patients, if partnership is still to be one of the goals of care? It is my hope that clarifying the challenge will lead to a better likelihood of addressing it successfully. Currently there are a number of ways of improving the engagement between doctors and their patients and of adapting care to make a better fit for patients which have been shown to make a difference in the processes and outcomes of care for this population. These will be discussed in the next chapter. In the following chapter and beyond, I will talk about a new approach to the routine interactions of care that can change the expectations on the part of health professionals and those of multiply-disadvantaged patients. The new interactions and expectations can lead to reciprocal and mutually reinforcing process that improves the health of these patients and the work experience of the healthcare team.

## Appendix

Increased incidence of:	Complex patients (multimorbid and/or high utilizing)	Disadvantaged patients	Trauma histories (high ACEs or PTSD)
Depression	Ford et al. [15], Violen et al. [50], Barnett et al. [51]	Barnett et al. [51]	Danese et al. [52], Löwe et al. [53], Larkin et al. [54]
Anxiety	Ford et al. [15], Violen et al. [50], Barnett et al. [51]	Barnett et al. [51]	Löwe et al. [53], Larkin et al. [54]
Medically unexplained symptoms	Edwards et al. [55]		Löwe et al. [53], Larkin et al. [54]
Substance use disorders	Mautner et al. [39]	Myers [21]	Larkin et al. [54]
Multiple chronic illnesses	Smith et al. [8], Ford et al. [15], Violen et al. [50], Barnett et al. [51]	Barnett et al. [51], Smith et al. [8]	Felitti et al. [3], Anda et al. [33]
Diabetes	Noyes et al. [7], Barnett et al. [51]	Barnett et al. [51], CDC [56], Adler and Newman [57]	Larkin et al. [54], Roberts [58]
Osteoarthritis	Violan et al. [50]	Adler and Newman [57]	Larkin et al. [54]
Lung disease	Barnett et al. [51]	Barnett et al. [51], Adler and Newman [57]	Felitti et al. [3], Larkin et al. [54]
Metabolic risk markers	Violan et al. [50]	Adler and Newman [57]	Danese et al. [52]
Hypertension	Noyes et al. [7]	Adler and Newman [57]	Su et al. [59]
Heart disease	Violan et al. [50]	CDC [56], Adler and Newman [57]	Larkin et al. [54], Sumner et al. [60]
Homelessness or insecure housing	Mautner et al. [39]	Mersky et al. [61]	Mersky et al. [61], Herman et al. [62]
<i>Problems with social determinants of health:</i>	Mautner et al. [39]	Adler and Newman [57], Mersky et al. [61]	Mersky et al. [61]
Being considered “complex”	By definition	Barnett et al. [51]	Anda et al. [33]
Coping with poverty	Barnett et al. [51], Mautner et al. [39]	By definition	Nurius [73]
History of trauma (ACEs)	Mautner et al. [39]	Mautner et al. [39]	By definition
Female gender	Violan et al. [50]	Mersky et al. [61]	Breslow [63], Uddin [64]
<i>Problems with care:</i>			

continued

continued

Increased incidence of:	Complex patients (multimorbid and/or high utilizing)	Disadvantaged patients	Trauma histories (high ACEs or PTSD)
Difficulty forming trusting relationships or partnerships	Mautner et al. [39]	Willems et al. [44], Street [65], Fox and Chelsa [66]	Green et al. [67]
<i>Problems for HPs:</i>			
HP is more frustrated with relationship with patient	Mautner et al. [39]	Mautner et al. [39]	Purkey et al. [68], Mautner et al. [39]
HP experiences extra stress from providing care and needs support	Bodenheimer and Berry-Millett [5]	Raja et al. [69]	Green et al. [67]
Underestimate incidence of trauma	Felitti et al. [3]	Felitti et al. [3]	Felitti et al. [3], Löwe et al. [53]
<i>Aspects of effective care:</i>			
HP is committed to helping patient become a partner in the plan of their care	Mautner et al. [39]	Fox and Chelsa [66], Raja et al. [69]	Netting and Williams [70]
HP takes a strength-based approach		Fox and Chelsa [66]	Green et al. [67], Purkey et al. [68]
Need a team to provide care	Frankel and Bourgeois [71], Dorr et al. [72], Smith et al. [8], Netting and Williams [70]		Mautner et al. [39]

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