Survivors of Intimate Partner Violence Speak Out

Trust in the Patient-provider Relationship

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OBJECTIVE: To identify characteristics that facilitate trust in the patient-provider relationship among survivors of intimate partner violence (IPV).

DESIGN: Semistructured, open-ended interviews were conducted to elicit participants' beliefs and attitudes about trust in interactions with health care providers. Using grounded theory methods, the transcripts were analyzed for common themes. A community advisory group, composed of advocates, counselors and IPV survivors, helped interpret themes and interview excerpts. Together, key components of trust were identified.

SETTING: Eastern Massachusetts.

PARTICIPANTS: Twenty-seven female survivors of IPV recruited from community-based IPV organizations.

MAIN RESULTS: Participants' ages ranged from 18 to 56 years, 36% were African American, 32% Hispanic, and 18% white. We identified 5 dimensions of provider behavior that were uniquely important to the development of trust for these IPV survivors: 1) communication about abuse: provider was willing to openly discuss abuse; 2) professional competency: provider asked about abuse when appropriate and was familiar with medical and social histories; 3) practice style: provider was consistently accessible, respected confidentiality, and shared decision making; 4) caring: provider demonstrated personal concern beyond biomedical role through nonjudgmental and compassionate gestures, empowering statements, and persistent, committed behaviors; 5) emotional equality: provider shared personal information and feelings and was perceived by the participant as a friend.

CONCLUSIONS: These IPV survivors identified dimensions of provider behavior that facilitate trust in their clinical relationship. Strengthening these provider behaviors may increase trust with patients and thus improve disclosure of and referral for IPV.

KEY WORDS: trust; domestic violence; physician-patient relations; patient-centered care; participatory research.

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Patient trust in the health care provider is a vital component of the patient-provider relationship.^{1,2}

Thom identified several physician behaviors that predict trust, including being caring, exhibiting technical competence, and communicating clearly.³⁻⁶ Similarly, Mechanic defined key elements of patient-physician trust in the context of managed care. His findings suggest that trust in one's physician derives from direct experience and strengthens when patients can make their own choices regarding medical care.⁷ However, little is known about patient trust among survivors of intimate partner violence (IPV).

Trust issues may differ among survivors of IPV because of the IPV dynamics, that is, progressive exertion of power and control, with loss of autonomy and social isolation.⁸ Indeed, the available evidence suggests that providers are concerned that their IPV survivor patients may not trust them,^{9,10} and IPV survivors report that trust is important to disclosure of abuse.^{11,12} Because a health care provider's main intervention with survivors of IPV is identification and referral, a lack of trust in the patient-provider relationship can impede interventions for IPV in the health care setting.

Although trust has been identified as important, it is not known what provider attributes or behaviors influence trust. We studied characteristics of trust in the patient-provider relationship from the perspective of IPV survivors. In particular, we sought to understand what elements of trust in the patient-provider relationship were unique to this population. For purposes of this study, we defined trust in the health care provider as characteristics of the provider that "foster confidence in the health care relationship."

METHODS

Study Design

Ethnographic interviewing elicited IPV survivors' experiences interacting with both physician and nonphysician health care providers. Grounded theory, a qualitative method of analysis, was used to elucidate views on patient-provider trust revealed in the narrative data.¹³

Study Participants

Survivors of IPV were recruited from community-based domestic violence counseling or sheltering programs in eastern Massachusetts. They were recruited by: 1) referral by the staff of a local domestic violence shelter or 2) through response to a flier sent to all domestic violence programs in eastern Massachusetts. Eligibility requirements included: female gender, ability to speak English, age 18 to 64, and history of an abusive intimate partner relationship within the past 3 years. Each participant was compensated \$25.

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Interview Technique

After approval by the Boston University Medical Center Institutional Review Board, data were collected from October 1996 through November 2000. Open-ended, in-depth interviews were conducted by 1 of 2 authors (JL, TB). All participants were interviewed in a private location. Each interview was audiotaped and lasted 1 to 2 hours.

Using an interview guide, the interviewer asked participants to describe encounters with health care providers, both related and unrelated to any medical or social problem associated with the abusive relationship. A health care provider was defined as a physician or nonphysician care provider (e.g., nurse, physician assistant, therapist, etc.). The interviewer also asked about barriers to accessing health care, about the abusive relationship, and general demographic information. The interviews were iterative, so that participants enrolled later in the data collection interval were probed about concepts developed during previous interview analysis until no new themes or concepts were derived.

Analysis

Each audiotaped interview was transcribed verbatim by a professional transcriber and reviewed for accuracy. All identifying information was altered. Each author independently reviewed all transcripts to elucidate meaning and identify prominent dimensions revealed in the survivors' words and examples. A preliminary coding scheme was developed as the authors met to discuss each of the first 10 interviews and develop coding labels for each concept raised by the participants. After 12 interviews, an advisory group met to discuss initial results from the interviews. The group consisted of 4 domestic violence advocates, 3 of whom self-identified as IPV survivors. Group members read 2 transcripts chosen for contrasting ideas. The group clarified and expanded themes previously identified, and also introduced new themes.

The authors then independently coded the subsequent interviews using this revised coding scheme. Coding was compared and differences of opinion were resolved through examination of the text. Coding data were compiled using NUD*ST, a computer software program for qualitative research (QSR International, Pty., Ltd., Melbourne, Australia).

The authors then reviewed every example listed in each coding category to ensure both its fidelity to the assigned concept and its relationship to descriptions of trust, before grouping individual coding dimensions into larger concepts. Finally, the conceptual framework developed was compared with the existing medical, psychological, and public health literature to provide context and setting. There were no conflicts of interest among any of the authors.

RESULTS

Twenty-seven female survivors of IPV, with a median age of 30 years (range 18–56 years), were interviewed.

Residential shelter staff recruited 14, while 13 responded to a flier. Sixteen participants (67%) were living in a residential program for battered women at the time of the interview. Two thirds were ethnic or racial minorities. Sociodemographic characteristics of the women are listed in Table 1.

Participants reported different severity of physical abuse. One participant experienced no physical injury, 12 (44%) experienced physical injury not requiring medical care, and 14 (52%) experienced physical injury requiring medical care. All participants reported multiple medical contacts during the period of abuse.

Each participant described a range of positive and negative experiences with health care providers for a total of 169 encounters, with an average of 6 encounters per participant (range 2–13). Providers' professional designations were sometimes difficult to determine, but included physicians, nurses, therapists, and other medical support staff. The duration of the patient-provider relationships described varied widely and ranged from brief emergency department encounters to decades with the same primary care provider. We were able to determine the gender of providers in 107 encounters (56 female, 47 male, 4 mixed groups). Analyses of these encounters as well as direct questioning about physician gender failed to find an association between physician gender and the presence or absence of trust in their health care relationships.

Table 1. Participant Demographic Information

Characteristic	Value (N = 27)	
	n	%
Ethnicity		
African American	9	33
Hispanic	9	33
White	5	19
Mixed/other	4	15
Education		
<12 y	11	41
12 y or GED	5	19
Some college	11	41
Children		
0	4	15
1–2	13	48
3+	10	37
Born in the United States		
Yes	22	81
No	5	19
Health insurance		
Medicaid	18	67
Other insurance	3	11
None	6	22
First language		
English	15	56
Spanish	10	37
Portuguese	2	7
History of substance abuse		
Yes	12	44
No	15	66

Participants' descriptions of their encounters with health care providers revealed 5 components of provider behavior upon which trust was based. They include: 1) communication; 2) professional competency; 3) practice

style; 4) caring; and 5) emotional equality. Each component has multiple dimensions (Table 2). In the following analysis, we illustrate each component, emphasizing dimensions unique to this population.

Table 2. Conceptual Categories of Trust

Conceptual Categories	Dimensions, Participant Responses
I. Communication	<ul style="list-style-type: none"> • Talks about medical issues "They make me feel very comfortable. They answer all my questions. If there's something seriously wrong, they don't hide it from me. They come out and tell me." • Talks about abuse "They treat me nice. They just asked me what happened and I tell them... then I start crying... they give me tissues to stop crying and everything is gonna be fine." • Listens "I can call her now and talk to her... She'll still listen to me... That's the type of person I like. You know, that's the reason why I left [the previous provider] is because he wasn't listening to me."
II. Professional competency	<ul style="list-style-type: none"> • Knowledgeable/thorough "She's a WONDERFUL lady... she's kinda young, but she knows what she's doin'... She go deep. 'Where's the problems?' You know? So you don't go home, just takin' the medicine for pain and nothing's happened." • Familiar "... it reached the point that... all I used was the emergency room. Because I was just getting so worn down by going in and trusting somebody else. I still get anxious about going but she puts me at ease, she knows the questions to ask. She knows about my history."
III. Practice style	<ul style="list-style-type: none"> • Accessible "I trust him with my life... He's also been the one to help me to go to detox, and he's always been there. ALWAYS. I can call the pager number in the middle of the night and put my number in and he calls back. He's... I love him." • Takes time "... this particular nurse, she was my little angel... usually everybody's in a rush... but she always took time, ... she really spent a lot of time. I don't know if she ever got in trouble for that, but she spent a lot of time with me and a lot of time with my family." • Confidentiality "I can say that I trust him... those things that I've told him that... that I know that nobody else knew... and, to me, I mean, that's confidentiality." • Shares control "She talked to me... and explained what a shelter would... be able to do for me, even if I didn't want to make any changes, that I can at least have space to be somewhere other than home, to make some decisions."
IV. Caring	<ul style="list-style-type: none"> • Nonverbal "He's a very loving person... I've never seen him upset. He always has a smile... And when you look into [his] eyes, you see that radiant smile, of peace. Inner peace... a little pat on your back when you leave." • Nonjudgmental "I didn't tell anyone about the abuse because I didn't want anyone to down me, and she didn't down me. She would just make sure I was OK." • Empower "It got verbalized... she just said things like 'you don't deserve to be treated that way.' And those were monumental statements." • Persistence "... in all honesty if I had been asked the first time I wouldn't take it. But if you had asked me four or five times I might actually have thought that you wanted to know."
V. Emotional equality	<ul style="list-style-type: none"> • Just like me "... She told me her daughter was in a similar situation... So, I felt a lot more comfortable... And that's why I'm here today." • Shares feelings "She asks about my home, personal questions, about the children. And she tells me about her family. This is why I consider her my friend."

Communication

When participants reported the presence of open dialog with a health care provider, they perceived a positive trusting relationship and a sense of being heard and understood. Conversely, participants perceived a lack of open communication to hinder trust.

An essential dimension of communication was the perception that providers presented medical information in an open and comprehensive manner. Additionally, 24 participants (89%) emphasized the importance of a provider's willingness to talk openly about issues of violence/abuse.

Another important dimension of communication, noted by 15 participants (56%), was the provider's willingness to listen respectfully and respond in a way that expressed an effort to hear and understand the patient's individual concerns.

Professional Competency

Participants repeatedly framed their positive and negative feelings about providers in terms of their professional competency. When a participant was confident in the clinical ability of her provider, she was more likely to place trust in their care relationship. Two distinct dimensions arose in analyzing what provider characteristics led participants to judge them as capable.

More than half ($n = 14$) of participants emphasized the importance of perceiving their providers as not only knowledgeable but also thorough. Such thoroughness was demonstrated by asking about social problems that might affect health. Participants also described competency in terms of a provider's familiarity with them as individuals. Eighteen participants (67%) noted specific instances of feeling known that derived from the length of the care relationship, the provider asking personal questions, caring for family members, or being known to the participant through contact outside of the medical setting.

Practice Style

Practice style, the logistics of a clinical practice and a provider's manner of approaching confidentiality and decision making, contributed to the development of trust.

Participants valued provider accessibility. They considered a provider accessible if s/he was available in a timely manner and easy to contact (via telephone and/or appointment). When participants felt their providers were logistically accessible, they also were likely to perceive them as emotionally accessible. Nearly half of participants ($n = 13$) reported that a provider's willingness to take time during encounters—indicated by the provider sitting down, listening closely, or answering questions—was an important component of trust, as it communicated a provider's interest and concern.

The ability of a provider to honor patient confidentiality was most explicitly connected to the development of

trust. Sixteen participants (59%) linked the significance of confidentiality to their ability to trust a given provider. Here, a young mother describes the provider to whom she disclosed her abusive situation:

I can say that I trust him...those things that I've told him that...that I know that nobody else knew...And, to me, I mean, that's confidentiality.

Confidentiality had particular importance for participants when the use of information had potential consequences. For example, several participants expressed concern that a provider's failure to keep confidentiality could lead to retribution from the abuser or involvement of Child Protective Services. Participants, many of whom felt shame at being victims of IPV, also worried that the abuse might become known publicly, exposing their situation to family, neighbors, or friends.

I was afraid that, even though I trusted him, I didn't know who (the doctor) was gonna talk to, or who he was gonna contact...especially if my son was involved.

When a participant felt confidentiality was respected by a provider, she was likely to feel empowered in the care relationship and in making decisions around medical treatment and/or abuse. Communicating confidentiality helped to foster participants' sense of control over their situations, and directly nurture their trust.

Similarly, 25 participants emphasized the importance of feeling their provider was willing to share control of both their personal information (as with confidentiality) and their health care decision making. Participants were likely to place trust in their provider when they felt they were treated as individuals capable of making informed choices about their own well-being, as illustrated by a participant who describes a trusted provider:

She talked to me...and explained what a shelter would...be able to do for me, even if I didn't want to make any changes, that I can at least have space to be somewhere other than home, to make some decisions...

Caring

Participants noted the strong impact of providers' personal commitment to them on the level of trust. Twenty-four participants (89%) suggested that they were likely to trust a provider who showed caring and concern for their well-being. Four dimensions, each involving a specific provider behavior or characteristic, emerged when we analyzed participants' perceptions of caring in the context of trust.

Participants noted that nonverbal communication could convey a sense of caring. They described gestures and body language that they associated with careful attention, warmth, and patience—for example, a smile, a pat on the back, sitting down to talk, and making eye contact. Likewise, participants were sensitive to perceived impatience or judgment in provider's speech, looks, or gestures. Six participants stressed the value of providers

who conveyed respect through nonjudgmental statements or gestures, and who avoided actions that might provoke embarrassment or shame, as in the following excerpt:

I didn't tell anyone about the abuse because I didn't want anyone to down me, and she didn't down me. She would just make sure I was OK.

On the other hand, 17 participants described negative encounters with providers they felt looked down upon them, whether because of their class, substance use, or involvement in an abusive relationship.

Thirteen participants (48%) discussed the role that empowering statements, such as "you don't deserve this," played in creating a positive encounter between themselves and a provider. These statements served multiple functions in building trust, concurrently validating the patient's experience as a victim, recognizing abuse without shaming or placing blame, and encouraging the patient to remain hopeful and feel she has options, as described by this survivor:

It got verbalized... she just said things like "you don't deserve to be treated that way." And those were monumental statements.

Nine participants described how a provider's willingness to take a persistent interest in their well-being led to the deepening of trust in the relationship. Participants discussed providers' repetitive actions, including asking about abuse, talking about abuse, making empowering statements, being patient and not "giving up" on them. As noted by one subject:

...in all honesty if I had been asked the first time I wouldn't take it. But if you had asked me four or five times I might actually have thought that you wanted to know.

Five participants also described an experience in which a provider's persistence was unwanted, and in certain instances, was felt to endanger the safety of the participant or her partner. In these experiences, the participants did not feel that their autonomy was respected. Persistence was felt to be positive when it was done in a caring manner, conveying respect for the participant's wishes and boundaries, and when conducted in a setting that was safe, and confidential.

Emotional Equality

The concept of emotional equality was raised in nearly two thirds ($n = 17$) of the interviews, and deserves particular attention because it characterized several patient-provider relationships described by participants as being instrumental in the decision to leave an abusive partner. In these relationships, trust had developed to the degree where participants felt supported enough by the provider to make a risky lifestyle change. Participants portrayed providers who were willing and able to engage on a personal level with their patients, creating greater equality in the patient-provider relationship.

Seventeen participants (63%) depicted a greater closeness with providers who they felt shared common ethnicity or life experiences (including abuse). The perception of commonalities bolstered participants' confidence that they were in a supportive environment, as pointed out by this survivor:

... She told me her daughter was in a similar situation... So, I felt a lot more comfortable... And that's why I'm here today.

Although gender would seem to be a potentially important commonality, much like ethnicity or common experience, participants' narratives revealed no clear relationship between the gender of the provider and trust in the care relationship.

Similarly, participants reported that trusting providers who were willing to share their own feelings. Ten participants (37%) explained that a provider who spoke about his or her own emotions made it easier for them to place trust in that care relationship, as this participant explains:

She asks about my home, personal questions, about the children. And she tells me about her family. This is why I consider her my friend.

DISCUSSION

This study of female survivors of IPV and their experiences with health care providers supports previous work on both trust within health care relationships and the role of trust in disclosure among survivors of IPV. Our findings are consistent with the growing body of literature indicating that survivors of IPV perceive lack of trust as a barrier to disclosure of abuse to health care providers.^{9,14,15} Furthermore, the elements of trust identified in this study fit well within the conceptual framework of patient-centeredness, an approach considered central to the delivery of high quality health care.

The provider behaviors found to be associated with trust among these survivors are similar to published descriptions of trust.^{3-7,16} As in Thom's and Mechanic's work, our participants emphasized the importance of the presence of competent actions and effective communication as well as behaviors that demonstrated caring and concern for their well-being. We also identified several elements of trust in the patient-provider relationship unique to our population of IPV survivors. These unique components stood out most dramatically in those encounters where participants reported disclosure of abuse or change in the status of the abusive relationship.

For example, although the importance of confidentiality was noted in prior research on trust,⁷ it held particular prominence for our participants, who felt the lack of it put them at considerable personal risk. The presence of explicit confidentiality within their care relationships allowed them to overcome barriers to disclosure and seeking help, such as shame, fear of reprisals, and fear of police or child protective services involvement. When present, explicit confidentiality seemed to empower the participant in the

care relationship and in making decisions around medical treatment and/or abuse.

The importance of confidentiality suggests that providers should specifically address it when approaching patients with questions of interpersonal violence. Explicit confidentiality on part of the provider requires an expression of its limitations as well, as in the case of active child abuse, where the provider is a mandated reporter. Studies on screening or intervention should assess the effect of explicit confidentiality on disclosure with health care providers.

While decision-making control has been noted previously in studies of trust, it was confined to the realm of institutional control, as in a managed care setting.⁷ In this study, the realm of control was centered on the individual provider. Providers who shared the decision-making process nurtured participants' sense of control, providing an empowering contrast to abusive relationships many participants viewed as uncontrollable.

The importance of emotional equality, a concept not previously emphasized in the literature on patient-physician trust, stood out strongly among study participants. When emotional equality was present, such as when providers willingly shared personal information, caring was transformed—the provider was more likely to be perceived as an equal than an authority figure. This served to eliminate the inherent imbalance of knowledge and power in health care relationships. When a provider shared personal information, it increased trust in the care relationship. Emotional equality was described most frequently by those participants who actually left the abusive relationship as a result of the patient-provider relationship. It may be that the exchange of personal information encouraged participants to view the care relationship as a safe environment for the disclosure of abuse, as well as further empowering them to consider their options. Introducing an environment of emotional equality raises concern about maintenance of professional boundaries. However, when providers simultaneously follow the ethical principals of beneficence, non-maleficence, and confidentiality, fostering emotional equality may enhance outcomes.¹⁷

With a national emphasis to improve quality of health care, patient-centeredness has emerged as a focus of an extensive body of literature. The conceptual framework of “patient-centered” care underscores the importance of developing trust in the patient-provider relationship. Current theories of a patient-centered approach stem from a biopsychosocial perspective in which the doctor and patient share power and responsibility through a therapeutic alliance.¹⁸ Patient-centeredness represents a style of practice in which the provider is responsive to the patients' wants, needs, and preferences, and has been associated with heightened patient satisfaction as well as improved health outcomes.¹⁹ Providers in our study who communicated directly, respected confidentiality, shared decision making, and engaged on a personal level with their patients were effectively forging a patient-centered therapeutic alliance. When these behaviors were present in the care

relationship, our participants were more likely to perceive their provider as trustworthy. Furthermore, their cumulative presence may result in the disclosure of abuse and/or a positive outcome.

Although this qualitative methodology gives rich, in-depth information about experiences with health care providers, our study methodology has several limitations. The use of ethnographic interviewing with a small number of participants has limited generalizability. Because participants in this study were self-selected from a group of survivors already engaged in community-based violence programs, they may have been more likely to be trusting. However, understanding the elements of trust in this population of women who have sought help is likely to reflect women who come to health care providers, a population for which interventions can be targeted.

Another limitation is that not all participants were asked directly about trust. This is due to the iterative nature of qualitative research, in that trust emerged as an important theme later in the analysis. To compensate for the lack of direct questioning, we constructed an indirect understanding of trust through their narratives. We accounted for this by rigorously testing the content of each code against a preset definition of trust. In this manner, we excluded concepts that were important for disclosure of abuse, for example, but that were not linked with developing trust with the care provider in the participant's narratives.

Conclusions

We identified elements of provider behavior that directly enhance or hinder trust in the patient-provider relationship among survivors of IPV. Medical providers must go beyond the traditional biomedical model when caring for survivors of IPV and incorporate a patient-centered approach, which puts patient-identified needs first. In particular, providers and health care institutions should explicitly state confidentiality procedures and remain aware of the potential impact of their behavior on patients. Future studies should use quantitative measures of trust to predict outcomes (e.g., disclosure, health status) among survivors of IPV. Increasing trust in the patient-provider relationship might allow for more disclosure of abuse and ultimately, more options for survivors.

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REFERENCES

1. Kaplan SH, Greenfield S, Ware JE Jr. Assessing the effects of physician-patient interactions on the outcomes of chronic disease. *Med Care*. 1989;27(suppl 3):110-27.
2. Safran DG, Taira DA, Rogers WH, Kosinski M, Ware JE, Tarlov AR.

- Linking primary care performance to outcomes of care. *J Fam Pract.* 1998;47:213-20.
3. Thom DH. Physician behaviors that predict patient trust. *J Fam Pract.* 2001;50:323-8.
 4. Thom DH, Campbell B. Patient-physician trust: an exploratory study. *J Fam Pract.* 1997;44:169-76.
 5. Thom DH. Training physicians to increase patient trust. *J Eval Clin Pract.* 2000;6:245-53.
 6. Thom DH, Bloch DA, Segal ES. An intervention to increase patients' trust in their physicians. Stanford Trust Study Physician Group. *Acad Med.* 1999;74:195-8.
 7. Mechanic D. The functions and limitations of trust in the provision of medical care. *J Health Polit Policy Law.* 1998;23:661-86.
 8. Freund K. Domestic violence. In: Carr PF, Freund KM, Somani S, eds. *The Medical Care of Women.* Philadelphia, Pa: W.B. Saunders Company; 1995:722-8.
 9. Gerbert B, Caspers N, Bronstone A, Moe J, Abercrombie P. A qualitative analysis of how physicians with expertise in domestic violence approach the identification of victims. *Ann Intern Med.* 1999;131:578-84.
 10. Sugg NK, Inui T. Primary care physicians' response to domestic violence. *JAMA.* 1992;267:3157-60.
 11. McCauley J, Yurk RA, Jenckes MW, Ford DE. Inside "Pandora's Box": abused women's experiences with clinicians and health services. *J Gen Intern Med.* 1998;13:549-55.
 12. Rodriguez MA, Quiroga SS, Bauer HM. Breaking the silence: battered women's perspectives on medical care. *Arch Fam Med.* 1996;5:153-8.
 13. Strauss A, Corbin JM. *Basics of Qualitative Research: Grounded Theory Procedures and Techniques.* Newbury Park, Calif: Sage Publications; 1990.
 14. McCauley J, Kern DE, Kolodner K, et al. The "Battering Syndrome": prevalence and clinical characteristics of domestic violence in primary care internal medicine practices. *Ann Intern Med.* 1995;123:737-46.
 15. Friedman LS, Samet JH, Roberts MS, Hudlin M, Hans P. Inquiry about victimization experiences. *Arch Intern Med.* 1992;152:1186-90.
 16. Thom DH, Ribisl KM, Stewart AL, Luke DA. Further validation and reliability testing of the Trust in Physician Scale. The Stanford Trust Study Physicians. *Med Care.* 1999;37:510-7.
 17. Butterfield MI, Frayne SM. Boundary issues in the management of patients with previous victimization. In: Liebschutz JL, Frayne SM, Saxe GN, eds. *Violence Against Women: A Physician's Guide to Identification and Management.* Philadelphia, Pa: ACP-ASIM Press; 2003:253-61.
 18. Mead N, Bower P. Patient-centeredness: a conceptual framework and review of the empirical literature. *Soc Sci Med.* 2000;51:1087-110.
 19. Stewart M, Brown JB, Donner A, et al. The impact of patient-centered care on outcomes. *J Fam Pract.* 2000;49:796-804.

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