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Short communication

It takes two to tango: A dyadic approach to understanding the medication dialogue in patient-provider relationships

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ABSTRACT

Objective: To describe typologies of dyadic communication exchanges between primary care providers and their hypertensive patients about prescribed antihypertensive medications.
Methods: Qualitative analysis of 94 audiotaped patient-provider encounters, using grounded theory methodology.
Results: Four types of dyadic exchanges were identified: *Interactive* (53% of interactions), *divergent-traditional* (24% of interactions), *convergent-traditional* (17% of interactions) and *disconnected* (6% of interactions). In the interactive and convergent-traditional types, providers adopted a patient-centered approach and used communication behaviors to engage patients in the relationship. Patients in these interactions adopted either an active role in the visit (*interactive*), or a passive role (*convergent-traditional*). The *divergent-traditional* type was characterized by provider verbal dominance, which inhibited patients' ability to ask questions, seek information, or check understanding of information. In the *disconnected* types, providers used mainly closed-ended questions and terse directives to gather and convey information, which was often disregarded by patients who instead diverted the conversation to psychosocial issues.
Conclusions: This study identified interdependent patient-provider communication styles that can either facilitate or hinder discussions about prescribed medications.
Practice implications: Examining the processes that underlie dyadic communication in patient-provider interactions is an essential first step to developing interventions that can improve the patient-provider relationship and patient health behaviors.

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1. Introduction

Collaborative patient-provider communication [including patient-centeredness and shared decision-making], plays an important role in helping patients with chronic diseases develop an accurate understanding of their disease and adhere to their treatment plan [1–4]. Despite the fact that it is dyadic, communication research has typically focused on *either* the provider (e.g., types of questions asked) or patient (e.g., type of information given) during clinical interactions [5,6]. However, in a conversation patients and providers influence each other's thoughts, attitudes, emotions, and behaviors [7]. Conversation analysis views patient-provider communication as a dyadic process that gives equal consideration to both partners [8,9]. This approach emphasizes the "co-construction of narratives" (i.e., stories jointly constructed) that are influenced by speaker and listener characteristics (e.g., age, gender), based on prior conversations, contextually-bound, and continuously being refined [10–12]. In this study we sought to empirically develop a typology of dyadic exchanges that describes how primary care providers and their hypertensive patients discuss antihypertensive medications. This process was modeled after social science research that has identified typologies of dyadic interactions [8,10,13,14].

2. Methods

Data were collected as part of an observational study conducted in three ambulatory care centers in New York City [15]. Eligible patients: 1) self-identified as non-Hispanic African American or White; 2) were diagnosed with hypertension and taking ≥1

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antihypertensive medication; 3) were ≥18 years of age and; 4) had at least one prior visit with the participating provider. All MDs/DOs or nurse practitioners providing care to enrolled patients were eligible. The Institutional Review Board of New York University Langone Health approved the study.

We audiotaped clinical interactions between 29 providers and 94 hypertensive patients (mean 3.44 patients per provider). After obtaining informed consent, research assistants started the tape recorder in the exam room and then left. Providers and patients were able to turn off the recorder at any time; 3% of patients requested this option. Patient and provider demographic data were collected prior to the audiotaped interaction. Patient-level data included age, sex, race/ethnicity, employment status, educational and income level, insurance status, and length of relationship with their provider. Data on antihypertensive medications and blood pressure were abstracted from patients' medical record. Provider-level data included age, sex, race/ethnicity, and duration of practice at the site. In addition, data on length of the interaction (i.e., total time in minutes from the first spoken utterance of the conversation to the final utterance) and talk-time (i.e., total number of utterances spoken by patients vs. providers) were derived from the audiotaped interactions. Utterances were coded for each independent and every non-restrictive dependent clause of a sentence spoken by the patient or provider.

The audiotaped interactions were transcribed verbatim and analyzed in two steps using the grounded theory constant comparison method [16,17]. In the first step, two members of the research team with expertise in behavioral medicine and ethnographic research reviewed the transcripts to identify overarching themes related to patient-provider communication behaviors (e.g., question-asking) and discussions about medication-taking (e.g., side effects). The coders iteratively developed a codebook to maintain coding consistency and transparency in coding decisions [18]. Eighteen (20%) transcripts were coded by a third reviewer to verify the themes. Discrepancies in coding were resolved through an interactive process of re-reading and discussing the transcripts until consensus was reached; the codebook was updated to reflect any changes. In the second step, two other members of the team reviewed the coded transcripts to identify dyadic communication behaviors that patients and providers would use in response to their partner's behavior (e.g., content of information given in response to provider questioning). As in step 1, a subset of transcripts was double-coded by an independent reviewer to verify the analysis. For both steps, assessments of inter-rater agreement were calculated using Krippendorff's alpha to ensure an acceptable level of agreement was reached (>0.80) between the coders [19].

3. Results

Table 1 shows participant and visit characteristics for the 94 interactions. Below we describe the typologies and the reciprocal patient and provider communication behaviors characteristic of each type.

3.1. Description of the patient-provider communication typologies

Four typologies of patient-provider communication were empirically derived from the analysis: *interactive, divergent-traditional, traditional-convergent, and disconnected*. Table 2

Table 1
Comparison of participant and visit characteristics by typology of patient-provider communication.

	Total Sample (N = 94)	Interactive (n = 54)	Convergent-Traditional (n = 15)	Divergent-Traditional (n = 25)	Disconnected (n = 7)	P[a]
Patient Characteristics						
Female Gender: n (%)	58 (57.4)	34 (63)	14 (46.7)	7 (56)	3 (42.9)	0.16
Mean Age (SD)	59.4 (10.8)	57.8 (11.5)	64.2 (8.4)	60.8 (10.9)	59.4 (10.8)	0.18
African American: n (%)	61 (60.4)	30 (55.6)	9 (60.0)	17 (68.0)	5 (71.4)	0.38
Income <$40,000: n (%)	67 (66.4)	37 (68.5)	8 (53.3)	17 (68.0)	5 (71.4)	0.59
Insurance Status: n(%)						0.90
None	19 (18.8)	9 (16.7)	3 (20.0)	5 (20.0)	2 (28.6)	
Medicaid	41 (40.6)	25 (46.3)	4 (26.7)	7 (28.0)	1 (14.3)	
Medicare	26 (25.7)	11 (20.3)	5 (33.4)	11 (44.0)	3 (42.9)	
Private	15 (14.9)	9 (16.7)	3 (20.0)	2 (8.0)	1 (14.3)	
High School and above: n (%)	90 (89.0)	49 (90.7)	12 (80)	23 (92)	5 (85.7)	0.74
Unemployed: n (%)	68 (67.3)	16 (70.4)	5 (66.7)	10 (60)	2 (71.4)	0.79
Mean SBP and DBP (SD)	132.2 (16.6)/ 77.0 (12.1)	133.5 (16.8)/ 79.5 (12.4)	123.5 (16.5)/ 74.5 (12.1)	132.2 (16.5)/ 74.2 (9.1)	141.2 (11.0)/ 74.2 (17.7)	0.19 0.35
Mean # Antihypertensive Medications (SD)	2.2 (1.2)	2.4 (1.4)	2.6 (1.0)	1.8 (0.8)	1.7 (0.8)	0.08
Mean Years with HTN (SD)	13.8 (11.3)	13.9 (11.4)	19.5 (13.3)	10.4 (8.9)	12.3 (9.8)	0.10
Diabetes: n (%)	57 (56.4)	31 (57.4)	7 (46.7)	16 (64)	3 (42.9)	0.41
Stroke: n (%)	15 (14.9)	7 (13.0)	3 (20.0)	4 (16.0)	1 (14.3)	0.62
Kidney Disease: n (%)	9 (8.9)	7 (13.0)	1 (11.1)	1 (11.1)	0 (0)	0.17
≥1 Years with PCP: n (%)	65 (64.4)	35 (64.8)	10 (66.7)	14 (56.0)	6 (85.7)	0.50
PCP Characteristics						
Female Gender: n (%)	18 (66.7)	9 (62.9)	5 (62.5)	2 (66.7)	2 (66.7)	0.89
Mean Age (SD)	36.2 (6.0)	33.4 (5.7)	35.7 (4.0)	42.1 (3.7)	33.3 (3.1)	0.004
Race/Ethnicity: n (%)						0.19
White	15 (55.6)	8 (61.5)	1 (33.3)	5 (62.5)	1 (33.3)	
African American	5 (18.5)	2 (15.4)	0 (0)	2 (25.0)	1 (33.3)	
Latino	2 (7.4)	2 (15.4)	0 (0)	0 (0)	0 (0)	
Asian	5 (18.5)	1 (7.7)	2 (66.7)	1 (12.5)	1 (33.3)	
Mean Years at Clinic (SD)	5.8 (4.7)	4.3 (3.8)	6.0 (4.4)	9.0 (5.8)	3.3 (2.1)	0.12
Visit Characteristics						
Mean Visit Length: minute (SD)	24.8 (10.2)	25.8 (10.6)	21.3 (7.1)	22.1 (9.7)	31.3 (7.1)	0.08
Mean Talk-time Ratio[b] (SD)	1.20 (1.13)	1.05 (1.03)	1.18 (1.31)	1.43 (1.32)	0.93 (1.01)	0.44

SD: Standard Deviation; SBP: Systolic blood pressure; DBP: Diastolic blood pressure; HTN: Hypertension; PCP: Primary care provider.
[a] comparisons across dyad types using a $\chi 2$ or standard *t*-test.
[b] Ratio of utterances spoken by patients vs. providers during the visit; scores >1 is equivalent to greater provider talk.

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