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Physicians' responses to patients' expressions of negative emotions in hospital consultations: A video-based observational study

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ABSTRACT

Objective: Patients express their negative emotions in medical consultations either implicitly as cue to an underlying unpleasant emotion or explicitly as a clear, unambiguous concern. The health provider's response to such cues and concerns is important for the outcome of consultations. Yet, physicians often neglect patient's negative emotions. Most studies of this subject are from primary health care. We aimed to describe how physicians in a hospital respond to negative emotions in an outpatient setting.
Methods: Ninety six consultations were videotaped in a general teaching hospital. The Verona Coding Definitions of Emotional Sequences was used to identify patients' expression of negative emotions in terms of cue and concern and to code physicians' subsequent responses. Cohen's kappa was used as interrater reliability measure. Acceptable kappa level was set to .60.
Results: We observed 163 expressions of negative emotions. In general, the physician responses to patients' cues and concerns did not include follow up or exploration. Concerns more often than cues led to lack of emotional exploration.
Conclusions: When patients expressed negative emotions or cues to such, hospital physicians tended to move away from emotional communication, particularly if the emotion was expressed as an explicit concern.
Practice implications: Medical training should enable physicians' to explore the patients' emotions in situations where it will improve the medical treatment.

1. Introduction

The health provider's response to a patient's cue to negative emotions or concern is of importance for the outcome of the provider–patient interaction in a variety of ways: comforting communication by the physician in response to negative emotions in the patient has been connected to degree of patient satisfaction [1]. Encouraging responses by the nurse on emotional cues improved patient recollection of medical treatment information [2]. Empathic response to negative emotions from the provider is important for the patient to feel listened to [3], and, on the side of the physician, to get diagnostic information from the patient [4]. According to Pollak et al. [5] "Empathic continuers" to patients' negative emotional statements or cues to such, decrease the need for a patient to restate the message and increases the likelihood of future disclosure of concerns. Even for the adherence of treatment plans, empathic physician response has been found to have a positive effect [6], and also for the clarification of consultation goals [7].

Further, absence of a proper response from the physician has been shown to increase the likelihood of the patient to emit more cues [8]. This has also been observed qualitatively and named the "escalation effect" [3]. So both the presence and absence of proper responses are of interest when we categorise physician verbal behaviour subsequent to patients' cue to negative emotions or concerns.

It is therefore a paradox that we know physicians often neglect the patient's verbal communication regarding negative emotions and cues to negative emotions [3,6]. If negative emotions in cancer patients are not addressed, it can affect patient functioning, emotional well-being, and may negatively affect survival [9–11].

Dealing with patients' negative emotions has a long tradition in psychotherapy and is the very core of the psychiatric profession. However, dealing with patients' negative emotions is not necessary considered a core skill in other medical specialities: in oncology, physicians have expressed lack of confidence in addressing patient emotional issues [12], under-detection of emotional needs is common [13,14], and many studies report

Abbreviations: CC, cue to negative emotions, concern; VR-CoDES, The Verona Coding Definitions of Emotional Sequences.

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that cue to negative emotions and concerns are often bypassed by the health provider [15–17]. This means that empathic opportunities are not used to its potential in the physician–patient interaction.

Most studies of this subject are from primary health and cancer care, and little is known about the actual responses to patients' negative emotions in hospital settings. As part of an intervention study, a large set of videotapes was collected from a 500-bed teaching hospital in the capital area of Norway (The Akershus University Hospital communication skills study) [18]. In the current study we aimed to describe how hospital physicians respond to negative emotions expressed as cue or concern in outpatient clinics.

2. Methods

2.1. Subjects

The Akershus University Hospital communication skills study involved 72 physicians and 497 videotaped encounters from several departments in the same hospital. The physicians were randomly drawn from the body of hospital physicians under 60 years of age. Participating physicians did not differ significantly from non-participating physicians regarding age, gender, and position [18]. Patients were recruited consecutively on dates when the physicians were available, 94% gave informed consent [19]. Encounters were taped during a still camera and extended microphone placed preferably to catch both physician and patient expressions, sometimes this was not achievable due to lack of space or use of diagnostic devices.

From the list of included physicians in the Akershus University Hospital communication skills study we drew 25 physicians based on the following criteria: at least two available video-taped consultations in the dataset before and after a communications skills training intervention (not part of the current article), none of which should be bedside or paediatric consultations. This gave us 100 consultations. Six consultations were not suitable for the use of The Verona Coding Definitions of Emotional Sequences (VR-CoDES) and replaced with other consultations satisfying the inclusion criteria. Of the replacements only two video tapes could be used for the same reason. No further videos satisfying the inclusion criteria were available for replacements. The study thus ended up comprising 96 consultations from the following specialities: 27 from internal medicine, 46 from surgery, orthopaedics and ENT (ear, nose and throat), and 23 from anaesthesiology, neurology and gynaecology

2.2. Interaction analysis

The VR-CoDES was used to classify patients' expressions of negative emotions in terms of cue or concern and to identify the subsequent physician responses. It is a newly developed interna-

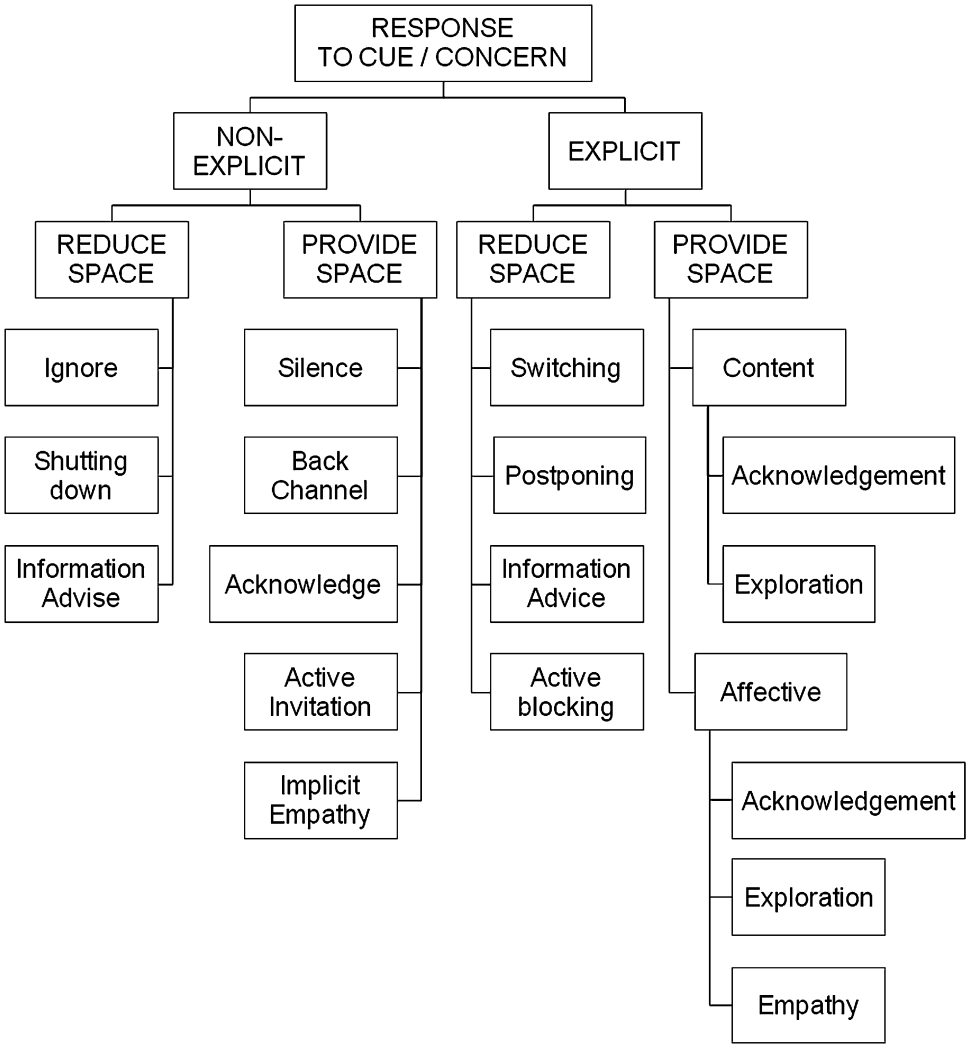

Fig. 1. The VRCoDES flow chart.