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Physician behavioral adaptability: A model to outstrip a "one size fits all" approach

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ABSTRACT

Objective: Based on a literature review, we propose a model of physician behavioral adaptability (PBA) with the goal of inspiring new research. PBA means that the physician adapts his or her behavior according to patients' different preferences. The PBA model shows how physicians infer patients' preferences and adapt their interaction behavior from one patient to the other. We claim that patients will benefit from better outcomes if their physicians show behavioral adaptability rather than a "one size fits all" approach.
Method: This literature review is based on a literature search of the PsycINFO® and MEDLINE® databases.
Results: The literature review and first results stemming from the authors' research support the validity and viability of parts of the PBA model. There is evidence suggesting that physicians are able to show behavioral flexibility when interacting with their different patients, that a match between patients' preferences and physician behavior is related to better consultation outcomes, and that physician behavioral adaptability is related to better consultation outcomes.
Practice implications: Training of physicians' behavioral flexibility and their ability to infer patients' preferences can facilitate physician behavioral adaptability and positive patient outcomes.

1. Introduction

Researchers in the field of physician-patient communication have invested considerable time and effort in the quest for best practices for physicians. Many agree that patient-centered communication is the best communication approach. Patient-centered communication entails the physician adopts the patient's perspective, addresses emotional aspects and shows empathy, as well as taking shared decisions and establishing a partnership in the physician–patient relationship [1,2]. Physicians who adopt such a patient-centered interaction style have patients with better subjective and objective medical consultation outcomes (e.g., satisfaction, trust, adherence, health improvement [3–6]). However, the findings are not unequivocal and some studies show contradictory or inconsistent results with respect to the benefit of patient-centered physician communication for patient outcomes [7–9]. Despite this not completely clear situation, best practice guidelines and communication trainings for physicians typically imply a patient-centered approach understood as a series of well-defined verbal and nonverbal behaviors for the physician to adopt, such as "eliciting and validating the patient's emotions", "avoiding interruptions", "forward lean to indicate attentiveness", or "maintaining eye contact" [10,p. 4].

Such best practice imperatives come with the disadvantage that they ignore a core aspect of the essence of patient-centeredness which is taking into account that each patient prefers a different interaction style. Patient-centeredness implies the notion of taking the perspective of each patient and–more importantly and often overlooked–of adapting the interaction behavior to each patient individually [11]. Indeed, not every patient benefits from a patient-centered physician communication style. Research shows that the relation between physicians' patient-centeredness and patients' outcomes depends on patients' characteristics. For instance, moderately anxious patients were less anxious when facing physician showing more patient-centeredness, but that more anxious patients' level of anxiety increased when facing the same kind of physicians [12]. Similarly, compared to less anxious patients, more anxious patients showed more tolerance for physicians perceived as more angry [13] or dominating [14]. So there seems to be no "one size fits all" in physician–patient communication confirming Epstein and Street's claim that "One key defining element of effective patient-centered communication is the clinician's ability to monitor and *consciously* adapt communication to meet the patient's needs" [10,p. 7].

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We thus posit that in order to be patient-centered, physicians should flexibly change their behavior from one patient to the other in order to meet each patient's particular preference in terms of physician interaction style. For instance, if a physician faces a patient who prefers a more paternalistic interaction style, he or she should be able to take the lead of the consultation with this particular patient and display more dominance behaviors like speaking more than the patient and setting the agenda, to mention just some examples. In another consultation, the same physician might face a patient who prefers more partnership in the physician-patient interaction and the physician should then be able to exhibit a more egalitarian interaction style such as making sure that the patient obtains equal amounts of speaking time and including the patient in the treatment decision-making process. We coin the term physician behavioral adaptability (PBA) to label a physician's ability to flexibly change his or her verbal and nonverbal behavior when facing different patients and to adapt his or her behavior according to the patients' different preferences.

The idea that PBA is an important factor of patient-centered care is not new, of course, and the inclusion of it in existing definitions and descriptions of patient-centeredness testifies to this. What is missing is more complex and comprehensive understanding of the mechanism of PBA and the empirical research that accompanies it. To date, there is only scarce research focusing on how physicians change and adapt their communication style from one patient to the other and how this affects patient outcomes. In the current paper, we develop a model of physician behavioral adaptability (PBA model) that is based on a literature review and on initial empirical data. The PBA model is useful for the understanding of the underlying mechanisms of behavioral adaptability and to guide future for research in this domain. We make the argument that PBA is an important factor of patient-centered communication that has so far been mostly overlooked.

1.1. Physician behavioral adaptability (PBA)

In order to show behavioral adaptability, the physician needs to correctly infer the patients' preferences and then attune his or her verbal and nonverbal communication to those preferences. We will look at this process in more detail in the PBA model (Fig. 1): during the medical encounter, the physician draws inferences about the patient's preferences based on the verbal and nonverbal behavior and the appearance cues emitted by the patient when interacting with the physician. Whether those inferences are correct depends on the physician's interpersonal accuracy defined as the ability to correctly assess others' traits and states based on their behaviors and appearance [15]. If the physician sees the patient for the first time, this is all the information available to the physician for inferring the patient's preferences. If the physician knows the patient or has patient information stemming from a referral or a colleague, this knowledge influences the inferred patient preferences on top of the actual verbal, nonverbal, and appearance cues the patient exhibits during the medical visit.

Based on the inferences, the physician choses the behavior he or she wants to exhibit. To display behaviors that will correspond to the patient's preference, the physician has to be able and willing to show the communication behavior that fits those preferences. Given that different patients have different preferences, the physician needs to master an array of different communication behaviors; he or she needs to possess what we call *behavioral flexibility*.

The patient perceives the physician's behavior and compares it to his or her actual preferences. To the extent that the physician's behavior is in line with the patient's actual preferences, the physician shows adaptive behavior.

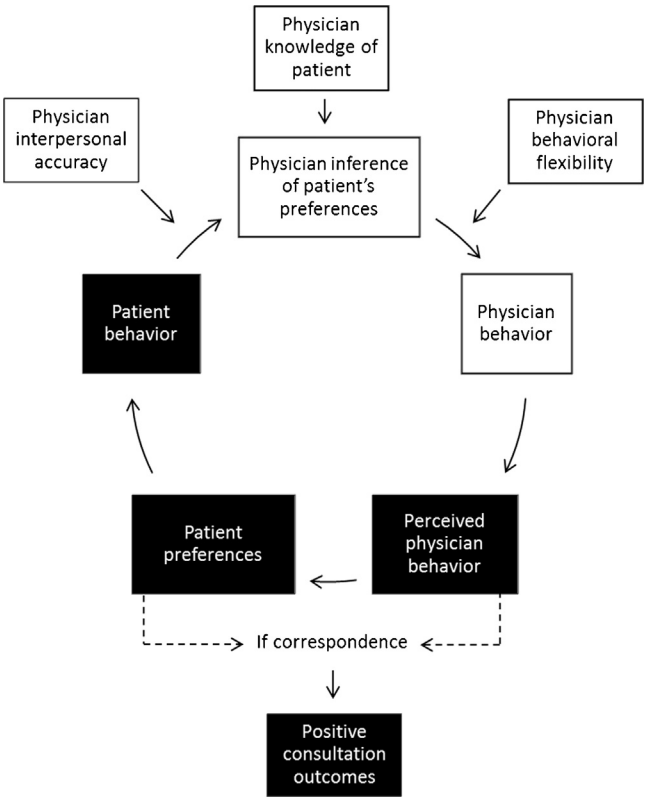

Fig. 1. The physician behavioral adaptability (PBA) model.
The black squares display the steps occurring on the patient's side and the white squares those happening on the physician's side.

Note that patient preferences are also influenced by the perception of the physician's behavior. Indeed, many theories and models point to the mutual influence of interactional partners' behaviors (see for example the Communication Accommodation Theory [16] or the Ecological Model of Communication [17]). In the medical interaction, patient's behavior influences the physician and the physician's behavior influences the patient as well. The loop construction of our model acknowledges this mutual influence.

As shown in Fig. 1, we posit that PBA will have positive outcomes for the patients. Expectancy Violation Theory (EVT [18]) theorizes that interaction outcomes are a consequence of expectations and preferences. Interestingly, the authors posit that expectations and preferences are two different concepts impacting on the outcomes at different stages of the assessment of the interaction. EVT posits that people naturally form expectations about their interaction partner's behaviors based on context, relationship, and communicator characteristics. If those expectations are met, the interaction is evaluated in a positive way. If the interaction partner's behaviors violate the expectations of a person but meet his or her preferences, the outcomes are evaluated as even more positive. If the expectations are violated and the preferences are not met, the outcomes are evaluated in a negative way [19]. We claim that PBA will lead to better consultation outcomes, because meeting patient's preferences will lead to positive interaction outcomes despite potential expectations violation.

2. Method

The main focus of this paper is to develop a model of physician behavioral adaptability that is based in relevant existing literature.