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Finding the right interactional temperature: Do colder patients need more warmth in physician communication style?

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ABSTRACT

Being aware of which communication style should be adopted when facing more difficult patients is important for physicians; it can help prevent patient reactions of dissatisfaction, mistrust, or non-adherence that can be detrimental to the process of care. Past research suggests that less agreeable patients are especially critical towards, and reactive to, their physician's communication style, compared to more agreeable patients. On the basis of the literature, we hypothesized that less agreeable patients would react more negatively than agreeable patients to lower levels of affiliativeness (i.e., warmth, friendliness) in the physicians, in terms of satisfaction with the physician, trust in the physician, and determination to adhere to the treatment. Thirty-six general practitioners (20 men/16 women) working in their own practice in Switzerland were filmed while interacting with 69 patients (36 men/33 women) of different ages (M = 50.7; SD = 18.19; range: 18–84) and presenting different medical problems (e.g., back pain, asthma, hypertension, diabetes). After the medical interview, patients filled in questionnaires measuring their satisfaction with the physician, their trust in the physician, their determination to adhere to the treatment, and their trait of agreeableness. Physician affiliativeness was coded on the basis of the video recordings. Physician gender and dominance, patient gender and age, as well as the gravity of the patient's medical condition were introduced as control variables in the analysis. Results confirmed our hypothesis for satisfaction and trust, but not for adherence; less agreeable patients reacted more negatively (in terms of satisfaction and trust) than agreeable patients to lower levels of affiliativeness in their physicians. This study suggests that physicians should be especially attentive to stay warm and friendly with people low in agreeableness because those patients' satisfaction and trust might be more easily lowered by a cold or distant physician communication style.

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Introduction

Some patients are more difficult to interact with and more difficult to treat (e.g., Breeze & Repper, 2002; Elder, Ricer, & Tobias, 2006; Haas, Leiser, Magill, & Sanyer, 2005; Steinmetz & Tabenkin, 2001; Strous, Ulman, & Kotler, 2006). Patients are considered as more difficult, for instance, when they do not adhere to treatment recommendations, when they are especially demanding (e.g., in terms of staff, time, or resources), when they are disruptive, when they are rude, or when they are hostile (Breeze & Repper, 2002; Schwenk, Marquez, Lefever, & Cohen, 1989; Steinmetz & Tabenkin, 2001). When such difficult behavior in the patient does not relate to an underlying psychopathology (e.g., psychosis, borderline personality) or to the complexity of the diagnosis (e.g., patient with multiple complaints), it often relates to personality characteristics represented by the lower end of the agreeableness dimension of Costa and McCrae's (1992) Big Five model of personality (Schwenk et al., 1989).

Research has shown that patients lower on the agreeableness dimension can be difficult patients in that they typically have a poorer alliance with their physicians (Burns, Higdon, Mullen, Lansky, & Wei, 1999), report more suspicion and mistrust with their healthcare providers, and show less adherence to the treatment (Christensen, Wiebe, & Lawton, 1997). Moreover, less agreeable patients report less satisfaction with medical care than people high in agreeableness (Hendricks, Smets, Vrielink, VanEs, & DeHaes, 2006). Qualitative research on difficult patients suggests that physicians can compensate some of the negative effects of patients' disagreeableness on the interaction outcomes (e.g., low satisfaction, mistrust in the physician, non-adherence to the treatment) by being

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especially attentive, empathetic, tolerant, non-judgmental – in other words by being particularly affiliative with those patients (e.g., Breeze & Repper, 2002; Elder et al., 2006; Haas et al., 2005; Steinmetz & Tabenkin, 2001; Strous et al., 2006). For instance, in summarizing previous research done on difficult patients, Haas et al. (2005) recommend that physicians improve listening behaviors and interrupt patients less, avoid blaming the patient, and express empathy. Such research suggests that conversely, when physicians adopt a communication style low in affiliativeness, less agreeable patients – maybe because they are more demanding and critical with others (Amitay, 2007; Costa & McCrae, 1992) – react more negatively than agreeable patients do. Research conducted outside the physician-patient context has shown that less agreeable individuals respond with greater quarrelsomeness to quarrelsome behavior (e.g., not responding to questions or comments, criticizing, raising one's voice, showing impatience) in others than more agreeable individuals do (Moskowitz, 2010). In sum, because less agreeable individuals are less tolerant and lenient with others (Amitay, 2007; Costa & McCrae, 1992) and more reactive to unfriendly behaviors (Moskowitz, 2010) than agreeable individuals, we expected them to show negative consultation outcomes particularly when the physician adopts an unfriendly communication style. More specifically, we predicted that less agreeable patients would react more negatively than agreeable patients to a relatively low level of physician's affiliativeness (i.e., to a physician behaving and communicating in a colder, more distant, and less friendly way) in terms of satisfaction with the medical visit, trust in the physician, and determination to adhere to the treatment. Identifying a physician communication style that negatively affects more difficult patient encounters can help guiding physician communication training. Being aware of which communication style to avoid when facing a more difficult patient is important for a physician in order to provide these patients with the same quality of care as patients who are easier to deal with.

Physician affiliativeness

Physician affiliativeness is signaled by behaviors that convey warmth, friendliness, interest, empathy, a desire to help, honesty, a nonjudgmental attitude, and/or humor (Buller & Buller, 1987). It can be expressed through nonverbal behaviors such as smiling, nodding, facial expressiveness, vocal backchannels (e.g., "uh-uh", "mmh"), soft touch, face-to-face position, forward lean, bodily relaxation, close interpersonal distance, or interactional synchrony (e.g., Andersen & Andersen, 1999). It can also be expressed verbally, through sentences reflecting empathy, through statements of reassurance and support, positive reinforcement, laughing and joking, courtesy, or psychosocial talk (for a review, see Beck, Daughtridge, & Sloane, 2002). Physician nonverbal and verbal affiliativeness has been related to many positive patient outcomes, including patient satisfaction (Beck et al., 2002; DiMatteo, Hays, & Prince, 1986), trust in the physician (Aruguete & Roberts, 2002), and adherence to the treatment (Aruguete & Roberts, 2002; DiMatteo & Lepper, 1998). However, patients react differently to the same physician communication style (Hall, Roter, & Rand, 1981; Street & Wiemann, 1987) and some patients are more demanding of physician affiliativeness than others (Cousin, Schmid Mast, Roter, & Hall, 2012; Graugaard & Finset, 2000).

Patients lower on the agreeableness dimension

The dimension of agreeableness represents the degree to which an individual tends to act and to communicate in an affiliative way (Costa & McCrae, 2007). Agreeableness is characterized by cooperative behaviors, a desire to create positive and warm relationships, and by trust in others. Disagreeableness represents the negative pole of this dimension and it is characterized by the opposite behaviors (e.g., non-cooperative behaviors, no or less of a desire to create positive and warm relationships, mistrust in others). Research shows that healthcare providers adopt a colder and more distant communication style with less agreeable patients (e.g., patients who express less positive affect and who are contentious) than they do with agreeable patients (Michaelsen, 2012; Street, Gordon, & Haidet, 2007). This is potentially a problem because less agreeable patients, having a tendency to be easily upset (Moskowitz, 2010) and to be critical towards others (Amitay, 2007), might react more negatively (e.g., in terms of interaction outcomes such as satisfaction, trust, and/or adherence) than agreeable patients to a physician communication style that is colder, more distant, and less friendly.

Research suggests that the personality trait of agreeableness predicts individuals' reactions to others' displays of affiliativeness, such as the level of attention individuals pay to affiliativeness in others (Hirschberg & Jennings, 1980), the level of distress they experience when facing non-affiliative behaviors in others (e.g., in interpersonal conflicts) (Suls & Martin, 2005), or the degree of quarrelsomeness they show in response to non-affiliative behavior in others (Moskowitz, 2010). However, the only studies that have investigated the influence of agreeableness on individual reactions in a medical context were simulation studies (Cousin & Schmid Mast, 2013a, 2013b). In those simulation studies, healthy and young participants were asked to put themselves into the shoes of real medical patients and to report their reactions to videos of physicians varying in their level of nonverbal affiliativeness. The present study is the first one to look at the effects of match (or mismatch) between physician level of affiliativeness and patient personality in a real medical setting. We measured agreeableness in actual patients seeing their actual general practitioners and we assessed the degree of affiliativeness in the doctor's communication style during the visit. Also, rather than relying solely on measures of physician nonverbal affiliativeness (i.e., smiling, nodding, leaning forward), we used a broader and more comprehensive measure, namely a composite measure of both verbal and nonverbal affiliativeness. The patient outcomes that we consider are patient satisfaction, patient trust, and patient determination to adhere to the treatment. Satisfaction and trust in the physician have been related to patient adherence (Fitzpatrick, 1991; Willson & McNamara, 2002), and patient adherence has been related to patient's recovery and health status (Hays et al., 2005; Horowitz & Horowitz, 1993). This is why we investigated those important patient outcomes in the present study.

Method

Participants

Physicians were general practitioners working in the French-speaking part of Switzerland who were contacted by phone and asked for their voluntary participation. Seventy-two were contacted and 39 of them agreed to participate (54% of the contacted physicians). For three of them, it was not possible to recruit patients that fulfilled the inclusion criteria (see below) resulting in a total of 36 physicians (20 male physicians and 16 female physicians).

For each physician, the first female patient and the first male patient who met the inclusion criteria (see below) and who agreed to participate on the day of the data collection were included in the study (for three physicians, it was only possible to recruit a male but not a female patient). Sixty-nine patients (36 men and 33 women) participated in the study. Patients' mean age was 50.7 (SD = 18.19; range: 18–84) and they consulted for different reasons

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