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## Doctor-patient communication and the quality of care

An observation study into affective and instrumental  
behavior in general practice

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Dank zij Jouke  
Voor Egbert en Sophie

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# Doctor-patient communication and the quality of care

An observation study into affective and instrumental  
behavior in general practice

Arts-patiënt communicatie en de kwaliteit van het consult

*Een observatiestudie naar affectief en instrumenteel gedrag in de huisarts praktijk*

## **Proefschrift**

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## *Contents*

Preface	i
1 Introduction	1
2 Implicit theories in doctor-patient communication	33
3 Room for the patient	55
4 Evaluation of an interview training course for general practitioners	73
5 Doctor patient communication and the quality of care	89
6 Who is to say that it was a good consultation?	113
7 Instrumental and affective aspects of doctor-patient communication	133
8 Conclusion	159
Samenvatting	169
Literature	193
Appendix 1	205
Appendix 2	207
Dankwoord	239
Curriculum vitae	243



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## *Preface*

This thesis is about doctor-patient communication in general practice. It is based on several observation studies of videotaped real-life consultations, collected in a series of consecutive research projects<sup>a</sup>. The main part of the thesis consists of six articles that have been published in various scientific journals; some were also presented as papers at national or international congresses. Each article can be read independently from the others; together they form an exploratory journey into relevant types of physician behavior in general practice.

The thesis starts with an Introduction (Chapter 1), in which the medical consultation in general practice is placed at the central stage of the health care system, and the importance of doctor-patient communication in the diagnostic as well as the therapeutic process is underlined. In doctor-patient communication, two main types of behavior are distinguished, affective behavior and instrumental behavior. Empirical evidence is given to show the relevance of both types of behavior. In the articles that follow, affective behavior is studied as well as instrumental behavior, as are their interrelationships.

A theoretical exploration of the background of these two distinguished types of behavior is presented as the first independently published contribution to this thesis (Chapter 2). Although this article was written exactly halfway through the empirical contributions, it is presented at the beginning of the thesis, to provide the reader with a general frame of reference.

The empirical articles (Chapter 3 to 7) can be seen as a series of validation studies. We tried not to stick to descriptive analyses, but to relate different types of GP-behavior to process or outcome measures held important for different aspects of general practice.

In Chapter 3 ('Room for the patient'), different types of GP-behavior are related to the opportunity that the patient gets to talk about his real concerns.

In Chapter 4 ('Evaluation of an interview training course for general practitioners'), this same measure is used; In addition, GP behavior before and after an interview training course based on the principles of Carl Rogers is compared, with special reference to those behaviors that were practised during the course.

No yardstick is used from outside the consultation itself in these two publications, while in the last three empirical publications (Chapters 5 to 7), a 12-member panel

of experienced general practitioners was recruited to get an external three-dimensional measure of the quality of care delivered, as well as an idea of the degree to which GP behavior reflects a general-medicine orientation (as opposite to a biomedical orientation). In these publications, GP behavior is also related to patients' satisfaction as an outcome measure. With these different types of sources and criteria, I hope to present a detailed and varied picture of relevant GP-behavior.

As a psychologist, my own roots are in the psychotherapeutic tradition, with much emphasis on the relevance of affective behavior. My first research interest when I entered primary health care as research area was to find out which of these psychotherapeutically based behaviors were adequate in general practice, too. This is clearly perceptible in what are chronologically speaking the first two articles ('Room for the patient' 1982, and 'Evaluation of an interview training course for general practitioners', 1985). As a result of working in primary health care, I soon realized that empathic behavior alone is not enough for a good general practitioner (an observation that should not come as a surprise to general practitioners). Accordingly, an exploratory journey into the relevant instrumental behavior has been undertaken. In the first articles some instrumental elements were added to our mainly affective observation system. In the last empirical article ('affective and instrumental aspects of doctor-patient communication', forthcoming), I even applied a predominantly instrumental observation system, to the same research material, in order to get a better sight on the instrumental side of general practice.

I do not pretend to be a Columbus. In my voyage of exploration, I did not discover the New World, and finding out which types of behavior are really relevant, proved to be more difficult than standing an egg on its end. Many answers still have to be found, many questions asked. I do, however, hope that this thesis will make a modest contribution to the understanding of relevant behavior in general practice. I certainly hope that it will contribute to a reevaluation of the underestimated, but highly relevant area of doctor-patient communication.



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# 1 Introduction

## *The relevance of doctor-patient communication in health care*

With the ongoing stream of information about new medical technologies that so readily attracts popular as well as scientific attention, it is sometimes hard to realize that, people's health problems, if ever they come to the notice of the health care system, are only seen by the General Practitioner; virtually all these problems are also solved within general practice and with simple techniques. A recent nationwide study of morbidity and interventions in (Dutch) general practice revealed that additional external diagnostic tests were asked for in only 7.6 % of the consultations in Dutch general practice, and that a referral was made to a medical specialist in less than 7 %, even though the modern GP is only a telephone call, fax or letter away from a vast arsenal of diagnostic tests and procedures<sup>1</sup>.

In doing his job, the GP tends to use very simple means indeed<sup>b</sup> <sup>c</sup>. As Eisenberg<sup>2</sup> stated : *"a sensitively ascertained history and a carefully done physical examination will often lead to the correct diagnosis without dependence on an extensive battery of costly, often superfluous and sometimes risky tests"*. A crucial role both in the diagnostic and the therapeutic behavior of the general practitioner is played by the mere exchange of information between GP and patient<sup>3</sup> a point that is also stressed by Cassell<sup>4</sup> who formulated the following four premises about clinical science: *"doctors treat patients, not diseases; the body has the last word; all medical care flows through the relationship between physician and patient; and the spoken language is the most important tool in medicine"*. Or in the words of Stephens<sup>5</sup>: *"If there is one respect in which post-Flexnerian epistemology<sup>d</sup> differs most from Flexnerian, it is in the relative importance of vision and hearing in knowing the patient clinically ..... The spoken word is the royal road to human understanding in medicine; the chief sources of knowledge about the patient are the spoken word and the doctor-patient relationship."*

### **Historical shifts in attention**

These figures and observations place the GP-consultation and doctor-patient communication at the centre of the professional arena where health problems are countered. One would imagine that, as a consequence, doctor-patient

communication would attract a great deal of scientific attention. This is not the case. Or, to be more specific: this is not always the case.

Attention to doctor-patient communication is often accompanied by an interest in the psychological and social aspects of people's health problems, their help-seeking behavior and the dynamics of the doctor-patient relationship, and it is fed by an increased awareness of the inadequacy of the classic biomedical model in this area. But while few people will deny the limited scope of the biomedical model, there are remarkable ups and downs to be seen in the scientific attention to factors in health care other than the strictly biomedical ones, and the crucial role of doctor-patient communication in clinical science. The remarkable interest in (ancient) history in publications about doctor-patient communication, with direct quotes from Hippocrates<sup>3 6-10</sup>, Plato<sup>11</sup>, Rufus of Ephesus<sup>12</sup>, or - for instance - a frequently mentioned respect for physicians of the pre-World War I period such as Osler<sup>6-7 13-15</sup>, Meyer<sup>16</sup> and Peabody<sup>2 17</sup>, or from just after World War II like Michael Balint<sup>5 18</sup> and the Dutch physician Querido<sup>18</sup> can best be understood as an ultimate attempt to bridge the gaps in attention **between** the different periods in which doctor-patient communication was a popular topic in the scientific press<sup>e</sup>; for in the last hundred years, most scientific attention has been attracted to biomedical research, based on the classic biomedical model. People who are interested in doctor-patient communication and the non-biological aspects of general practice have to rely on small peaks of attention in particular periods of time.

This is demonstrated for the postwar period in the Netherlands by Verhaak<sup>19 f</sup>, who analysed the content of the scientific papers in the leading Dutch scientific journal for General Practitioners ('Huisarts en Wetenschap'). He found two marked periods of interest in the non-biological aspects of health problems: one at the end of the fifties, when it was mainly psychiatrists like Balint and Weijel and internists like Groen who asked the general practitioner to pay attention to these matters, and another period in the seventies, when the scientific leaders of Dutch General Practice themselves<sup>20-35</sup>, both within and outside Huisarts en Wetenschap, again drew attention to the many health-problems in general practice that can not be understood within the biomedical framework; this time with a particular focus on the role of the GP and the GP-patient relationship in the accompanying processes of somatic fixation. Multidisciplinary coöperation within the primary health care team was another topic that held people's attention in the seventies as a possible answer to the multifaceted health problems in general practice; the seventies were a boom period for health centres in the Netherlands. But attention faded again and the eighties can be characterized as a pragmatic period. The relationship within the profession, between general practitioners and medical specialists, became more important than the interdisciplinary relationships with co-workers in the primary health care team; and, under the influence of the medical faculties, the research programmes of the University General Practice Departments turned increasingly towards the technical-medical side of medicine, which made Tielens, Chairman of the Dutch College of General Practitioners warn the assembled researchers into

general practice not to lose sight of its idiosyncrasies<sup>36</sup>. Recently, however, a new wave of interest in the essentially biopsychosocial nature of general practice, and the relevance of doctor-patient communication for an adequate primary health care seems to be growing in the Netherlands; with the series Balint-inspired cases by Dokter and Verhage<sup>37-38</sup> in *Huisarts en Wetenschap*, and its special issue on doctor-patient communication in the spring of 1991. The same shifts of attention in England<sup>39</sup> and America<sup>16</sup> have been demonstrated at about the same time. The Wickenburg Conference on 'The Task of Medicine'<sup>18</sup> is a good example of the most recent peak of attention in the United States.

### **An apparent resistance to change**

More interesting than these peaks, however, are the shifts of attention in between. Why is more continuing research effort not concentrated on the intriguing problem of the multidimensional, multifaceted character of health problems and help-seeking behavior, since we have known for such a long time that problems without a biological base are abundant in general practice and since reviews of behavioral as well as medical research have now taught us convincingly, that even somatic problems are embedded in psychological and social factors<sup>15-16 40-53</sup>. In Kerr White's words: *"In the face of this evidence .... we need to ask why medicine has been so slow in acting to implement and increase this knowledge. Why do we continue to behave as if (this knowledge) did not exist?"*<sup>18</sup>

### **The imbalance in the appreciation of the scientific base of medical interventions**

White's fascinating book 'The task of medicine', a report of an expert-conference on the medical paradigms of our time, provides us with some answers to this intriguing question<sup>18</sup>. An important problem in the balance between the biological and the humanistic side of medicine is, that generally the former is regarded as 'science' whereas the latter is seen as 'art'. As a consequence, there is an inclination to overestimate the scientific value of biomedical observations and to underestimate the value of patients' own reports about their health problem as not being scientific.

This relative neglect of patients' own experiences (*"stop telling me about your problems and answer my questions"*<sup>18</sup>) may be fostered by the fact that 60 % of the health problems in general practice cannot be classified in diagnostic categories, because they are really symptoms, problems, complaints or conditions that duck out of the regular roles of medical decision making. And: *"you don't have 'it' until we name 'it', and when we do, you have 'it'"*<sup>18</sup>. When no diagnosis can be found, the health problem gets labelled as 'early', 'self-limited', 'trivial', 'amorphous', 'functional', 'intractable' or worse<sup>18 54</sup>. As if these health problems were not the outer manifestations of much suffering, pain, anxiety, discomfort, disability and sickness leave! White<sup>18</sup> remarked that *"with the biomedical model successfully*

*bolstered by the dualism of Descartes, the reductionism of Newton and the automotive culture of General Motors, change is held unnecessary by most and impossible by few". Adherents to the biomedical model just put these health problems outside the realm of medicine. As George Engel formulated it: "with mind-body dualism firmly established under the imprimatur of the Church, classical science readily fostered the notion of the body as a machine, of disease as a consequence of breakdown of the machine and the doctor's task as repair of the machine... This was so, even though in practice many physicians, at least until the beginning of the 20th century, regarded emotions as important for the development and course of disease"<sup>16</sup>. General Practitioners nowadays still know that they can not cling to the biomedical model alone, without neglecting many of their patients. And as McWhinney<sup>55</sup> stated "those who accept the biopsychosocial model do not do so because it pushes back the boundaries of medicine to personal maladjustments and social conflicts. They accept it because people with diseases like cancer, heart disease, multiple sclerosis and macular degeneration have a deep yearning to be understood". Not only do health problems that cannot be explained within the framework of the biomedical model need a more inclusive medical model; as stated before, there is rapidly accumulating recent evidence indicating that even in chronic somatic conditions, the origin, the severity, the natural course, the reaction to treatment and even mortality are highly influenced by psychological and social factors, as well as by their relationship with the health care system<sup>15-16 40-53</sup>.*

While there is a tendency to underestimate the patient's own record of his health problem as a valid source of information, there is, at the same time, an overestimation of the scientific value of biomedical observations: *"Doctors have an altogether unwarranted faith in the reliability of clinical methods and tests. How else are we to explain the indifference to matters of sensitivity and specificity in ordering tests and evaluating test findings without weighing a priori probabilities?"<sup>2</sup>.*

Of course nobody will deny or belittle the relevance of biomedical research and its major influence on the enormous progress in scientific medical knowledge, which finds its way in new diagnostic and therapeutic tools; it has saved many, many lives. It is not surprising that so many people, physicians as well as laymen are fascinated by the rapid developments in biomedical research. And it is clear that a new medical model can never be placed in opposition to the biomedical model, but it must be considered as a supplement<sup>16 18 56</sup>.

In the general awe for the merits of the biomedical model, its limits, however, are easily overlooked. From within academic medicine, we are warned that we must not overestimate the immutability of the knowledge it has produced, as well as the scientific base of most of the interventions in everyday clinical practice. Eisenberg<sup>2</sup> reminds us of Beeson's instructive task of comparing the treatments recommended in the first (1927) edition of an important American textbook on medicine with those in the 14th (1975) edition of the same textbook. By contemporary standards, Beeson rated the value of 60 percent of the remedies in the first edition as harmful,

dubious, or merely symptomatic; only 3 percent provided fully effective treatment or prevention<sup>9</sup>. Ten years later, Stephens<sup>5</sup> noticed with regard to the treatment of hypertension: *"therapeutic fads come and go, official recommendations get revised repeatedly, educational campaigns for physician and patients rise and decline, yet hypertension remains a major health problem and seems likely to continue"*. And, in the same book, White<sup>18</sup> concludes, after reviewing the literature: *"we should be crystal clear...that probably no more than 20 % of the therapeutic interventions are supported by objective evidence that they do more good than harm....Of equal importance is the observation that, on average, the ubiquitous placebo effect accounts for some 30 to 40 % of clinical benefits. The related, but probably discrete, Hawthorne effect accounts, on average, for about 15 to 20 %. Apparently about a quarter of all benefits are still a mystery!"* And he ends by urging researchers to be more curious about the black box in physicians' healing power: *"Too often physicians take the view that improvements in their patients' well-being, unassociated with a demonstrably efficacious intervention, are the result of 'just the placebo or Hawthorne effects'. Perhaps we should look at these combined phenomena,...call them 'Factor X', propose that they be investigated extensively, and look on them as the most powerful therapeutic agents in existence"*. And with these remarks, White is stepping in the shoes of Michael Balint<sup>57</sup> who thirty years earlier called the physician's attention to the same phenomenon with his widely quoted observation: *"the doctor as the drug"*.

Not being a physician myself, it is difficult for me to weigh this information, but these citations suggest that there seems to be no rational reason for the persistent overestimation of the biomedical 'state of the art', nor for the underestimating of the value of the 'biopsychosocial model' in understanding and treating human health problems. Yet both occur. And I would not be a psychologist, if I were not interested in the apparent 'resistance to change'. Not in order to propagate psychologically-based medicine in general practice, for as DiMatteo<sup>6</sup> stated: *"It is obvious that the practice of medicine in modern times in a manner that emphasizes compassion and ignores technical expertise is quackery"*, but to put some weight on the other side of the balance and to try to right the evident disequilibrium between the biotechnical and the psychological aspects of modern medicine. In DiMatteo's words: *"It is not so obvious that the technical treatment of patients without attention to the socio-emotional dimension of the physician-patient relationship may result in equally serious problems."* To prevent misunderstanding, I would like to emphasize, that the old GP is not the model, now. The modern GP needs the sensitivity and skills to listen, hear and observe, but he needs also as much technical-medical knowledge and skill as the biomedical science can give him. In Huygen's words<sup>58</sup>: the GP has also an important biomedical task, even in the prevention of unnecessary illness and processes of somatic fixation (my translation). But if there is ever to be a better balance in the present disequilibrium between the biological, psychological and social factors in modern medicine, the reasons for the resistance-to-change must be revealed.

## Push-and-pull factors

In an analysis into the possible reasons for the persistently predominant influence of the biomedical model and the resistance-to-change to a more biopsychosocial model, some pull-and-push factors can be discerned. Let us review them briefly.

As stated before, it is often suggested that one major factor in the resistance to a more inclusive medical model is the prevailing view that the biomedical model is based on science, whereas the biopsychosocial model must be considered as art. However, Truax<sup>59</sup>, Fine<sup>13</sup>, DiMatteo<sup>6</sup>, Eisenberg<sup>2</sup>, Inui<sup>11</sup>, Schwartz<sup>60</sup>, and others have convincingly demonstrated that the humanistic side of medicine can be studied in a scientific way, too. DiMatteo<sup>6</sup> has called it 'the science of the art of medicine'. And the accumulating body of knowledge on the psychological and social aspects of health, illness and illness-recovery, based on sound empirical research<sup>h</sup>, make this claim (i.e. that only the biomedical model has scientific value) untenable. At least no more tenable than the claim that biomedical interventions in everyday general practice are based on science. I dare say that time is nearly past when the biological part of patients' health problems could be considered as the 'hard' part that can be measured, if measured well enough, and the psychological and social parts as the 'soft' parts that easily change and are difficult to determine in an objective way.

As other pulling factors favoring the biomedical model and its accompanying technocratic health care, Eisenberg<sup>2</sup> mentioned: the elegance of molecular biology, the professional socialization in the years before vocational training<sup>i</sup>, and the misattribution of therapeutic effects. As factors pushing away from the biopsychosocial model, he mentioned scepticism about the 'reality' of psychosocial factors and the difficulty of unlearning old habits. White<sup>18</sup> added a financial element to the push-and-pull factors, which certainly must be taken seriously: *"As long as the pecuniary rewards in medicine ignore such elements as time devoted to listening, observing and explaining, experience and wisdom in dealing with interpersonal, domestic occupational and social stress, simple ambulatory management based on "wait-and-see" as a diagnostic or therapeutic manoeuvre, and a probabilistic, rather than a deterministic, approach to dealing with the patient's problem, it seems unlikely that a more inclusive theory of health and disease will find widespread acceptance."* And Engel<sup>16</sup> has pointed to the power of vested interests, social, political and economic ("the medical industrial complex") which are - in his opinion - "formidable deterrents to any effective assault on biomedical dogmatism".

But the most important pull-and-push factor is probably that the classic clinical method tells the clinicians precisely what they have to do to get the required results, and provides precise criteria for validation<sup>55</sup>. New developments in biomedical knowledge are generally presented with clear new decision rules for the GP. The

General Practitioner himself is never at stake: knowledge changes; the GP himself does not have to change, he only needs to use the new knowledge. And that is much easier than realizing that it is *he* himself who has to change (as is always necessary when working with the biopsychosocial model), and realizing such a thing is still much easier than actually changing yourself; for working on the principles of the biopsychosocial model not only provides the physician with another view of the patient, his every day life, and his health problems from the classic biomedical model; it also provides him with another view of the dynamics of the doctor-patient relationship and thus it reaches to the core. This is probably the most important factor in the observed resistance-to-change. In the end, changing doctors is more important, as well as more difficult than changing the body of knowledge in medicine. In that light, it is encouraging to notice that several studies have shown that interviewing can be taught<sup>4 61-63</sup>, although much more research and carefully designed and evaluated training programs will be necessary in the years to come. If only to make an optimal use of the knowledge gathered in biomedical research.

### **A positive climate for the biopsychosocial model**

There are also pulling factors *towards* the biopsychosocial model, and perhaps now more than ever. McWhinney<sup>55</sup> remarked that, *"paradoxically, it is the success of medical technology that has exposed so vividly the limitations of the traditional method"*, a conclusion he shares with Brody<sup>64</sup> who cites several sources to emphasize his statement that *"despite unprecedented advancements in knowledge and technology, the American people have never been more disillusioned and discontented with health care delivery"*. This general dissatisfaction with the health care system (probably felt more strongly in America than in the Netherlands) is mentioned by many American authors<sup>18 55 64 65</sup> and is considered as a major factor pulling towards a more inclusive medical model<sup>55 64</sup> be it only to prevent malpractice litigation (*"be kind to the patient"*)<sup>18 65</sup>. As Brody stated: *"From the physician's perspective, the use of technology has become synonymous with progress. Patients, however, see things differently. They generally evaluate a medical intervention in terms of cost, inconvenience, discomfort, and dysfunction. They are likely to be more risk-averse and therefore favor more conservative interventions than physicians"*. Usually patients are also very much aware of the psychological and social aspects of their health problem<sup>66-69</sup>. Perhaps, the fascination by and concentration on the technical-medical side of health care has diminished the communicative skills of the physician. McWhinney<sup>55</sup> suggested that *"concentration on the technical aspects of care has diverted us from the patients' inner world, an aspect of illness the (clinical) method does not routinely force on our attention. The complexities and discomforts of modern therapeutics have made it even more important for us to understand the patient's experience"*.

Whether based on a general dissatisfaction with the health care system or on a legitimate inclination of the population to want to gain more control of the system that means so much to their lives and well-being and for which they expend so much money (direct or indirect via taxes or insurances), it is certain that the 'consumerism' of our time has a growing influence on what happens in medical care, especially in general practice. The recent continuous stream of research on and publications about different aspects of the Dutch health care system by the Netherlands Consumer Organisation, which used to restrict itself to the testing of washing-machines, television sets, and so on, must be seen in this light. On the one hand, patients know more about illnesses and their cures than ever, as health is a popular topic on radio and television, in newspapers and glossy magazines. And, on the other, they are more emancipated than they used to be: they want to play a part in medical decisions; they want to know about alternatives to threatening therapeutic interventions; they want to discuss behavioral rules, before accepting them. They want to try medications (Aids!) before they have been scientifically tested. As Sorenson<sup>54</sup> and Brody<sup>64</sup> have pointed out, this is particularly true of those areas of medicine, in which rapid (technological or biomedical) developments have confronted the physician with uncertainty, for instance, with respect to ethical questions. All these factors demand a more egalitarian relationship between GP and patient. They have clearly produced a shift in the power-balance<sup>64 70-73</sup>, and are demanding new communication skills of the General Practitioner.

This central position of the patient is also seen in WHO's declaration 'Health for All by the year 2000'. This has produced a worldwide shift from a predominantly supply-regulated health care to a more demand-regulated care. Patient needs have to be the starting-point in organizing health care, and, to be honest, this has hitherto not been the case. This caused our attention to shift to other parts of the health care system: to preventive care, to mental health care, and most of all: to primary health care. It has also taught us (those who did not already know) that the major health problems of our time (cancer, cardiovascular diseases, suicide, accidents) are considerably influenced by factors outside the classic biomedical model: by stress, by lifestyle and bad habits in eating, drinking and risky behavior, that can only be influenced by behavioral and educational techniques. And as the average age of mortality approaches the biological boundary of life, more attention is being paid to the quality of life and to individual differences in its perception. This is especially true for chronically ill patients who are the major customers of today's general practice. They, too, need often more care than cure.

For a final understanding of the importance of doctor-patient communication in general practice, it is illustrative to quote Stephens<sup>5</sup>, an American Professor of Family Practice:

*"Patients, never merely bodies or disembodied spirits, present themselves to physicians in exasperating wholeness, not realizing what dichotomous dilemmas they create for their physicians' science. They do not come in battalions, but one by*



*one, always with connections to others, to society, to culture, which are also present by proxy and which cannot be ignored with impunity. A small proportion of patients are the bearers of well-defined Flexnerian diseases; most bear illnesses, the fear of disease, or simply questions about their health. I see few who have no clinical concerns."*

I hope that with the foregoing, I have been able to legitimize and substantiate my own scientific as well as human curiosity in doctor-patient communication in general practice, as a major medium in improving health care for patients in the broad sense that they deserve. That is the reason why I have chosen doctor-patient communication as topic for my thesis. To quote Stephens<sup>5</sup> for the last time:

*"The first great task of medicine is to create a relationship with the patient and the second is: to learn how to hear what that relationship reveals."*

## *Doctor-patient communication: The relevant elements*

Now we have seen the important role of the medical consultation in general practice, and more specifically the role of doctor-patient communication in producing adequate health care, it is time to analyze the relevant elements in doctor-patient communication: what are the active ingredients? What is 'Factor X' composed of? Let us therefore review the literature.

In the literature about doctor-patient communication, two types of GP-behavior are thought to be important: instrumental or task-related behavior and affective or socio-emotional behavior<sup>6 11 18 72 74-82</sup>. It is probably no coincidence that this distinction resembles the distinction between the biological (so-called: 'scientific') side of medicine and the psychosocial or humanistic side (sometimes called 'the art of medicine'), although it is certainly not the same. Both types of behavior (instrumental and affective) are necessary to serve the purposes of both sides of medicine (the biological and the humanistic): when the GP is not asking the right questions (instrumental behavior), he will probably not elicit relevant information about the patient's own 'lifeworld' (humanistic medicine); when he does not show his empathy and concern (affective behavior), there is a fair chance that the patient will not comply with the prescribed regimen, and thus fail to recover (biological medicine). But the resemblance can be explained. Parallel to the mind-body dualism, there is another dualism pervading medicine: it is the dichotomy between cognitions and emotions. Instrumental behavior (as well as biological medicine) belongs to the cognitive domain, whereas affective behavior (as well as humanistic medicine) belongs to the emotional domain. However, for the sake of clarity, I want to stipulate that instrumental and affective behavior must both be considered to be relevant for the whole wide range of modern medicine.

Let us elaborate both concepts on the basis of empirical evidence, found in literature, and on a short vignette, found in the videotapes, illustrating both types of behavior in practice, so that we know, what we are talking about\*.

### **The instrumental Consultation**

An elderly woman enters the surgery. After exchanging formal greetings, she tells the GP that she has recently had some dizzy spells, about which she is worrying quite a lot ("I hope it is nothing serious"). The GP asks her to tell him some more about the dizzy spells. She finds it difficult to explain. ("Everything looks funny") and says again that she does not like it at all. After asking her a series of questions about the time and circumstances of her dizzy spells, the GP summarizes: "if I understand correctly, you only get these spells when you are standing up, stooping or something like that; not when you are just sitting down?", the patient agrees. Then the GP asks her what the dizzy spells are like ("Do you feel you are spinning round or is the room?"). The patient answers that she is spinning round. When the GP asks her if, perhaps, her hearing has been deteriorating for

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\* The figures about the differences between the two consultations are in the appendix.

some time, the patient starts telling a rather confusing story about her most recent contact with the otologist. She is not wearing her hearing aid now. The GP says that he will examine her. During the physical examination, - including an ear examination, some neurological tests, taking the patient's pulse and blood pressure - the patient again expresses her concerns ("one starts worrying about it..." ... "I hope it won't get me into trouble"). She also starts talking about a recent surgical operation for facial neuralgia, which she suspects to be the cause, about recurrent problems with her lower dentures, which make her nervous, and about her weekly gym sessions, which she would like to continue. The GP concentrates on the physical examination with accompanying instructions and questions. Sometimes he nods or mutters to show that he is listening to what the patient is saying. After the examination, the GP sits down behind his desk and tells the patient what he has found: she did well on the neurological tests; the pulse is all-right; the blood pressure a bit low (140-70). He does not think that the problems are caused by the patient's ears or vestibular system. He advises her to avoid sudden movements, explaining that the heart needs more time to pump the blood around, when the blood pressure is low; this could explain the dizziness. He suggests the patient to follow his advice for a few weeks to see if this helps. He does not want to give any medication yet. If it gets worse she should make an earlier appointment. The patient asks whether there is anything she should stop doing. The GP says no and she asks again if she can continue her weekly exercises. The GP says that it is very important for her to continue her gymnastics, and that it is perfectly safe for her to do so, as long as she avoids sudden movements. The patient sighs and says she does not know how this could have happened. The GP comforts her by saying that it probably will be better in a month's time. Then the patient produces a list with her regular medications, for which she needs a refill. The GP sees that she is still using diuretics, which she got from another physician, when her blood pressure was too high. This was not mentioned in the GPs records. He is visibly startled. He tells the patient that he wants her to stop these medications, because these could be the cause for her current problems. She must reduce the medication from three times a week to once a week, to start with. He repeats this instruction several times to be certain that the patient has understood him. A new appointment is made for two weeks time. The consultation lasted about 14 minutes.

## Instrumental behavior

The instrumental dimension refers to those aspects of a service that provide a means to a set of ends<sup>83</sup>. In GP-consultations the ultimate purpose of the service is: problem-solving, i.e. solving patient's health problem. Information-exchange is seen as the most important means of achieving this purpose<sup>11 80 84-86</sup>. Information-exchange (information-seeking and information-giving) is necessary in several steps of the problem-solving process, and has therefore to serve several sub-ends.

Much attention has always been devoted to **history-taking** as a very important, perhaps the most important part of the diagnostic process<sup>2 5 18 87</sup>. Stoeckle<sup>72</sup> even states that in medical writings more attention is paid to the technique of eliciting information from patients for diagnosis than is paid to the doctor's communication with them. Putnam<sup>80</sup> concludes that 56-85 % of the diagnoses can be made on the basis of history alone. Asking sufficient questions, asking the right questions, asking questions about psychosocial and lifestyle matters in addition to biomedical

matters, asking open-ended questions as well as close-ended questions and a good balance between the two<sup>88</sup> are all regarded as important elements.

In addition on history-taking, **providing information** to the patient is very important<sup>72 80 81 85 89-94</sup>. Information-exchange is not without problems. Waitzkin<sup>3 95</sup> showed that doctors underestimate the patients desire for information: patients want as much information as possible, and doctors frequently do not realize this preference. Doctors correctly perceived patients' informative needs in less than one third of the consultations; in 6 % doctors overestimated, and in 65 % they underestimated patients' desire for information<sup>3</sup>. On the other hand physicians tend to overestimate their own informativeness: on the average, doctors overestimated the time spent giving information by about a factor of nine<sup>95</sup>. As a consequence, patients are often dissatisfied with information that they do receive<sup>93 96</sup>. Yet, on the average, patients are rather passive in information-seeking<sup>3 71 74 84 95</sup>. Another major communication problem in medical practice is that what is said by the GP is not always understood by the patient, nor recalled after the consultation<sup>97</sup>. After reviewing the literature, Ley<sup>98</sup> reported that 7 to 53 % of the patients do not understand what they have been told and that patients forget between 28 % and 71 % of the information presented. Waitzkin<sup>3</sup> mentioned, as a third problem, the manipulative side of the GPs information-giving. A physician can manipulate information in order to gain control over the consultation or the patient, or in order to keep non-medical matters outside the consultation<sup>88</sup>; this is also reported by Davis<sup>73</sup>. The GP is the one who decides what to tell, and what to withhold, and his decisions do not always correspond with the patients wishes.

In doctor-patient communication research, providing information is the element of instrumental behavior which is most studied.

Recently much attention has been devoted to a third sub-end of the consultation, which has to do with the medical consultation as a **pedagogical encounter**. A changing morbidity pattern, with many chronic illnesses and health problems that have their origin in human behavior and lifestyle more than in infectious germs as used to be the case, demands a more preventive approach from the GP and a more active role by the patient himself in his own healing process<sup>84</sup>. Stott<sup>99</sup> found that this idea was accepted by a substantial majority of the (English) patients, who expected their GPs to be interested in their lifestyle and supported the role of the GP in lifestyle-advice. For an intervention to be successful, a patient must first *understand* what his doctor wants to tell him, secondly he must *recall* what he was advised by his doctor and thirdly, he must *comply* with the instructions and advice. These are important outcome criteria in this research area. Ley<sup>98</sup> and his co-workers have done a lot of research in this area; they have summarized the implications of their research in a set of (technical) recommendations for GPs (for instance about the form of the information and its distribution throughout the consultation<sup>100</sup>. Rost<sup>101</sup> found that asking closed-ended questions as well as giving information resulted in higher levels of patient recall. Roter<sup>82</sup> found that giving

information and counseling were the best predictors of patient recall and patient satisfaction. Garrity<sup>102</sup> concluded, after reviewing the literature that the correlational and intervention studies that deal with the clinician-patient interaction as a pedagogical encounter provide support for the notion that practitioners who manage to present therapeutic recommendations to patients clearly and specifically find higher levels of follow-through in their patients. In addition to clear instructions Svarstadt<sup>103</sup> distinguished another important factor in promoting compliance: i.e. motivating the patient, a factor that was also mentioned by DiMatteo and DiNicola<sup>97</sup> Demak and Becker<sup>104</sup> and Stott and Pill<sup>99</sup>. Roter's concept 'counseling' also has a motivational component<sup>105</sup>.

Giving information and explanations (including clear instructions)<sup>98 103</sup> and counseling and persuading (including motivating the patients) are regarded as the relevant elements here.

Besides information-exchange, another type of instrumental behavior is thought to be important in doctor-patient communication, albeit at a more abstract level than the previous ones: **structuring** the course of the consultation in a systematic way. In the Netherlands especially, this aspect has received considerable attention. The Dutch College of General Practitioners developed 'the methodical approach' during the seventies<sup>106</sup>. It is a method derived from social work casework<sup>107</sup> to emphasize that in general practice the classic biomedical method is not sufficient<sup>106</sup>. The main elements are: clarifying the reason for encounter (which may be considered as a specific type of information-seeking), structuring the consultation, evaluating the process of care and (an affective element): promoting an open and clear relationship with the patient, in which the patient has freedom of choice. Only the first two elements, however are widely accepted in the Netherlands and are integrated in the vocational training for general practitioners<sup>106</sup>. There is still not much research done on the effects of 'the methodical approach'. From the scarce results it can be postulated that a goal-oriented and systematic approach is related to an adequate treatment of medical as well as psychosocial problems<sup>107-108</sup>. More psychosocial fragments occurred in consultations in which the GP clarified the reasons for encounter<sup>109</sup>, which may be considered as a measure of the room GP allows the patient to talk about his emotional concerns, an interpretation that is consistent with the finding that those GPs who attribute a lot of influence to psychosocial aspects also have the habit of clarifying the patient's reason for encounter<sup>110</sup>.

Clarifying the reason for encounter is also a major element in **tuning the mutual expectations**. There is growing evidence that not meeting patient's expectations is one of the most important reasons for patient dissatisfaction<sup>83</sup>. Korsch<sup>74</sup> and Francis<sup>111</sup> found in their classic research in a paediatric ward, that mothers were most dissatisfied with the visit, when they received no explanation of the causes of their children's illnesses. Woolley<sup>112</sup> found that of the patients whose expectations were not met, 35 % proved to be dissatisfied with the outcome of the consultation,

as opposite to only 2 % of the patients whose expectations were met. Like and Zysanski<sup>113</sup> also reported that patient satisfaction could be predicted best from the GP's meeting patient requests. Tuning the mutual expectations is the more important because physicians and patients often have different frames of reference, which causes misunderstanding and confusion<sup>114</sup>.

In the patient's frame of reference much more attention is paid to psychosocial factors than in the physician's frame of reference<sup>66 67 115</sup>. Bain<sup>115</sup> suggests that the main thrust of the physician's activity is the acquisition of facts, interpretation of symptoms and signs, and the creation of a diagnostic labels, while the patient is frequently more concerned with how the physician's findings will affect social and family matters. It would seem important to make use of the patient's frames of reference in medical decision-making<sup>116</sup>. Garrity<sup>102</sup> and Pendleton<sup>117</sup> concluded, after reviewing the literature that complementary expectations regularly yield patient satisfaction and compliance.

**Mutual agreement** between doctors and patients over the definition of problems, priorities, means of evaluation and therapeutic decisions and expectations is thought to be another, but closely related essential component of the doctor-patient relationship<sup>64, 118</sup>. Compatibility of physician and patient expectations is for instance seen as crucial for patient follow-through on medical advice<sup>102</sup>. Svarstadt found that congruence between doctor's and patient's perception of what the patient should do was the best predictor for compliance<sup>102</sup>. Starfield<sup>119</sup> found that problems about which practitioners and patients agreed were more likely to be reported as improved, regardless of perception of severity. McWhinney<sup>55</sup> reported a study in which the factor most strongly associated with recovery at one month was the patient's complete agreement with the doctor's opinion.

Clarifying the reason for encounter and fully explaining the illness and the treatment are thought to be important elements here<sup>64 88</sup>.

## The affective consultation

A middle-aged woman enters the surgery. When seeing her coming in, the GP greets her with the words: "Hello, Mrs. X. You don't often honour us with a visit, do you?" The woman answers that, indeed, she is not a regular, but now her brother has urged her to visit the doctor, because yesterday, she suddenly found herself in the bushes, when she was riding on her bike. With some sense of humor, she added: "Well, I thought, what am I doing here in the bushes?" The GP laughs and says: "yes, I can imagine that you thought what am I looking for in the bushes." The patient says, that she had felt a bit dizzy, just before it happened, and that she had had several dizzy spells in the last few weeks. She added that she has been very busy with her two children and her chronically ill father, whom she had to care for. But she herself had thought that things were going better, now the children were grown up. She feels rested now. But her brother had asked her if something was wrong with her, because she was not looking very well. And the dizzy spells bother her, and she also sleeps badly. Her brother suggested that she might have high blood pressure, just like her mother (and he accused her of being as reluctant to visit the doctor as her mother had been when she was still alive). She wonders where the dizzy spells come from. She hardly uses any salt.

The GP explains that high blood pressure can have multiple causes: heredity, salt, overweight, stress, to name but a few. The woman reacts by saying that everybody suffers from stress now and then. She describes herself as a cheerful person, but admits that sometimes things can be difficult.

For instance, her husband has been sick since two years now. This caused some gossip in the family, which she found difficult to take. But now she feels that it does not bother her any more. However, she wants to know the cause of her dizzy spells. While she is speaking, the GP is very attentive, nods, gives verbal encouragements prompting the patient to go on and has a lot of eye-contact.

When the patient has finished her story, the GP summarizes that the patient, in fact, has two questions: she wants her blood pressure taken, to be sure that it is not too high, and she wants to know the cause of her dizzy spells. The patient agrees, and asks if dizzy spells can be caused by high blood pressure. The GP says "no", and continues "in 99 % of the cases, dizzy spells are caused by stress, problems, fatigue, etc. The patient recognizes this ("I thought so"). The GP continues: "In 1 % of the cases there is an organic cause, but this is easy to exclude by means of a physical examination.

After a moment of silence, the patient says: "Well, I am a bit nervous every now and then, but who is not these days?" The GP says that everybody is nervous every now and then, but some people can talk about it easily, and others cannot. The GP asks, if the patient is able to talk about her 'nerves'. The patient agrees that this might be the trouble, adding: "medications won't help; you have to solve your problems, yourself. But do I have a problem? I do not know." The GP tells the patient that it is not only the big problems that cause symptoms like dizzy spells; sometimes they come from minor problems which you may find difficult to talk about. This elicits a long story from the patient about her in-laws who live next door and intrude in her personal life. She does not like this at all. It causes all kinds of friction and makes her feel an outsider in the family. The GP talks about the feelings the patient must have, and makes supportive statements about her expressing her anger now. She explores the situation, looking for ways to change the situation. The in-laws have decided to sell their house. The patient hopes that this will clear things up. She is longing for neighbors with whom she could have a more detached relationship. The GP agrees that this would be much better, and then ends this part of the conversation by suggesting to take her blood pressure and make a new appointment for a physical examination and a further talk about the problems in a week's time. The GP repeats the plan-of-work, asking whether the patient has understood everything, and explains: "time is short now, so we will take your blood pressure, because you want to be sure that your blood pressure is not too high. You know by now, that your blood pressure has nothing to do with your dizzy spells. Even if I were to find very high blood pressure now, it would have nothing to do with your dizzy spells. But perhaps you can reassure your brother as well when you know what your blood pressure is.

The blood pressure proves to be 140-98. In answer to the patient's question, the GP says that the lower value is a bit high. The GP adds that this is probably so, because the patient is a bit nervous at the moment. The GP repeats that it has nothing to do with the reported symptoms.

She ends the consultation by asking patient to agree with her plan-of-work, which means: making a new appointment in a week's time, in which the blood pressure will be taken again, and a physical examination will be done to exclude organic causes for the dizzy spells. She suggests the patient ask the practice nurse to make it a double appointment, so that there is more time for a longer chat about the things that are worrying her, and to find better ways of coping with them. The patient agrees.

Just as with the instrumental GP, this consultation lasted about 14 minutes.

## Affective behavior

While the instrumental dimension refers to those aspects of a service that provide a means to a set of ends, the expressive or affective dimension refers to those aspects of a service that the consumer considers ends in themselves: i.e. a good interpersonal relationship<sup>83</sup>. As a consequence, O'Connor considers the instrumental dimension as a service quality dissatisfier, and the affective dimension

as a service quality satisfier. GPs affective behavior undoubtedly plays a prominent role in patient satisfaction<sup>74 76-77 97 102 117 120-121</sup>. As the main purpose of affective behavior is to build and maintain a good interpersonal relationship, it is no wonder that many researchers have chosen the continuity of the doctor-patient relationship as an other important outcome criteria. Much research has been done into the relationships between affective behavior and subsequent appointment-keeping. DiMatteo<sup>76</sup> found that the most important aspects of physician's behavior in predicting the patients' willingness to return for care involved patients' feelings of being cared about by the physician, the degree to which their physicians took time with them, explained and listened to them and were accessible when needed. He also found<sup>121</sup> that the physicians nonverbal decoding skills were related to patient compliance with scheduled appointments. Ross found that good psychosocial care encourages the use of physicians' services. Physicians who have open give-and-take relationships with their patients, who listen to them and are sensitive to them as social and psychological beings have clients who are not reluctant to return to the doctor. Physicians who are insensitive, uncaring and autocratic however discourage utilization<sup>122</sup>. Buchsbaum<sup>123</sup> cites two other authors who both found that the most common reason for patients terminating the physician-patient relationship was the patient's perception that the physician was not caring. Hall<sup>124</sup> and Falvo<sup>9</sup> also found a positive relationship between the physician's affective behavior and subsequent appointment keeping. Ware<sup>125</sup> found that patients with favorable attitudes toward the interpersonal manner of doctors were more likely to choose to see their regular doctor in response to vomiting blood; those with less favorable attitudes were more likely to choose the hospital emergency room.

The purpose of affective behavior is to create a good interrelationship between physician and patient. However, what is considered a good interpersonal relationship differs in the literature.

Some authors (mainly sociologists or social psychologists) refer to the interpersonal relationship between doctor and patient mainly as a **social relationship** with elements as 'good manners' or 'basic etiquette'. In the publications of Hall and Roter for instance<sup>81 82</sup>, a GP is considered to show socio-emotional behavior, when he makes many personal remarks, creates a relaxed atmosphere by laughing or joking, and gives the patient compliments or signs of approval. Wolraigh<sup>127</sup> concept of 'social amenities' proved to form one factor together with Roter's 'personal remarks' in a factor analysis of the combined observation systems of Roter (RIAS) and herself (MCBS). Important elements of Svarstadt's concept of 'approachability' are: greeting, responding to the patient's first questions and soliciting new questions, smiling and laughing, refrain from clock-watching and mumbling or cutting off patients<sup>102</sup>. In Freemon's study, the affective tone of the consultation is determined by the physician's social conversation and his friendly attitude<sup>89</sup>. Garrity concludes that the concept of 'affective behavior' relates and perhaps is similar to what others call 'social support'<sup>102</sup>.



Clinical psychologists and psychiatrists will not agree with him. According to authors with a psychotherapeutic background, the importance of a good interpersonal relationship between physician and patient resides in its therapeutic qualities as such: "*Clinical medicine is above all else communication between two people, it is about communication between two people, it is about establishing an effective working relationship in which there is mutual trust*"<sup>12</sup>. This statement refers to the basic conditions for the helping relationship, the 'sine qua non' of the doctor-patient relationship. The first to make these basic conditions explicit was Carl Rogers, undoubtedly the most cited author among psychotherapeutically oriented researchers into doctor-patient communication<sup>6 70 97 107 120 122 128-130</sup>. He distinguished several basic or 'core' conditions which are essential in the **therapeutic relationship**: empathy, respect, genuineness, unconditional acceptance, warmth. Carkhuff<sup>131</sup> was the one who firstly made clear that these basic conditions are not only important in psychotherapeutic relationships, but actually in all kind of helping relationships, professional as well as non-professional. Michael Balint<sup>57</sup> was the first to implement these ideas in medical practice with his appealing notion of 'the doctor as the drug'.

The basic or 'core' conditions were considered by Carkhuff<sup>131</sup> as so-called 'nonspecific factors'. He stated that the helper's effectiveness may largely be accounted for, independent of his orientation and technique, by assessing the level of core conditions he offers. He estimates, citing others, that as much as 60 % of the effectiveness of the therapeutic process may be due to nonspecific relationship factors. Recently White<sup>18</sup>, Lemmens<sup>132</sup> and Dijkhuis<sup>133</sup> have pointed out that these ideas are not, as yet, outdated.

Several authors have mentioned several elements as the 'core' conditions of the therapeutic relationship; Hornsby<sup>128</sup> mentioned empathy, respect, and warmth as the core conditions of the first stage of the helping process, which consist of facilitative behavior. Empathy was defined as the physicians ability to show the patient that he really understands the patients problems. Respect was defined as the ability of physicians to accept their patients as they are with their own set of values, warmth was defined as the degree to which physicians communicate a sense of caring for their patients. Fine<sup>13</sup> mentioned empathy, respect and genuineness, Dryden<sup>129</sup> empathy, unconditional acceptance and genuineness, Rudner<sup>134</sup> empathy, warmth and genuineness. All authors agree, however, that empathy must be considered as the most important factor: "*Empathy is perhaps the most critical of all helping dimensions. Without empathy there is no basis for helping. From it flows the appropriate and meaningful employment of all other dimensions and ultimately the resolution of the helper's problem*"<sup>131</sup>. Compared with the interpretation of the interpersonal relationship as primarily a social relationship, in the therapeutical interpretation of the doctor-patient relationship other types of behavior are thought to be important: eliciting feelings, paraphrases and reflections, open questions, silence, listening to what is said, but also to what the patient is unable to say (his anxiety, uncertainty, the problem-behind-the-problem), verbal encouragements, etc.<sup>92 97 120 135-139</sup>. That is what was meant by Michael Balint when

he said: *"When you ask questions, you only get answers."*<sup>57</sup> Furthermore, nonverbal behavior is considered very relevant in this approach<sup>7 8 76 97 140</sup>, especially eye-contact, facial cues, and body positioning.

Other authors have arrived at the same kind of relevant behaviors from a somewhat different line of reasoning. One line of thought has to do with the typical **stress-laden situation in medical care**. Many authors<sup>8 45-48 77 97 141-142</sup> have pointed to the fact that for most patients, illness is an emotional affair. Patients experience anxiety and uncertainty. In turning to the doctor the patient therefore has two goals: the solution of an illness problem and the solution of an anxiety problem<sup>77</sup>. Yet, going to a doctor is in itself an emotional affair, too<sup>8 46 64</sup>. In going to a doctor the patient loses his independence, his normal capacity to solve his own problems. As a consequence, he experiences two types of anxiety, which have a somewhat paradoxical relationship with each other: on the one hand he is afraid about his illness problem, (that this is serious, that perhaps, he will die or become an invalid as a result of it; on the other he is afraid that nothing is wrong, that his doctor will not take him seriously, perhaps even see him as a malingerer. This complex interwoven set of anxiety ensures that reassurance alone is seldom enough in general practice. Probably it is also an explanation for the finding, that solving the illness problem does not necessarily solve the patient's anxiety-problem. In the last decade, an elaborate theoretical framework has gradually been developed by Ben Sira, to deal with this complex stress-illness-visit relationships<sup>45-47 77 141-143</sup>. He concludes from his own work and his appreciation of the literature, that GP's affective behavior is the most important factor in meeting patient's needs; interest, devotion and time are considered to be the relevant elements.

There is still another line of reasoning to be mentioned which has led researchers to the same type of affective behavior. For several reasons (changing morbidity pattern, emancipating patients, consumerism), there is a general tendency to argue for a more **egalitarian relationship** between doctor and patient. In terms of Szasz and Hollender's famous models<sup>18</sup>: a change from the activity-passivity model to a guidance-cooperation model, and (with some kind of health problems and some kind of patients) to a mutual participation model. In this perspective, Byrne and Long<sup>70</sup> have developed their 'power-shift model' to measure the degree of influence the GP grants his patient in the diagnostic and therapeutic phases of the consultation. They mention as important steps in a patient-centred medical consultation: relating to the patient; enabling the patient to talk about his problem, utilising such skills as reflecting, interpreting and silence; allowing the patient to define his own problem, seeking out his own ideas, and enabling him to generate his own solutions. McWhinney<sup>55</sup>, Stewart and co-workers<sup>17</sup> take a similar stand when they define patient-centred care as *"care in which the doctor responds to the patient in such a way as to allow the patient to express all of his or her reasons for coming, including symptoms, thoughts, feelings and expectations"*. In patient-centred behavior the physician is enjoined to discover the patients expectations, his

feelings about the illness, and his fears. He does this by trying to enter the patient's world and to see the illness through the patient's eyes<sup>55</sup>. Patient-centredness was found to be associated with the doctor having ascertained the patient's reasons for coming and with resolution of the patients concerns. It was also associated with the patient feeling understood and resolution of the patient's symptoms<sup>17</sup>. However, no relationship was found between patient-centred behavior and patient satisfaction.

Many elements of affective behavior find their origin directly or indirectly in psychotherapeutic theories. It comes therefore as no surprise that researchers who employ affective elements in their observation systems often show interest in the relationships between affective behavior and the physician's ability to detect psychosocial or psychiatric problems. Verhaak<sup>19 110</sup> discovered that general practitioners with an 'open conversation style', characterized by much affective behavior (verbal and nonverbal empathy, as well as patient-centred behavior) notice a psychosocial component in patient's health problem more often than GPs with a traditional conversation style; they also talk more about mental health problems with their patients. Marks<sup>144</sup> concluded after seeing that a psychiatrist was not better than a general practitioner in detecting psychiatric illness, when he had to rely on the GP's interview, that the detection of psychiatric illness is highly dependent on the way a patient is interviewed. Doctors who show a lot of empathy and ask many psychosocial questions are likely to be accurate raters of psychiatric disturbance. Gask<sup>61</sup> found a significant overall change in the ability of general practice trainees to detect psychiatric illness after a training course, together with a marked change in interview style: after the training the trainees demonstrated a more empathic interviewing style, they were more likely to sense the patient's distress and to define the main problem accurately. They asked also more psychosocial questions, were more likely to comment on affect-laden comments and gave increasingly appropriate psychosocial advice. More or less similar results were achieved with a group of experienced general practitioners<sup>145</sup>.

## *Research problem*

The research problem to which I will address myself in the empirical parts of this thesis is:

**which elements of General Practitioner Behavior provide good quality of care?**

Attention will be paid to instrumental behavior as well as affective behavior as well as their interrelationships. Many of the above mentioned behavior elements will come back in the articles as part of one or more of the observation systems. The following criteria are used as indicators for good quality of care:

- 1 the discussion of psychosocial problems, when these are thought to play a role in the patient's health problem.  
(Chapters 3 and 4).
- 2 panel-assessed quality of care on three dimensions: technical-medical care, psychosocial care and an adequate management of the physician-patient relationship; panel-assessed degree of generalist orientation (as opposite to a biomedical orientation).  
(Chapters 5 - psychosocial quality only -, 6 and 7).
- 3 patient satisfaction (Chapters 5, 6 and 7) and patient's appraisal of the general practitioner's task scope (Chapter 6).

The empirical articles all have a slightly different approach to the general research question. In the Conclusion, I shall try to integrate the different research results, but first a theoretical framework is presented to account for the sometimes confusing results in the literature.

## NOTES

- a. The research material on which this thesis is based has been collected in three consecutive research projects:
- 1 an evaluation study of an experiment with mental health consultation in general practice (Chapter 3),
  - 2 an evaluation of a interview training course for general practitioners (Chapter 4), and
  - 3 a cross-sectional study into the inter-physician variation in the interpretation and treatment of psychosocial complaints in general practice (Chapters 5,6 and 7). See the annexes for further details about the observation instruments in each of the studies.
- b. as can be seen in the next table, exchange of information in one way or another, physical examination and the prescription of drugs are the GPs most common activities

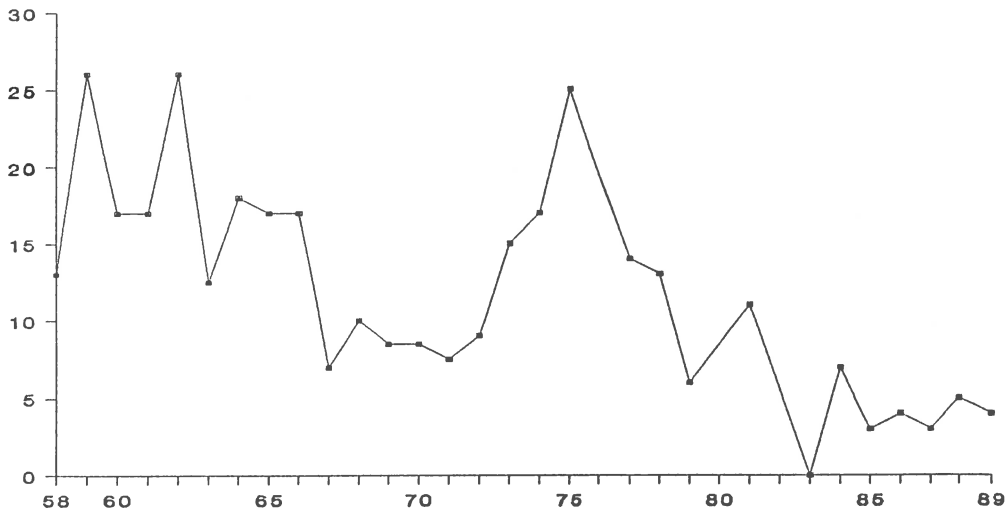
### Interventions within General Practice

<b>A</b>	<b>Diagnostics</b>	(76,0%)
	* Physical examination	71,8%
	* blood	2,3%
	* urine analysis	4,7%
	* other	1,9%
<b>B</b>	<b>Therapeutics</b>	
<b>B1</b>	Medical conversation	(64,0%)
	* information and instruction	45,7%
	* counseling and reassurance	32,4%
	* health education and advice	13,5%
<b>B2</b>	Medication	(59,2%)
	* prescriptions	56,6%
	* med. without prescr.	2,5%
	* changing dose	1,9%
<b>B3</b>	Medical Technical Interventions	10,6%
	* minor surgery + wound care	2,7%
	* injections	2,1%
	* vaccinations	1,6%
	* other	4,7%

Source: National Study of Morbidity and Interventions in General Practice.  
NIVEL, 1991.

- c. That this is also true for much hospital-based care is shown by Hampton et al.<sup>87</sup>, who let some physicians record their diagnosis and a prediction of the method of management after reading the patient's referral letter, again after taking the history, and again after physical examination. A comparison between these diagnoses and predictions and the final ones (two months later) revealed that in 82.5 % of the cases, the diagnoses after reading the referral letter and taking the history were the same as the final one; the physical examination was useful in only 9 % of the cases, and the laboratory investigations in a further 9 %. In this study in only one patient (out of 6) for whom the physician was unable to make any diagnosis after taking history and examining the patient, did laboratory investigations lead to a positive diagnosis. Putnam<sup>80</sup> concludes that 56-85 % of the diagnoses in internal medicine can be made on the basis of history alone.
- d. Flexner was the man who (in the beginning of this century in the United States ) successfully limited the domain of medical education to topics from the biomedical model. All psychological and social elements were banned out of the curriculum. This has influenced the education of many generations of physicians.
- e. In a recent article Wolpe<sup>146</sup> described this as one part of the four-part strategy that is used by "heretics" who want to challenge an entrenched orthodoxy: "they reaffirm their central place in the mythology of the discourse by appealing to charismatic founders, historical examples and basic values to show the historical primacy of their ideology. This is the heretical legitimation."

f. Figure 1.1 Proportion of articles on psychological topics per volume (per annum) in 'Huisarts en Wetenschap'.



See also for a socio-philosophical analysis over the same period the thesis of Annemarie Mol and Peter van Lieshout, entitled "Ziek is het woord niet"<sup>147</sup>. Medicalisering, normalisering en de veranderende taal van de huisartsgeneeskunde en geestelijke gezondheidszorg 1945-1985".

g. Pickering<sup>15</sup> gives about the same figures, when he states: "I would guess that of every 100 patients seen by a primary care physician, two or three can be treated with the confident expectation that they will behave in a certain way within probability limits. In another five the effects of certain operations or drugs are sufficiently well understood to give the physician some confidence that he is interfering on the patient's behalf. In some 90 % however, the effects of treatment are unknown, or there is no specific remedy known to influence the course of the disease".

h. Let us work this out for hypertension, as part of this thesis involves hypertensive patients. There is a growing amount of literature on psychosocial influences on the origin, course, and treatment effects of hypertension. Among the population, it is widely assumed that stress plays an important role in the origin of hypertension, as was illustrated in the Netherlands in a nationwide research project run by the Netherlands Consumers Organisation<sup>68</sup> and in the United States of America in a survey by the National Institute of Health<sup>69</sup>. Blumhagen<sup>148</sup> reported that 72 % of a group of patients with biomedically defined hypertension, believed that they had a physical illness, characterized by excessive nervousness caused by untoward social stress, especially chronic external stress.

On the contrary, heredity is thought much less important by the majority of people, while this is thought to be an important factor by most physicians<sup>149</sup>, and the most important by some of them<sup>150</sup>. By comparing identical twins, it is suggested that the genetic component will explain a maximum of 60% of the variance. Other contributory factors are probably diet, obesity, stress and personality<sup>149</sup>. Also some sociodemographic characteristics seem to be of relevance. Age is important, as well as sex<sup>151</sup>. Among blacks hypertension occurs twice as much as among whites and it tends to be more severe for blacks<sup>152</sup>. The lower socioeconomic classes also seem to have a higher risk for hypertension, as well as people with a low level of education<sup>153</sup>. Lindgärde<sup>49</sup> found in a longitudinal study, that it was not the socioeconomic status of the family at childhood as such, but a lower cognitive ability, resulting in lower education, which explained the variance in blood pressure rate. In this study the men who developed hypertension were also psychosocially disadvantaged with respect to divorce rate and job dissatisfaction. They also reported less physical activity in leisure time and were more obese. Other stress factors that are generally thought relevant are sustained vigilance (e.g. amongst air traffic controllers<sup>49, 149, 154</sup> urbanization<sup>40, 149</sup>, and crowding<sup>154</sup>. Literature about personality characteristics as type A-personality, coping style, anxiety and hostility-repression reveal conflicting results. Baile<sup>149</sup> concludes "although there is evidence suggesting that there is a psychosomatic aspect to

hypertension, we are a long way from understanding the psychophysiological mechanisms mediating the relationships being identified".

There is also considerable literature about the influence of (incorrect) labelling of hypertension on the psychosocial well-being and sickness absenteeism. Bloom<sup>155</sup> found that a mislabeled group reported more depressive symptoms, lower present health and a worsening of their health over the past five years. Mann<sup>154</sup> cites some other studies with the same kind of results. These results were not confirmed in his own study, however, which he contributes to the special care for the persons screened in the follow-up visits, and especially to the non-specific effect of attendance at the clinic, where the (same) nurse established a warm and supportive interest in the trial group which she was supervising. He suggests that in screening-programs, it is important to develop a personal and stable relationship with the persons screened, because such a therapeutic relationship can counteract the possible negative psychological effects of screening. Similar results and similar conclusions have been reached by Moum<sup>156</sup>.

The relevance of patient education by a personal doctor in changing patient behavior and enhancing compliance in hypertensive patients is demonstrated by Inui<sup>157</sup>. Schulman<sup>158</sup> reported that an Active Patient Orientation (APO) (which means that the patient is actively involved in the treatment by two-way communication, joint decision-making, emphasis on self-care, and a supportive attitude) is effective in keeping the blood pressure under control. Other behavioral techniques that are thought important in the management of hypertension are aerobic exercise<sup>159</sup>, biofeedback<sup>149</sup>, relaxation techniques<sup>149, 159</sup>. However, it is not certain, what the working ingredient is. At any rate, personal attention seems a very important factor in the management of hypertension. A recent prospective randomized trial in the Netherlands into effects of paranormal healing on the reducing of blood pressure in essential hypertension showed marked decreases in blood pressure over a 15-week period, but this occurred also in the control group<sup>160</sup>. The authors suggest that the fall in blood pressure in all three groups either was caused by the psychosocial approach or was a placebo effect of the trial itself.

Anspach wrote a remarkable article on the subtle ways by which the medical students' implicit 'world of knowledge' is shaped by one particular form of professional socialization: the gradual learning process on how to make a good case presentation. She discerned four features of case presentations, which all favour a technocratic approach to medicine: (1) the separation of biological processes from the person (depersonalization: "Baby Girl Simpson was the 1044-gram product of a 27 week gestation"), (2) omission of the agent (e. use of the passive voice: "she was extubated", when actually there was made a life-and-death decision), (3) treating medical technology as the agent, and consequently mitigating the responsibility about medical decision-making ("auscultation of the head revealed a very large bruit"), and (4) account markers, such as "states", "reports", and "denies", which emphasize the subjectivity of patients' accounts. Technology 'reveals' and 'shows'; the physician 'notes' or 'observes'; the patient 'reports' and 'denies'. "Thus although medical students are taught to attach more weight to the patient's history than to the physical examination or laboratory findings, the language of case presentation devalues patients' accounts. By using this language, physicians learn a scale of values which emphasizes science, technology, teaching and learning at the expense of interaction with patients. Whether used intentionally or unwittingly, the language of case presentation contains certain assumptions about the nature of medical knowledge. The practices I have discussed both reflect and create a world view in which biological processes exist apart from persons, observations can be separated from those who make them, and the knowledge obtained from measurement instruments has a validity independent of the persons who use and interpret this diagnostic technology"<sup>161</sup>.

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## 2 Implicit theories in doctor-patient communication\*

### Introduction

There is not much theory in research on doctor-patient communication other than an incidental and isolated example (mostly dissertations). The research in this field has provided us with a host of interesting publications, but also with a bulk of seemingly contradictory research findings. These form a highly ambiguous picture, described so vividly by Inui and Carter as "*a Rorschach test for readers, that is apt to reveal as much about the reader, as about the results themselves*"<sup>1</sup>. Table 1 shows this 'Rorschach-test'. It is a review about the relationships between doctor-patient communication and the most common outcome measure in doctor-patient communication research: 'patient satisfaction', firstly published by Pendleton<sup>2</sup>, in 1983, later reproduced by Inui and Carter (1985)<sup>1</sup>. Many different variables prove to be related to patients' satisfaction. The table shows a complex picture indeed.

While more factors can be found that may have contributed to the apparent difficulty of synthesizing the research results from different projects<sup>1-5</sup>, it is mainly the lack of systematic theorizing that can be held responsible. More authors have commented on this. Researchers often conclude their empirical publication with a call for more theory. Reviewers of this extensive research field (as Tuckett et al.<sup>6</sup>, Roter et al.<sup>3</sup>, Hall et al.<sup>4</sup>, Inui et al.<sup>7</sup>, Carter et al.<sup>8</sup>) have elaborated criticisms on the lack of theory. And, still one level higher, critics of the reviewers (such as Leventhal<sup>9</sup>) have accused some of them of making exactly the same mistake. So we face a deep-rooted problem.

This article presents no comprehensive theoretical framework for the understanding of all the different results from different projects, as Leventhal did when proposing the use of a system theory for explaining all and everything that happens in doctor-patient communication as well as in patients' compliance with doctors' orders<sup>9</sup>. Also no attempt is made to condense the multitude of variables found and to reduce them to a restricted number of categories, as for instance Hall, Roter and Katz did

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in their courageous meta-analysis<sup>4</sup>. Instead a third route is chosen to get a better grip on that intriguing Rorschach test that was described by Inui and Carter: In this article the (often implicit) theoretical notions that actually do play a role in concrete research are explored. It will be shown how these notions are embedded in the methods and measures of observation research, in the way the data are handled, and - as a consequence - how these (implicit) theoretical notions eventually influence the results of observation research - or the lack of results.

Table 2.1 Interactional Analysis Studies Relating Clinical Communication Process to Satisfaction Outcomes

Study	Aspects of satisfaction	Variables shown to be related
Korsch et al.(1958) *	Dissatisfaction	No reassurance
Freemon et al.(1971)	Satisfaction	Proportion of doctor talk high <sup>a</sup> Doctor behavior warm and friendly Doctor volunteered information Doctor discussed causes of problem Patient expressed agreement and understanding Much social chat
Korsch et al.(1971)	Satisfaction	Doctor showed friendly interest
Korsch and Negrete(1972)		Doctor discovered concerns Doctor dealt with expectations Doctor gave specific instructions Doctor offered continued support Doctor expressed trust in caretaking ability of mother
Kupst et al.(1975)	Satisfaction	None
Larsen and Rootman (1976)	Satisfaction	Doctor conformed to patient's expectations
Roter (1977)	Dissatisfaction	Increased patient questioning after experimental intervention
van Dorp (1977)	Dissatisfaction	Doctor asked many closed questions
Woolley et al.(1978)	Satisfaction	Doctor used empathic questions
	Satisfaction with care	Satisfaction with outcome Continuity of care Communication about patient expectations Patient expectations fulfilled
	Satisfaction with outcome	Actual outcome Satisfaction with care
Romm and Hulka(1979)	Satisfaction	Patient memory of specific information
Stiles et al.(1979)	'Affective' satisfaction	Patient explained condition in own words early in interview
	'Cognitive' satisfaction	Doctor freely informed patient about illness and treatment at end of interview
DiMatteo et al.(1979)	Patient's positive evaluation of doctors' behavior	Patients' age Patients' sex Patients' occupational status Patients' level of education
	Patients' expressed willingness to return to same doctor	Patients' positive evaluation of doctor's behavior Seriousness of problem

Table 2.1 (continued)

Study	Aspects of satisfaction	Variables shown to be related
Ben-Sira(1980)	Patients' positive evaluation of doctor's behavior	Patients' degree of concern about problem Patients' level of education
Friedman et al.(1980)	Satisfaction Doctor's non-verbal expressiveness	Aspects of doctor's personality
Hall et al.(1981)	Contentment with visit results	Negative doctor affect expressed in voice tone with positive affect communicated through words
Wartman et al.(1981)	Satisfaction with quality of provider-patient interaction	Not receiving prescriptions associated with greater satisfaction
Cornstock et al.(1982)	Satisfaction with doctor characteristics and performance	Courteous behavior and provision of information; female patients more satisfied with female doctors
Inui et al.(1982)	Satisfaction with technical interpersonal and communication aspects of clinic visits	Positive association with increased patient opportunity to provide information; negative association with doctor and patient verbal behaviors suggesting tension or anxiety and with assertive patient verbal behaviors
Eisenthal et al.(1983)	Global satisfaction with visit	Doctor gives clear and complete explanation of medication and seeks patient agreement with plan; patient states requests before disposition phase of visit
Ley (1983)	Satisfaction with communication	Understanding of instructions
Wasserman (1984)	Satisfaction with technical and interpersonal aspects of visit	Positive association with encouraging and emphatic behaviours

\* Citations for 1968 -1980 work may be found in Pendleton<sup>2</sup>; the others in Inui and Carter<sup>1</sup>

## The two Faces of Medicine

To start with, a distinction is made between, what Putnam et al. called: 'the two faces of medicine'<sup>10</sup>: 'technology and humaneness', 'cure and care', the 'science and the art' of medicine. This much used distinction<sup>1 3 11-26</sup> goes as far back as Hippocrates, who noticed, in the fourth century before Christ that "*the patient, though conscious that his condition is perilous, may recover his health simply through his contentment with the goodness of the physician*" (cited from Dimatteo, 1979<sup>11</sup>). While in early times, doctor-patient communication often was the only means a physician had of curing a patient<sup>1</sup> (be it by the placebo-effect, the Hawthorne-effect, or perhaps the unknown factor X<sup>12</sup> that provoked Michael Balint to his famous assertion 'The Doctor as the Drug'<sup>27</sup>), nowadays the attention, the respect and the flow of money has shifted to the instrumental side of medical science. Nevertheless there are enough sound people who realize the equal importance of these two domains of medical science, as was recently demonstrated in an important Conference on 'the Task of Medicine' in the United States, the 'Wickenburg Conference'<sup>12</sup>.

Let us put some colour into these two faces of medicine. Cure and care are distinctive in several respects:

- they are considered as 'science' versus 'art'
- their origin is in biomedics versus psychology or psychiatry
- their focus is on technology and humaneness
- the patient is considered as a case, or as a person
- he has a disease or an illness, that can better be described as a dis-ease
- the purpose is problem-solving, or creating a therapeutic relationship
- the physician's behavior is instrumental versus affective, or expressive in nature.

Doctors' behavior in consultations can be described as somewhere along this cure-care dimension. It has even been demonstrated, that doctors do develop a typical communication-style of their own, that can be located on this dimension<sup>28-31</sup>.

## Patient's Needs

From the patients' point of view the same kind of distinction can be made. Patients have a health history before they enter the consulting room: they have observed certain symptoms; they have considered these as serious enough to undertake some action; their own actions and counseling from their social environment has not proved to be of sufficient help; they have decided to make arrangements to go see a doctor<sup>32</sup>. Essentially every illness can be considered as a breakdown<sup>33</sup>. The patient, when entering the consulting room, is at the height of an accumulating stress curve<sup>18-20 34</sup>. Stress with two distinctive aspects: uncertainty and anxiety<sup>35</sup>. Uncertainty, because he wants to know what is the matter with him (what is it? what caused it? what has to be done to relieve it?) Anxiety, because he is afraid (afraid that perhaps it is bad or will get worse; afraid that he will not be able to resume his normal daily life; afraid that he will perhaps die). Some authors<sup>33 36</sup> have pointed to

the fact that going to the doctor itself produces additional uncertainty as well as anxiety ("What can I expect? Will I be taken seriously?"). In turning to a physician, the patient thus has two goals: the resolution of an uncertainty problem, and the resolution of an anxiety problem, both problems being interrelated and hence requiring simultaneous attention<sup>33</sup>.

The first problem reflects a cognitive need; as Engel said: "*the need to know and understand*"<sup>37</sup>. He wants instrumental behavior: information, especially explanation and clarification<sup>38-47</sup>. He can get that from the physicians' verbal behavior. On the other side is the anxiety problem. This reflects an emotional need; in Engel's words: "*the need to feel known and understood*"<sup>37</sup>. The patient wants to be accepted as a patient<sup>37 48-50</sup>, to feel that he is not a malingerer. He wants positive affect<sup>11 15-18 50-51</sup>, and most of all reassurance<sup>50 52</sup>. He is therefore attuned to the verbal and non-verbal behavior of his physician. Moreover, there is a growing evidence that the need for cure and the need for care are intricately interlinked<sup>33 50</sup>. It is obvious that many medical problems cannot be resolved by an empathic attitude alone (CARE). A newer insight that is as evident is that many medical problems cannot be solved by instrumental behavior alone (CURE). Psychological factors, as for instance stress and anxiety do play an important role in the onset, the process and the outcome of very many medical problems<sup>12 33 35 53-55</sup>.

## Unraveling the Rorschach

Let us now turn back to Inui's Rorschach-test (see Table I). The Table pictures all variables in doctor-patient communication research that have found to correlate with patient satisfaction. To unravel the Rorschach, some actions are taken: Firstly, all background and outcome variables that have nothing to do with doctor-patient communication itself are removed<sup>b</sup>. Not because they are not important, but because for this moment we want to concentrate on the communication itself. Then the remaining variables are clustered according to the principal needs of the patient as just discussed: the need for information and the need for positive affect. The result of this exercise can be seen in table 2.2. The Rorschach-test becomes a meaningful picture. The communication variables which are found to be related to patients' satisfaction can easily be classified in three categories:

- 1 affective behavior
- 2 information giving (especially the volunteered information)
- 3 meeting patients' expectations.

Table 2.2 Interactional analysis studies relating three types of communication variables to satisfaction outcomes

Study	Affective variables	Instrumental variables	Other variables
Korsch et al.	No reassurance		
Freeman et al.	Proportion of doctor talk high Doctor behavior warm and friendly Patient expressed agreement and understanding Much social chat	Doctor volunteered information Doctor discussed causes of problem	
Korsch et al.	Doctor showed friendly interest		
Korsch and Negrete	Doctor discovered concerns Doctor offered continued support Doctor expressed trust in caretaking ability of mother	Doctor gave specific instructions	(Doctor dealt with expectations)
Larsen and Rootman			(Doctor conformed to patient's expectations)
Roter		Increased patient questioning after experimental intervention	
van Dorp		Doctor asked many closed questions Doctor used empathic questions	
Woolley et al.			Communication about patient expectations (Patient expectations fulfilled)
Stiles et al.		Patient explained condition in own words early in interview Doctor freely informed patient about illness and treatment at end of interview	

Table 2.2 (continued)

Study	Affective variables	Instrumental variables	Other variables
Ben-Sira	(Patients' degree of concern about problem)		
Friedman et al.	(Aspects of doctor's personality) Doctor's non-verbal expressiveness		
Hall et al.	Negative doctor affect expressed in voice tone with positive affect communicated through words		
Cornstock et al.	Courteous behavior	Provision of information	
Inui et al.	Negative association with doctor and patient verbal behaviors suggesting tension or anxiety and with assertive patient verbal behaviors	Positive association with increased patient opportunity to provide information	
Eisenthal et al.		Doctor gives clear and complete explanation of medication Patient states requests before disposition phase of visit	Doctor seeks patient agreement with plan
Wasserman	Positive association with encouraging and empathetic behaviors		



The first two categories coincide with the two basic needs of the patient: the need for positive affect and the need for information. They also coincide with the two domains of medical practice: care and cure.

The third category does not follow directly from our contemplation on the cure-care dimension. But it refers to empirical evidence, theorizing as well as common sense that all patients are not the same; they can have and do have different needs and expectations with regard to their health care. Health beliefs<sup>56</sup>, locus of control<sup>57</sup>, explanatory models<sup>58</sup> or frames and heuristics<sup>59</sup>, these all are theoretical concepts that try to grasp the variety in patient behavior. There is even some evidence that patients can be distinguished as having an affective or an instrumental orientation to medical care: Coser (cited by Mathews<sup>39</sup>) found that patients with a so-called primary orientation concentrate on obtaining attention and sympathy, while those with an instrumental orientation see the hospital as a place where tasks must be carried out to effect cure. There is also some evidence that the type and degree of seriousness of patients' complaints do affect the need for instrumental versus affective behavior<sup>33</sup>. When patients are different in their specified needs for medical care, even on the cure-care dimension, it is not surprising to find a third cluster of relevant physicians' behavior in the collected research results: meeting patients' expectations.

### **Affective versus instrumental behavior**

At this point a conclusion to be drawn from literature is that there are three groups of variables, three types of physician behavior that seem to predict patient satisfaction: affective behavior, information giving and meeting patients' expectations. With this conclusion, nothing has yet been said about the relationship between these types of behavior, their relative weight, their relative impact, etc. And here looms the next problem.

Until recently researchers worked mainly within one of the two domains. Some were interested in patterns of information exchange with patients of different age, sex, race, or social background<sup>41-42 51 60-65</sup>; in types of behavior that were effective in promoting recall or compliance<sup>22 43-44 64 66-71</sup>; in the effect of question asking by patients on subsequent appointment-keeping<sup>72-74</sup>; all task-related behaviors in the domain of problem-solving or medical CURE. Others were interested in evaluating interview skills<sup>49 75-84</sup>, in the detection of mental problems<sup>31 79 80 82 85-87</sup>, or in the degree the physician helps his patient to explore and express himself<sup>75 83 88-89</sup>; all affective behaviors in the domain of the therapeutic relationship or medical CARE. Only recently have the interrelationships between instrumental behavior and affective behavior attracted the attention of researchers. And here again, we get quite contradictory results. Some researchers postulate that patients cannot discriminate between the doctor's affective and instrumental behavior, and therefore base their evaluation of the doctor's technical performance on his affective behavior; there is some empirical evidence for this statement<sup>11 12 15-18 30</sup>. Others claim that patients can and do discriminate between these two types of

behavior and let their satisfaction depend on their evaluation of the doctor's technical behavior more than on his affective behavior<sup>4 22 90</sup>. Some people argue that the doctor's instrumental behavior and his affective behavior are highly interrelated, and indeed in some projects there are high correlations between the external evaluations of these two types of behavior<sup>14 18 23 49 91</sup>. Others claim that there is a trade-off between the two types of behavior, and have found some evidence for this statement in their own research findings<sup>68 90</sup>. Again contradictory results that can partly be explained by the implicit theoretical notions of the researchers, and more specifically by the researchers' sensitivity to the different faces of medicine. Researchers who started within the instrumental tradition keep finding a preponderance of instrumental behavior, even if they have supplemented their original observation methods gradually with some measures for caring behavior, as for instance Hall and Roter did<sup>90</sup>. On the other side: researchers who started within the caring tradition keep finding a preponderance of affective behavior. Here, Ben Sira is a good example<sup>14-18</sup>.

### **The influence of a-theoretical decisions on concrete research**

An underestimated problem in research on doctor-patient communication (as well in much other research in the social sciences) is the influence of a-theoretical decisions on concrete research. The choice of an observation instrument is a good example. All too often, an observation instrument is chosen without much further thought, mainly because of its availability and proven high reliability. Svarstadt<sup>4 3</sup>, complained that many studies of consultations have been guided by their techniques rather than by any theoretical perspective. And the problem is that the choice of an observation instrument has in its turn an essential influence on the specific measures, the plan of analysis, and, at last, inevitable on the results<sup>92</sup>. Let us make this a bit more concrete. And let us therefore return to our CURE-CARE dimension.

CURE and CARE happen to have their own types of observation instrument. On the instrumental side, we do find Bales<sup>93</sup> with his Interactional Process Analysis. Bales has certainly inspired by far the most researchers on doctor-patient communication<sup>7 8 22 26 61-64 68 69 72 82 83 90 94-96</sup>. It seems however that not all of his followers understood his theoretical position when they chose to use or modify his observation system (although Bales himself warns that an observation instrument in itself is an extended set of hypotheses about the structure of interaction). Bales developed his classic observation system to study the problem-solving process in small groups. He assumes that all behavior is principally oriented to problem-solving; it is task related. It is also a social process. Therefore, the accent lies on information-exchange. Bales' theoretical background is formed by information and communication theories. He has elaborated notions about the influence of role, status, availability of resources etc. on the process of information-exchange. He acknowledges that sometimes behavior is mainly expressive (or affective) in nature,

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but that is only to maintain or restore the interpersonal relationship, needed to facilitate the problem-solving process. Expressive behavior has no purpose of its own. Bales' categories are shown in Table 3. The numbers 4-9 are meant to classify the task-related or instrumental behavior. The numbers 1-3 (positive) and 10-12 (negative) are meant to classify socio-emotional or expressive behavior.

Table 2.3 Bales' Categories for Interactional Process Analysis

1. Shows solidarity	7. Asks for orientation
2. Shows tension release	8. Asks for opinion
3. Agrees	9. Asks for suggestion
4. Gives suggestion	10. Disagrees
5. Gives opinion	11. Shows tension
6. Gives orientation	12. Shows antagonism

As can easily be seen, these categories are well suited for measuring socio-emotional concepts, such as the degree of conflict or consensus (essential for understanding problem-solving), but they can not measure therapeutic concepts such as empathy, warmth, etc., necessary for understanding anxiety reduction. So research that only uses Bales-like observation systems, will never be able to assess the essentials of caring behavior. It will even not be able to estimate its relevance in doctor-patient communication. If your only tool is a hammer, you see every problem as a nail.

On the other side of the cure-care dimension we do find the psychologist Carl Rogers<sup>97</sup> and the psychiatrist Michael Balint<sup>27</sup>. They have inspired the observation instruments of the researchers who are interested in affective behavior<sup>75 76 78 81 84 88 88 89 98-104</sup> with their concepts like empathy, respect, warmth, genuineness, devotion and unconditional positive regard. Carkhuff<sup>105</sup> and Truax<sup>106</sup> have done much work to develop measures to capture this type of behavior for research purposes. This research is firmly rooted in the psycho-therapeutic tradition. It is assumed that the physicians' unconditional positive regard will help to create a therapeutic relationship, in which a patient gets enough warmth and security to explore his problems and to try behavior change. It is an essentially non-directive approach. The doctor is there to facilitate the patient. But here too, we have the problem of the hammer and the nail: researchers within this research tradition are all too often only aware of the therapeutic qualities of the doctor-patient relationship, and do not have an open eye for the problem-solving aspects of the encounter or for patients' need for clear and clean information (*"I just want to know what it is and how to get rid of it"*).

So the two faces of medicine generate two separate research traditions that have a completely different theoretical background, and are (as a consequence), different from each other in many other respects, too. They both have their strengths and they both have their blind spots. The main differences are shown in Table 4.

Table 2.4 Observation methods within the Cure-Care Dimension

Cure	Care
purpose: problem-solving behavior: task-related/instrumental	purpose: creating a helping relationship behavior: socio-emotional/affective
methods: * audio * verbal behavior * comprehensive * detailed * countings	methods: * video or direct observation * verbal + non-verbal behavior * selective (salient parts) * global * ratings; some countings
reliability high/validity moderate	reliability moderate/validity high

### Two types of observation instruments: two types of problems

The Bales-like observation systems, originally meant to measure problem-solving behavior (CURE), usually make use of audio and code only the verbal behavior. The psycho-therapeutic oriented observation systems, meant to measure the affective behavior (CARE), usually make use of video or direct observations. Verbal behavior is measured as well as non-verbal behavior.

Different methods, different findings. Examples are easy to give. Silence, for instance, is a very powerful therapeutic tool, as well as listening. These passive behaviors are non-verbal in nature. Mehrabian concluded in a broad review of the literature, that only 7 % of the emotional communication is transferred via verbal behavior; another 22% is transferred by voice tone; 55 % is only transferred by visual cues, eye contact, body positioning, and so on (cited by Strecher<sup>107</sup>). Friedman<sup>36</sup> has pointed to the fact that patients are very observant of and sensitive to the non-verbal communication of health practitioners for a number of factors. First of all, illness generally provokes fear, anxiety and emotional uncertainty. Under these conditions, many patients will look for subtle cues as to how and what they ought to be feeling. Second, most patients are likely to be searching for information about the nature of their disease, its severity, its course and their prognosis. It has been shown, that non-verbal behavior 'leaks out' messages that are not meant to be told<sup>13</sup>. Patients are very sensitive to this<sup>36</sup>. Patients are also very sensitive to possible inconsistencies between the verbal and non-verbal behavior<sup>89</sup>. These are in the theoretical school of Rogers considered as a lack of genuineness, one of the basic concepts of Rogers' unconditional positive regard<sup>89</sup>. From this evidence, we must conclude that emotional communication can not effectively be measured by systems that only code verbal behavior like the Bales-like observation systems. And when yet this is done, it is not surprising to find seemingly contradictory results.

Another problem with the Bales-like observation systems has its origin in the way behavior is coded. In Bales-like systems, each unit of behavior is counted, the important ones, as well as the unimportant, and they all have a similar weight in the

analysis. This procedure gives a high reliability, but a moderate validity at most. Moreover, the analysis is mostly correlational in nature, with the underlying (but seldom explicit) assumption that 'more' is always 'better'<sup>1 7 108</sup>. There is no way to value that one salient remark, that made the patient speak up. There is also no tradition of looking for the optimum in certain physician's behavior that can easily be somewhere in between the minimum and the maximum<sup>6</sup>. Frequencies are sometimes replaced by proportions<sup>22</sup>, but probably more on empirical than on theoretical grounds. And there is no way to value the form of the behavior against the content of the message<sup>6 108</sup> (For instance a doctor can ask questions as : *"where does it hurt?"*, *"when did it start?"*, *"what makes it better or worse?"* or he can ask his patient: *"what are you most concerned about?"*, *"How does your problem upset your life?"* *"How do you think I can help you?"*). These are all questions, and must be coded as question in a Bales-like observation system. But the first group of questions consists of instrumental behavior, and the second of affective behavior.

The care-oriented researchers do face problems of their own with their observation systems. Studies in this field are often criticized because of methodological weaknesses. While researchers in the Bales-like tradition are criticized because of an undue attention to the technical aspects of their research<sup>6</sup>, the researchers in this group seem to be so involved in the content of their doings (often research within the sphere of medical education) that their publications often show a lack of methodological sophistication<sup>78 84 100</sup>. The training seems to be more important than its scientific evaluation (and, of course, in some respects it is). Details about research design or - for instance reliability figures - are often not given<sup>107</sup>. The habitual scoring format of caring behavior (rating scales) has met serious criticism, because of its supposedly low reliability. The reliability figures are indeed usually somewhat lower than those of counted verbal utterances<sup>22 73 80 88 90 98</sup> but yet this does not seem the biggest problem, because mostly these are of an acceptable height (over .70). Barsky et al.<sup>109</sup> and Dimatteo et al.<sup>14</sup> conclude on the evidence from the literature, as well as from their own research that both methods (counting verbal utterances and using rating scales) do have reliabilities that are high enough to use in research and application. A problem with global rating scales that is more difficult to solve has to do with the so-called Halo-effect<sup>100</sup>: empathic behavior is often perceived as a Gestalt; the correlations of its components highly interrelated<sup>14 84</sup>. While empathic behavior is easily recognized by the clinician, it is difficult to pin it down in certain countable behaviors. And that is a problem in research. Measuring the 'art' of medicine, sometimes seems an art in itself, and not a scientific endeavor.

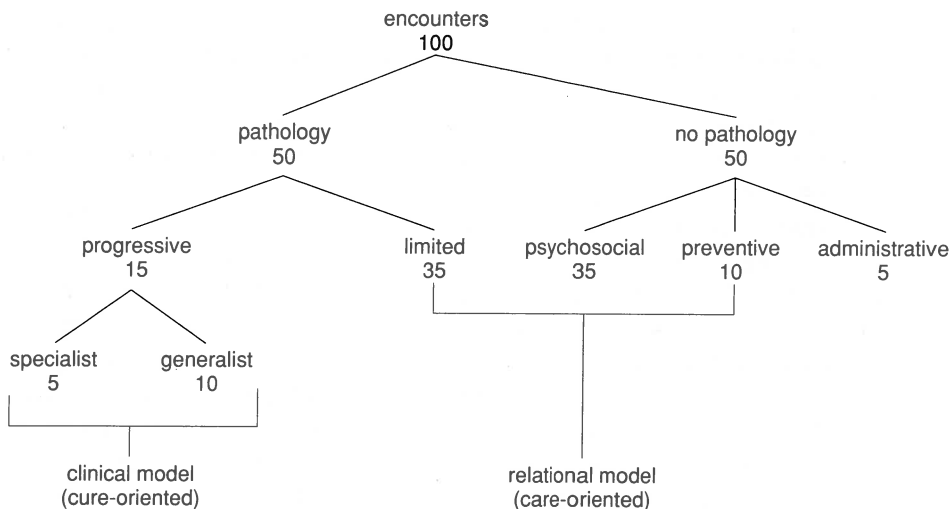
But perhaps the most important problem in care-oriented research is that one usually does not try to grasp the problem-solving behavior. And empathy is not enough in a medical consultation; several authors have pointed to that<sup>21 75 80 110</sup>. Care-oriented researchers are empty-handed when confronted with the need (which sooner or later will occur) to measure the problem-oriented side of medicine. Some have resolved this problem by adding an active part to the mainly passive

caring process<sup>75 79 80 89</sup>. Hornsby et al. proposed a three-phase model for counselling in general practice<sup>89</sup>. In this model more active behavior is indicated when the earlier stages of creating a good relationship and helping the patient to express himself have been passed. Empathic behavior is seen by those authors (and others<sup>88</sup>) as a 'conditio sine qua non', but not as a sufficient condition of its own. This may be a sufficient solution for those consultations in which psychological problems do play an important role, and perhaps also in consultations in which the most important purpose is to motivate the patient to change his behavior (as in preventive consultations), but surely not always and everywhere to the same degree. Sometimes a patient just wants to know what he has and how that can be cured in the fastest possible way! Sometimes a mainly instrumental approach is indicated.

Cure and care are both necessary in most consultations, but often in different degrees. This can be illustrated with the diagram in table 2.5 (cited from Kushner, 1981<sup>111</sup>).

Table 2.5 Content of General Practice

Chart devised by L.P.Carmichael, MD from data included in NAMC Survey, 1975.



From every encounter in general practice, about 50% deals with pathology, the other 50 % not. These last 50% do need a chiefly care-oriented (or administrative) approach. From the encounters with pathology, 35% of that pathology is self-limiting in nature: it will disappear, no matter what the doctor says or does. Patients' satisfaction will probably be more dependent on the affective than on the instrumental behavior. Only 15% of the presented problems is progressive in nature, and from this 15%, 5% is referred to medical specialists. The other 10% deserves a mainly cure-oriented approach, but the problems in this category will



often be rather serious and arouse much anxiety in the patient; so even in these cases the doctor cannot refrain from some affective behavior, for - as stated before - anxiety has proved to have a deleterious effect on the recovering process of people who are seriously ill.

This Table gives perhaps an additional answer to the discrepancies found in the relative weight of instrumental versus affective behavior in patients' evaluation of health care: Hall and Roter usually exclude psychological problems and preventive visits from their samples or use simulated patients with pulmonary problems (who by definition cannot feel the need for anxiety reduction, as real patients can and do)<sup>22 72-74 90 94</sup>. This can give an additional explanation for their constant finding of a preponderance of instrumental behavior. Ben Sira on the other hand questioned a representative sample with the whole range of problems<sup>15-18 33</sup>, many of these would need a primarily affective approach.

## Concluding remarks

The foregoing line of reasoning makes it clear that the results of research on doctor-patient communication are often influenced by the lack of systematic theory. The choice of an observation instrument, the choice of measures, the choice of a plan of analysis, they all reflect underlying theoretical notions with consequences for the results that can be expected.

This article is also a plea for scientific curiosity. Starting a research project on doctor-patient communication, we must start by asking ourselves WHY? And we must keep asking ourselves WHY?

**WHY SHOULD THIS TYPE OF PHYSICIAN'S BEHAVIOR, BE IMPORTANT IN THIS TYPE OF CONSULTATION WITH THIS PARTICULAR TYPE OF PATIENT.** And that does mean: not counting mechanically, and not rating mechanically. It means an intelligent hybrid of coding systems, that captures the need and the purpose of both affective and instrumental behavior in different types of consultations with different types of patients. And perhaps this also shapes an opportunity for integrating the interesting literature on health beliefs, explanatory models, frames of references and locus of control in research on doctor-patient communication.

## NOTES

- a. This has to be: "*proportions of doctors talking in a highly affectionate tone*". It is wrongly cited by Pendleton and reproduced by Inui and Carter.
- b. Background variables and outcome variables that are closely linked to communication variables are not excluded, but put between brackets in Table II.

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## 3 Room for the patient\*

### Introduction

General practice is still a young science. It is not more than thirty years ago that a kind of emancipation movement started within the world of general practice in which general practitioners became aware of the value and unique nature of their profession. Until then the general practitioner had been regarded mainly as a specialist without a specialism, a physician who simply knew less than a specialist. This was reflected in the area of medical education. There was no such thing as a course in the area in general practice. Medical training took place entirely in lecture halls, laboratories and hospitals. General practice was of no account.

Seen in this light it is not surprising that practitioners, in search of an identity, began by borrowing freely from other disciplines. The social sciences proved a congenial choice, particularly given the psychosocial nature of many problems and the emphasis on a personal and integral primary care. Gradually it became clear, however, that psychological theories or psychologist's tools were not always applicable to general practice. In contrast to the psychologist, the general practitioner is constantly required during consultations to solve the problem of whether the patient's complaint is physical or psychosocial in nature. Woe betide the physician who wrongly identifies a mortal (i.e. physical) danger as psychosocial!

Moreover, the GP, with a turnover of two or three patients per quarter of an hour and forty to sixty patients per day, cannot in general find the time to have a quiet discussion with his patients about the background to their problems. And yet he must discuss their problems with them. On the other hand, unlike the psychologist, he has the advantage of knowing his patients and, given suitable prior training, of being able to use this knowledge in the virtual certainty that his patient will come back sooner or later. Finally, the physician's problem is different in that it often concerns such an early stage of development that a bit of support will allow the patient to continue on his way.

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\* Translated reprint from: Bensing, J.M., Verhaak, P.F.M. Ruimte voor de Patiënt. Nederlands Tijdschrift voor de Psychologie en haar Grensgebieden 1982, 37,1, 19.

We mention these examples to show that psychological care differs fundamentally from general practice in a number of respects.

At the present time general practice has reached the stage where it is confronted with the not inconsiderable task of having to integrate a medical model which is no longer adequate with a model from the behavioral sciences which is not yet adequate into a single health care model suitable for general practice.

The article presented here should be seen in this light. It is an article in which concept analysis is central. We have chosen a concept from the behavioral sciences which could in our opinion play an important role in modern general practice. This is the concept 'room for the patient', by which we mean in a general sense: the chance a patient gets during consultation to bring to the surface what is really worrying him or her.

We have chosen this concept because the classical medical model is characterized by a minimum of room for the patient (consider, for example, medical anamnesis) whereas in modern general practice, where complaints are regarded as ambiguous, techniques are needed which leave ample room for the patient's own initiative but in a context of the daily battle between time and attention.

In this article we wish to investigate in how far the concept 'room for the patient' may be of use in the study of doctor-patient communication.

With this aim in view we shall define the concept 'room for the patient' operationally in a variety of ways - using the literature as inspiration - and measure the different variables resulting from the definitions in a random sample of video-recorded doctor-patient talks. In order to gain more information about the internal consistence of the concept 'room for the patient': the connections between the various operational definitions will subsequently be examined.

Finally, in order to find out whether the concept in question corresponds to reality in general practice, two groups of consultations will be compared which may be expected to differ from each in proportion to the frequency of the defined variables.

The article will conclude with a discussion.

### **Room for the patient: a theoretical exploration**

Rogers<sup>1</sup> was the first exponent from the 'soft sector' to effect a serious breakthrough in general practice. His 'unconditional positive regard' found an immediate response with Dutch general practitioners<sup>2-4</sup>. Communication training courses for general practitioners were organised (by the Netherlands Institute for General Practice among others) whose aim was to decondition doctors from the anamnesticly oriented question routines acquired in medical training and to cultivate a mode of behaviour in which more room was given to the patient<sup>5</sup>. The concept of Rogers was central from the beginning in these courses. General practitioners were taught to adopt a passive position. To listen rather than ask questions. To reflect where before they had given interpretations. To be quiet and

wait where they had been ready with advice. And these techniques proved effective. Patients who had previously been extremely difficult began to discuss their problems.

Many doctors experienced a new dimension in their profession. A sense of euphoria developed, characteristic of all emancipation movements. The door to the new science of general practice appeared to have been found.

The official representatives of the medical profession were also attracted to the new movement. Thus a working committee of the Royal College of General Practitioners wrote the following in a publication entitled 'The future General Practitioner': "...*the ideal consultation. The doctor's attention is devoted exclusively for a short period of time to the life and problems of another human being. He is there to listen and help. His training will have made him receptive to a wide range of distress signals and give him the means, or knowledge of the means, to answer them. The occasion will be unhurried and something will be gained by both participants; a good consultation brings satisfaction to the doctor as well as to the patient*".

In 1977 the Landelijke Huisartsen Vereniging (the Dutch National Association of General Practitioners) also stated that instead of asking a closed list of anamnestic questions the general practitioner should show an interest in and be open to his patient's problems, spot non-verbal signals, identify himself with patients, probe their feelings etc<sup>6</sup>.

With this publication the creation of room for the patients had become official policy for the general practitioner.

However, the notion 'unconditional positive regard' soon showed its limitations in general practice. It was vitiated by the fact that the theory had been developed in a context of care in which time did not pose a serious problem. But after their discourse training many practitioners noticed in despair that consultations were becoming longer. The unconscious techniques with which they had managed to restrict their consultations to five or ten minutes often appeared to have gone by the board.

In this connection Stimson<sup>7</sup> draw attention to the role of the general practitioner as manager. A good deal of his energy is spent not only on real care but on the time-management of consultations. He has to give his patients room as well as finish his consultations in reasonable time. To achieve this he has all kinds of verbal and non-verbal controls at his disposal. The sociolinguists Coulhard and Ashby<sup>8</sup> also emphasize the controlling part of the doctor in the consultation: "*the development of the discourse is tightly controlled by the doctor, who decides whether and when the patient shall transmit that information*". They point out the importance of interruption as a weapon in the doctor's struggle against the clock as well as the use of what they call 'markers' i.e. concluding, often abrupt remarks which signal the end of the consultation (or one of its parts) to the patient ("Splendid, I shall give you some more of those pills"). More recently, it has been shown by Byrne and Heath<sup>9</sup> among others that the doctor's non-verbal behaviour can also be an important factor in the

direction a consultation takes. Particularly variables such as eye contact, posture or changes of posture and reading or writing during the consultation proved to be important controlling factors.

### **Room for the patient: an examination of the variables**

The following variables have been selected from the preceding observations as indicators of the fact that room for the patient is real in consultations<sup>a</sup>.

#### ***Length of the consultation***

Although the duration of a consultation is one of the most obvious variables in measuring the room for the patients, there exist in the literature contradictory views as regards the value of this variable. Byrne and Long<sup>10</sup> discovered in their analysis of 963 doctor-patient talks that the length of a consultation is a measure of its effectiveness. In general, ineffective consultations last shorter and show a narrower time range. (The notion 'effectiveness' here refers to the degree in which doctor and patient pursue a common goal as against their talking at cross-purpose; an ineffective consultation invariably involves at least one dissatisfied party). This slightly contradicts the results of Korsch et al.<sup>11</sup> in which 800 talks between pediatricians and mothers were analysed (varying in length between two and forty-five minutes) which showed no connection between the length of consultations and the patient's satisfaction. By contrast, Ben Sira<sup>12</sup> found a high correlation between patients' satisfaction and the time spent per patient (with correlations of .75, .78 and .75), but it is unclear whether objective time was measured in this research or, as we rather suspect, subjective time, which might be better termed 'degree of relaxation'.

These contradictory results might be explained by the fact that patients do not always need room in consultations. The degree of satisfaction with the doctor's behaviour in a patient who only wishes to have his ears syringed will correlate with the effectiveness of the treatment rather than with the time spent. On the other hand, a patient who is keen to talk about his problems will appreciate above all the amount of time devoted to him.

As expected, some researchers<sup>13-15</sup> have found that consultations in which a psychosocial diagnosis is made, with doctor and patient both (!) taking psychosocial matters into account, and in which psychopharmaceutical drugs are prescribed take longer than consultations without these characteristics.

All in all, the variable 'duration of the consultation' is an interesting variable to consider in our analysis.

It was measured with an automatic timing device.

#### ***Doctors' and patients' speaking time***

Following Matarazzo, Kruihof<sup>16</sup> found a correlation between speaking time of the interviewer and that of the interviewee. Experimental doubling of the interviewer's

speaking time automatically led to a twofold increase in the interviewee's speaking time. Bain<sup>13</sup> found that in consultations involving a psychosocial diagnosis both doctor and patient talked longer<sup>b</sup>. It seems that two partners in conversation directly effect each other's speaking time.

Both variables have been included in our research. As in the case of the variable 'duration' they were measured with an automatic timing device.

### ***Degree of relaxation***

Research by Ben Sira<sup>12</sup> has already been mentioned in which there is a high correlation between the patients' satisfaction and the time they were given. Ben Sira's variable 'time' is one of the three components of 'affective behaviour' (the others being 'devotion' and 'interest'). The variable 'relaxed' is also found in Van Dorp<sup>17</sup> under the label 'conducting the conversation in a quiet tempo'. This variable showed a significant correlation with the degree of patients' satisfaction (.44 and .39) in two of the three experimental case studies.

The variable 'relaxed' was scored on a five-point scale<sup>c</sup>.

### ***Attentive behaviour***

A number of researchers have shown the relevance of the variable 'attention' in doctor-patient talks. In Van Dorp<sup>17</sup>, 'attention' was one of the items on an evaluation list which correlated highly with the factor 'communicative and problem-solving behaviour'. Ben Sira<sup>12</sup> concluded from his research that "*attention is the most salient expression of affective behaviour*", and also that the doctor's affective behaviour ('the art of care') is the best predictor of patient satisfaction (probably because the patient knows too little about the technical side of medical behaviour to be able to judge his doctor in this area). Marks et al.<sup>18</sup> found that empathy (i.e. a factor consisting of the variables 'attention' and 'interest/-involvement' together with the personality variable 'conservative' accounted for 67 per cent of the variation in the correct identification of psychiatric disorders. Finally, Byrne and Heath<sup>9</sup> emphasize the importance of non-verbal attention in consultations. They found in their analysis of (in fact, an unspecified number of) video tapes of doctor-patient talks that doctors who show a greater degree of patient-oriented behaviour are more likely to nod and utter noises of encouragement, change position more often and consult or write less on their cards when the patient is talking than their more doctor-oriented colleagues.

'Attention' has been scored on the basis of the doctor's posture eye contact and non-specific continuation signals (nodding, humhumming etc.)

### ***'Interest/involvement'***

Some aspects of the variable 'interest/involvement' have already been dealt with in the preceding sections. In Ben Sira<sup>12</sup> the variable 'interest' was one of the components of the doctor's affective behaviour and, as we saw, this behaviour was closely connected with patient satisfaction. In Marks<sup>18</sup> the variable 'interest' was

also grouped with the variable 'attention' in one cluster and together these accounted for the correct identification of psychiatric disorders.

Degree of interest has been scored on a five-point scale.

### ***Process variables***

Our interest in process variables of stimulation (and inhibition) has its main origin in the idea, developed in Stimson and Webb<sup>7</sup>, of the doctor as manager of his consultation. The variable 'prompting' cannot be traced in the literature as such (although some of the question strategies mentioned in Van Dorp<sup>17</sup> and Byrne and Long<sup>10</sup> are suggestive in this respect). We do find the variable 'sustainment' in Van Dorp (as an index consisting of three items), in which it, together with the above mentioned factor 'communicative and problem solving behaviour' is responsible for patients' satisfaction. When the doctor broaches a subject this is scored as 'prompting'. When he pursues an ongoing topic in detail 'sustainment' is scored.

Although the variable 'interruptions' often occurs in the more reflective literature, it is rarely found in quantified form. An exception is Van Dorp<sup>17</sup> where the variable in question is measured by means of an observer questionnaire as well as a patient questionnaire. In both cases the variable correlates with a factor labelled 'conversation tempo' by Van Dorp. The relationship between 'conversation tempo' and 'patient satisfaction' is not discussed in Van Dorp.

The variable 'interruption' was counted and instances added per conversation fragment.

This concludes the number of variables selected to measure the room given to the patient by the doctor. In addition, some variables have been selected which may be regarded as functions of the room given.

### ***Patient volubility***

In addition to the speaking time of the patient, which may be seen as an objective measure of the patient's talkativeness, a qualitative measure, 'patient volubility' was introduced, which was divided into the sub-variables 'starts' (i.e. the number of times a patient introduces a new topic of his own accord) and 'elaboration' (i.e. an observer-linked evaluation measure scored on a five-point scale concerning the degree to which the patient says more than is strictly necessary for the course of the consultation). Since most investigations have concentrated on the verbal behaviour of the doctor no traces of these variables have been found in the literature.

### ***Number of medical complaints by the patient***

The last variable to measure patient involvement is the number of medical complaints presented by patients during consultations. Bain<sup>13</sup> found a correlation between the number of complaints presented and the length of the consultations, as did Raynes and Cairns<sup>15</sup>. An additional reason for incorporating the variable 'number of medical complaints' is that patients show a general tendency to choose

a medical entry into the conversation. Psychosocial problems are discussed only in the second instance<sup>19</sup>.

Finally, two variables have been selected which concern the doctor's evaluation of the patient's complaint. It has emerged from the literature that these variables effect the manner in which the doctor controls the consultation<sup>13 15 18</sup>. They are, first, the measure in which the doctor judges the complaint or the aggregate of complaints to be psychosocial and, secondly, the seriousness of the complaint as judged by the doctor.

Both measures are registered by the doctors themselves on a five-point scale.

This concludes the survey of the total number of variables used in our analysis. Presently we shall take a look at the interconnectedness of these variables to find out whether they do, indeed, refer to one and the same concept or whether several independent concepts might be involved. Before proceeding with this part of the investigation, however, we shall first offer a description of the research material used.

### **The research material**

The research material consists of a total of 273 video-recorded doctor-patient conversations involving six different doctors. The video recordings were made at randomly selected consultations. The material was examined by two observers (psychologists), who evaluated the consultations independently of each other. After completion of the observers' task a final evaluation of every consultation was compiled from the two independent evaluations according to fixed procedures. The results presented in this article relate to these final evaluations.

The only further use made of the observer forms has been to determine to what degree the individual observer evaluations differed. With regard to the countable items, correlations between two observers in general varied from .75 to .95. Evaluation items showed lower correlations, varying from .60 to .90<sup>c</sup>.

### **Results**

In 33 per cent of the consultations doctors judged their patients' complaints to be purely somatic. This implies that the doctors suspected the presence of psychosocial problems in two-thirds of the consultations. This did not always lead to concrete action, since over half the consultations are concerned with somatic matters only.

In processing the video material the scores of the somatic conversation fragments (N=219) have been consistently distinguished from the psychosocial conversation fragments (N=112). Both somatic and psychosocial fragments have been added as per kind.

Table 3.1 Relationship between length of consultation (excluding medical examination) and subject of conversation

	Number	consultations with exclusive somatic topics	consultations with psycho-social topics
< 3 minutes	101 (37%)	74%	18%
3-6 minutes	91 (34%)	48%	44%
> 6 minutes	81 (29%)	20%	65%

The average time per consultation (excluding examination time) is just over five minutes (5'08"). Variation is considerable: conversation time is less than three minutes in 37 per cent of the consultations, between three and six minutes in 34 per cent of the consultations and longer than six minutes in the remaining 29 per cent. It is interesting to determine in how far there exists a connection between the length of a consult and the topics introduced. As we saw earlier, patients will normally choose a medical entry into their consultation<sup>19</sup>. On the basis of this presupposition we may expect to find that difficult psychosocial problems do not feature in extremely short consultations simply because the patient will not have the room to introduce them. The data in table 3.1 confirm this expectation: psychosocial matters are discussed in 65 per cent of the longer consults (> six minutes) but only in 19 per cent of the extremely short consultations (< three minutes).

Table 3.2 Doctors' and patients' speaking time (in minutes and seconds)

	whole consultation	somatic fragments	psychosocial fragments
doctors' speaking time X sd	2'08" (1'47")	1'24" (1'04")	1'55" (1'45")
patients' speaking time X sd	2'11" (1'50")	1'21" (0'41")	2'07" (1'57")

Doctors' and patients' speaking times are equal on average. This implies that on average doctor and patient have an equal amount of speaking time available for both somatic and psychosocial topics. These time scores are on average slightly higher for the psychosocial fragments than for the somatic fragments but what is rather striking is the much narrower range for patients in the somatic fragments. It should be noted here that the standard deviation for the time used by doctors in the somatic fragments can be related for the most part to inter-doctor variation<sup>20</sup>. The direction of the somatic discourse fragments is more predictable as it were.



Table 3.3' Relaxation', 'Attentive behaviour' and 'interest' (in percentages)

	whole consultation			somatic fragments			psychosocial fragments		
	-	0	+	-	0	+	-	0	+
relaxed	18	30	52	19	42	39	11	25	64
attention	12	28	60	11	27	62	11	14	75
interest	22	33	45	20	47	33	16	28	56

The data concerning the variables 'relaxed', 'attention' and 'interest/involvement' have been included in table 3.3. They have been reduced to a three-point scale: negative, neutral and positive. The table shows that doctors rarely score negatively for any of the three variables in either kind of discourse fragment. Neutral evaluation scores for doctors are somewhat more frequent in the somatic fragments whereas positive scores for doctors are slightly more frequent in the psychosocial fragments. The scores for the variable 'attention' are invariably high.

Table 3.4 Process variables of stimulation and inhibition (percentage of consultations in which behaviour occurs)

	whole consultation	somatic fragments	psychosocial fragments
prompting	45%	23%	61%
sustainment	60%	49%	49%
interruption	42%	34%	42%

Table 3.4 shows the figures for the process variables of stimulation and inhibition. They indicate the percentages of the consultations for which the variables in question have been scored (regardless of their frequency in any given consultation). We see that 'sustainment' is the most frequently used process variable. (Also compare Van Dorp<sup>17</sup>). This intervention is used in almost equal measure by doctors in somatic as well as psychosocial discourse fragments (not surprisingly in view of the fact that medical anamnesis has also been scored as 'sustainment').

The variable 'prompting' is considerably more frequent in psychosocial fragments. It also seems that patients are interrupted somewhat more frequently in psychosocial fragments.

Turning to 'patient volubility' the same picture emerges concerning the evaluated degree of talkativeness as we saw earlier for the variables 'relaxed' and

'interest/involvement'. Patients are described as taciturn in a small number of consultations. Whereas neutral or positive evaluations are given in about equal proportion in the somatic consult fragments, patients are more often described as 'talkative' in the psychosocial parts. The average number of starts by patients is 6.7 in the psychosocial parts as against 4.5 in the somatic parts.

Table 3.5 Relationship between number of medical complaints and length of consultation

	one complaint	two complaints	three or more complaints
< 3 minutes	62%	39%	20%
3-6 minutes	25%	40%	45%
> 6 minutes	13%	21%	35%
N	101	70	99

Finally, the number of medical complaints by the patient. This is 2.3 on average. In 37 per cent of the consultations one single complaint is presented, in 26 per cent two complaints and in 39 per cent three or more. Table 3.6 shows that the number of complaints is directly related to the length of the consultation.

### The connection between the room-giving variables

In order to examine the connection between the different variables we have applied factor analysis to the variables introduced so far. The results of the analysis are shown in table 3.6 below.

Four factors emerge from factor analysis which are clearly different.

Factor 1 consists of the prompting of new and the sustainment of current topics, the doctor's interruptions, the length of the consultation the number of medical complaints and the nature and seriousness of the complaint. This factor characterizes the type of consultation in which the doctor describes the complaints as serious and psychosocial and tries to pursue the matter by means of procedural interventions. These consultations take up relatively more time. We shall call this factor 'conscious control by the doctor'

Factor 2 consists of the variables 'relaxed', 'attention' and 'interest'. They are the same variables as those in Ben Sira<sup>12</sup> which together formed the affective behaviour of the doctor (which accounted for the patient's satisfaction with the way he was treated). Consequently, we shall call this factor 'the doctors affective behaviour'.

Factor 3 consists of patient volubility variables.

Factor 4 consists of the relative speaking times for doctor and patient.

Table 3.6 Factor analysis over the 14 variables (N = 212)  
Principal component analysis with varimax rotation

	factor 1	factor 2	factor 3	factor 4
length of consultation	.69	.19	-.00	-.06
doctors' speaking time *	-.04	.07	-.03	.77**
patients' speaking time *	.16	.01	.12	.72**
relaxed	.14	.80	-.06	.00
attention	.08	.69	-.11	.12
interest	.04	.83	.11	-.01
prompting	.72	.16	-.04	.07
sustainment	.57	.23	-.04	.07
interruption	.40	-.19	.17	.02
starts patient	.01	-.07	.75	.07
elaboration patient	.04	.03	.91	.03
number of complaints	.58	-.18	.05	.01
psychosocial complaint	.45	.12	.12	.23
seriousness of complaint	.36	.03	-.04	.01
Eigen value	2.65	1.76	1.41	1.07
Percentage explained variance	38%	26%	21%	15%

\* Corrected for length of consultation

\*\* It is not an error that both scores have a positive load since the variables are non-complementary (silence being a factor)

With a forced three-factor solution the first three factors emerge in practically the same form. The relative speaking times of doctor and patient in this case do not correlate with any other factor. With a five-factor solution we can identify our original four factors as the first four factors, after which prompting and sustainment (without time and complaint variables) again feature as the fifth factor. In the following analysis we shall continue with the four-factor solution because it contains all the variables without duplication.

On the basis of this analysis we conclude that the concept of room for the patient refers to the following mutually independent concepts:

- conscious control by the doctor
- the doctor's affective behaviour
- patient volubility
- the relative speaking time of doctor and patient.

It will be interesting at this stage to determine in how far consultations which may be expected, on theoretical grounds, to differ in terms of room accorded to the patient in fact differ with the four factors under discussion.

## The concept 'room for the patient' tested in practice

We have already mentioned the fact that patients do not need room for every type of consultation. The classical model may well be the most appropriate for the treatment of strictly somatic complaints. But this is by no means the case for psychosocial complaints. Consequently we have selected from our research material those consultations which we suspected by the doctor not to be strictly somatic.

It is our hypothesis that within the group of consultations with a psychosocial diagnosis the sub-group in which psychosocial problems are discussed will differ on the room-giving variables mentioned from the sub-group in which only somatic matters are discussed.

Table 3.7 shows in how far this is, in fact, the case.

Table 3.7 Comparison between two types of consultations with standardized factor scores from the concept 'room for the patient'

	consultations with a psychosocial diagnosis by the doctor				significance of F value
	conversation somatic topics		conversation psychosocial topics		
	X(n=59)	sd	X(n=85)	sd	
1 conscious control by the doctor	-.46	.48	.66	.85	p < .001
2 affective behaviour	.14	1.04	.17	.76	n.s.
3 patient volubility	.11	1.58	-.03	.53	n.s.
4 relative speaking time of doctor and patient	.15	1.52	.07	.39	n.s.

We would expect the two groups of consultations to differ on all four factors, We see, however, that this is only true for one factor, namely, factor 1 ('conscious control by the doctor'). This means that a doctor who suspects the presence of psychosocial problems (on average) shows an equal amount of affective behaviour, regardless of whether those psychosocial problems are discussed or not.

It is also the case that patient volubility is equal to both types of consultation as well as the relative contribution to the discussion by doctor and patient. The only difference lies in the factor 'conscious control by the doctor'. The question of whether psychosocial problems are discussed in consultations where the doctor suspects them to play a part appears to depend only on the doctor's view of the seriousness of the complaint and the degree to which these psychosocial factors play a part, as well as the number of complaints presented and the effort the doctor

puts into raising these problems (prompting and sustainment). It seems (although our analysis does not allow this kind of causal interpretation that the doctor's conscious control depends on his evaluation of the complaint (incidentally, this holds for stimulatory as well as inhibitory control). This line of thought corresponds closely to current labelling theories and would seem a fruitful area for further research.

However, the absence of the postulated relation between the factor 'affective behaviour' and our criterion (discussing psychosocial topics) is perhaps even more interesting. This concept is, central to the literature from which we have quoted. Of all the variables examined here it comes closest to the Rogers's concept of 'unconditional positive regard'. It forms the core of the general practitioner's task as described in 'The future General Practitioner'. It is, according to Ben Sira<sup>12</sup>, the most important component of the doctor's behaviour to effect patient satisfaction (which, in turn, is closely connected with many other relevant matters such as therapy loyalty and the like<sup>21</sup>. Communication training instructors have tended to concentrate on this factor, particularly in the early years. In short, 'affective behaviour' is a concept that has raised many eager expectations. And yet, its effects are nil in this analysis!

A possible explanation of this unexpected result might be that affective behaviour cannot be produced on command; but, rather, that it is a feature of a physician's character, which he may or may not (or to a greater or lesser extent) display in general.

In order to ascertain this we have compared the scores of the different doctors for the factor 'affective behaviour'. Table 3.8 shows the results. It also shows that doctors do, indeed, differ from each other in the degree to which they display affective behaviour. This corroborates the supposition that affective behaviour is part of a doctor's general character. In addition we see that the factor 'conscious control' discriminates between doctors. This means that some doctors show conscious control behaviour more often than others, but also, as we saw earlier, that they show it more often in some consultations than in others. This latter connection was missing in the factor 'affective behaviour'

Table 3.8 Comparison between six doctors with standardized factor scores from the concept 'room for the patient' (consultations with an psychosocial diagnosis only)

	DOCTORS												signifi- cance F-value
	1		2		3		4		5		6		
	N=32 X	sd	N=17 X	sd	N=21 X	sd	N=32 X	sd	N=19 X	sd	N=23 X	sd	
1 Conscious control by doctor	.21	.89	.10	.78	.41	1.03	.22	.84	.84	.97	.14	.82	p < .001
2 Affective behaviour	.30	.73	.52	.62	.36	.64	.60	.91	.05	.67	-1.06	.81	p < .001
3 Patient volubility	.15	.53	-.04	.59	.11	.48	.10	.53	.09	.59	.40	2.30	n.s.
4 Relative speaking time of doctor and patient	.18	.53	.08	.38	.02	.36	.22	1.93	-.02	.32	.10	.45	n.s.

The other two factors, according to tables 3.7 and 3.8, differ neither between the various types of consultations nor between the different doctors and are therefore of little value at present for the further development of the concept 'room for the patient'.

## Summary and discussion

In this article we have carried out a number of analytic exercises involving the concept 'room for the patient', by which we roughly mean the number of opportunities a patient gets in a consultation to discuss what is really worrying him. The specific reason why we have chosen this concept is that it originated in the behavioral sciences and is being adopted into general practice in all sorts of ways at present. In our opinion this process is not entirely free of problems because treatment in general practice differs from treatment in psychological practice in a number of fundamental ways. We hope that a measure of conceptual analysis may contribute to a better integration.

We started our investigation with an exploration of the literature, in which the concept 'room for the patient' can be frequently found in many guises and formulations. On this basis we have selected a number of variables (fourteen) which all seemed to refer to something one might call room for the patient. We have measured these variables in a considerable number of video-recorded doctor-patient talks.

With the application of factor analysis the vague concept of 'room for the patient', with which we started this article, turned out to divide into the following four mutually independent factors:

- a conscious control by the doctor,
- b the affective behaviour of the doctor,
- c the patient volubility and
- d the relative speaking time of doctor and patient.

On further analysis the first two factors in particular turned out to produce some interesting findings. When we selected only those consultations from the whole group in which the doctor had made a psychosocial diagnosis, and subsequently compared, in terms of the above-mentioned four factors, the consultations in which psychosocial subjects were discussed with those in which only somatic matters were discussed (note that the discussion of psychosocial matters is considered criterial here for the concept 'room for the patient') we found that only the first factor had a discriminating function. The second factor ('affective behaviour'), which is invariably regarded in the literature as the factor par excellence relating to the concept 'room for the patient' and which is most frequently used in communication training, appears not to discriminate between the two types of consultation. We supposed that this surprisingly negative result might be due to the fact that a doctor's affective behaviour is a function of his general character rather than his ability to display this behaviour at will.

A variance analysis, in which the scores for the different doctors were compared with each other for the different factors, confirmed our suspicion. Differences did, indeed, emerge. In other words, some doctors show a greater amount of affective behaviour than others. This may imply that the factor 'affective behaviour' has established itself as a necessary condition to get the patient to talk about his problems (this will have to be determined by further research) but the results presented here show that it is by no means a sufficient condition. Apparently, patients only allow themselves to discuss their problems if the doctor stimulates them in this direction. And it seems that the doctor only does this if he considers the complaints to be serious enough and the psychosocial components important enough. Further research will have to show whether these suppositions have any basis in fact.

## NOTES

- a. Initially we had selected more variables. However, these have been omitted from this article either because they turned out to be incapable of being scored reliably or because they yielded uninterpretable results (see the NHI report 'Konsultatieprojekt Eindhoven: gespreksgedrag' by J.M. Bensing and P. Verhaak, Utrecht, 1980). Apart from this the analysis omits some variables but which, in fact, referred to the same concept. Without exception a single variable has been chosen from these clusters which correlated most highly with the others.

- b. This also holds for consultations involving patients with a higher social status and for consultations with chronic patients. Incidentally, the contributions of doctors and patients in these cases were not measured in seconds but in 'units of expression'
- c. For an exact description of the observational procedures which were followed as well as the processing of the observations we refer to the above-mentioned report 'Gesprekgedrag' of the consultation project at Eindhoven. We also refer to this report for a complete survey of the reliability scores.



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## 4 Evaluation of an interview training course for general practitioners<sup>\*</sup>

### Abstract

This article describes the evaluation of an experimental training in doctor-patient communication for general practitioners. The training was based on Rogers's theory and accommodated to the specific situation of the general practitioner. The main concept of this theory is the notion of 'unconditional positive regard'. It was expected that doctors would change their communication behaviour and that as a result patients would talk more about their psychosocial problems. The training was restricted to the diagnostic process, no therapeutic interventions were taught.

The effect of this training has been measured by comparing video tapes of live doctor-patient consultations, before and three months after the training. The most important result of this evaluation study turned out to be the change of the doctor's behaviour in the expected direction, but surprisingly the outcome of the consultation did not change at all: the doctors were empathically listening, but the patients did not talk more about their problems.

Creating room for patients is not sufficient to induce them to discuss their personal problems with their doctors. Perhaps they do not feel like discussing their personal problems with them at all.

### Introduction

General practice has increasingly become an interdisciplinary science, a melting pot of the medical and social sciences. From the moment that professional training courses started in the Netherlands (in 1973) social scientists have been involved in education and research in this area. There can be little doubt that this type of collaboration between medical and social sciences is connected with the growing interest in the psychosocial problems of general practice. In order to solve these problems, attempts are being made to assess whether certain elements taken from psychological theories of care might be of use to the general practitioner. The traditional medical approach to the detection and treatment of psychosocial

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\* Reprint from: Bensing, J.M., Sluijs, E.M. Evaluation of an interview course for general practitioners. *Social Science & Medicine*, 1985, 20, 7, 737-744.

problems has proved less than satisfactory. Consequently, the need has arisen to borrow freely from promising related disciplines. In this context, courses in interview training for general practitioners have been in existence for several years in the Netherlands. These courses are partly based on the theories of Rogers<sup>1</sup>. One of the central themes of these theories is the notion of 'unconditional positive regard'. This implies that those in the caring professions are, above all, expected to assume a passive, attentive and empathic attitude in which listening plays the most important part. This desired type of attitude is, of course, rather different from the active type of behaviour that normally characterizes family doctors. The Netherlands Institute of Primary Health Care has examined as to how far practising general practitioners are able to acquire the relevant skills from training courses and what effect this has on their care. This article constitutes a summary report of this research.

## Research Framework

The effects of an interview training-course for general practitioners (GPs) have been examined with the aid of video-recordings of consultations. Two months before the first training sessions pre-test measurements were taken with the participating GPs and post-test measurements were taken 3 months after the last session. The camera was fixed with no cameraman present in the consultation room. Only complete consultations were recorded. The video material was scored on specially designed observation forms. Each consultation was scored independently by two observers. For data concerning inter-observer reliability see Refs (3-5). The training course was given by psychologists. The aims of the course were formulated as follows:

- 1 The training concerns interviewing skills (and is therefore different from personality training).
- 2 The training is not aimed at medical therapy strategies (i.e. it is non-therapeutic), but rather concentrates on the creation of optimal condition for the patient to express possible psychosocial problems (i.e. it is diagnostic).
- 3 The skills acquired during training are considered to be generalizable to the general practice situation.

## Definition of the research problem

The general hypothesis which lies at the basis of this research is as follows: when a practitioner has followed an interview training course, he will be more capable of creating the kind of conditions in which patients of any kind are able and prepared to bring forward, and possibly discuss the psychosocial aspects of their complaints and problems.

Three research questions may be deduced from this general hypothesis:

- 1 Has the GP's interview behaviour substantially changed after the training in comparison with their behaviour before?

- 2 If so, do they really give their patients more room during consultations to bring forward psychosocial aspects or problems?
- 3 Are psychosocial aspects and problems during consultations in effect discussed more frequently after the training than before?

The following section first contains a discussion of the manner in which the three questions just formulated have been investigated and secondly a presentation of the results.

## Observation scheme

In attempting to answer the *first* question concerning the interviewing behaviour of GPs the extensive system of interview categories proposed by Byrne and Long<sup>2</sup> was used. This system allows for an exhaustive description of the GPs' interviewing behaviour, since every utterance can be classified under one of the 50 possible categories. In this way an interviewing profile emerges for each practitioner who has registered exactly how often he 'asks direct questions' how often he 'reflects'. how he 'gives information' etc. The system of categories is usable for our purposes, because it contains (*inter alia*) all the behavioural items explicitly aimed for during the training sessions. NHI research in other areas has confirmed the reliability of this system, yielding inter-observer correlation coefficients from 0.40 to 0.87<sup>3</sup>.

The *second* research problem concerns the amount of room given to the patient during the consultation. This concept has been defined and made operational in different ways according to the literature. In general it refers to the chances which patients get during interviews to bring forward their real worries. In the article 'Room for the patient'<sup>4</sup> various possible ways of operationalizing this concept are described and interconnected. A number of these variables have also been measured in this research, namely:

- the duration of the consultation (this being an objective measure for the time devoted by the GP to his patient),
- the speaking-time ratio between GP and patient,
- the attention, interest and calmness of the GP during the consultation (scored by means of a five-point scale).

The *third* question is related to the degree to which psychosocial aspects are being raised during the consultation. Here too variables were used which had proved useful in earlier research at the NHI<sup>5</sup>. In this research two aspects are of high importance: the frequency with which the physician perceives psychosocial aspects in the complaints of his patient, called psychosocial diagnosis; and the frequency with which the physician and his patient actually talk about these psychosocial aspects, expressed in the number of psychosocial consultation fragments.

## Results

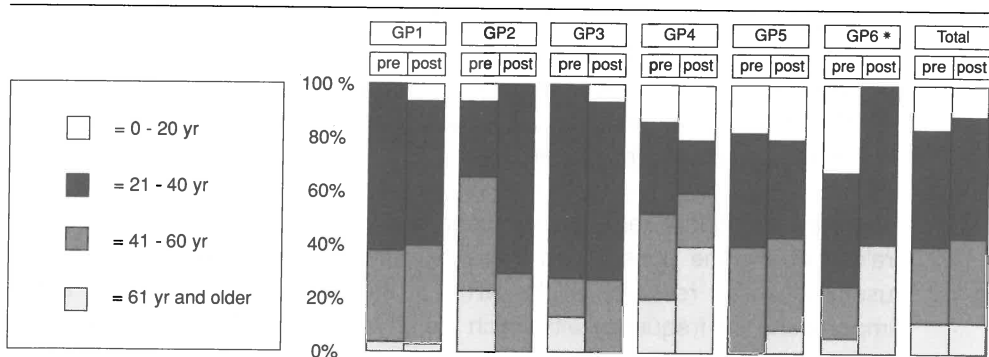
### Background data

In figure 4.1(a) and 4.1(b) the pre-training and post-training measurement concerning the number of consultations per GP are presented. The figures for the number of consultations are self-explanatory. With regard to the age distributions of patients it should be noted that the post-test figures show many more older patients for GP 6; this will have to be taken into account in the analyses. The post-test figures show relatively fewer men and more women for GP 5. Note also that the total random test contains a higher percentage of women (68%) compared to the percentages (57%)<sup>6</sup> <sup>7</sup> found in other studies. We have no explanation for this phenomenon.

Figure 4.1 a Number of consultations and classification of sex in pre- and post-test

		GP1		GP2		GP3		GP4		GP5		GP6		Total	
		pre	post	pre	post	pre	post	pre	post	pre	post	pre	post	pre	post
Number of consultations		18	15	12	13	14	15	20	15	17	13	25	10	106	81
Sex	Male	1	4	1	2	4	7	5	6	10	3	8	4	29	26
	Female	17	11	11	11	10	8	15	9	7	10	17	6	77	55

Figure 4.1 b Classification of age of patients in pre- and post-test



\* Significant difference pre-test and post-test  $P < 0.05$ .

### Question 1 How far have the GPs changed their behaviour after the training?

In table 4.1 the data concerning the interviewing behaviour of the GP are shown. In the evaluation of the results all the 50 interview categories used by Byrne and Long

have been applied, but for the sake of clarity we only present here those categories which occur in at least 20% of the consultations. Table 4.1 shows how often each GP uses a particular category per 10 consultations. By using a two-tailed t-test we have checked both for one physician and for all physicians together which categories are being used significantly more or less in the post-measurement in comparison with the pre-measurement. The fact that the same differences are significant in one category and not in other categories is caused by the big differences in the standard deviations. Moreover the numbers in table 4.1 have been rounded, by which means the differences sometimes seem smaller than they really are.

For those who are not deterred by this, table 4.1 contains some potentially interesting data. Starting with the last column, in which the average frequency of interview categories for the total number of GPs is shown, we can deduce from the post-test figures eleven categories which have been used significantly more. These are mainly the categories which refer to the empathic behaviour of the GP, who is explicitly tackled in training. It also turns out that GPs are more informative and provide more explanations to the patients after the training. There is only one category which occurs significantly less frequent after training: GPs interrupt their patients less often (category No. 41).

In spite of these figures it may not be concluded from these data that interview training has had the same positive effect on all GPs: there are considerable differences. GP 6 is the one who has changed most in every respect, although it should be noted that his patients are considerably much older post-test than pre-test. GP 2 and, to a less extent GP 1, also show some changes. The GPs 3, 4 and 5 hardly seem to have changed at all.

This plethora of data has been reduced by means of a factor analysis (see table 4.2) in which only those categories are used which occur at least in 20% of the consultations. A forced three-factor solution with varimax rotation yielded three dimensions which are interpreted as follows.

The first factor reflects the amount of information and explanation which the GP gives to the patient, the second factor denotes the empathic behaviour of the GP and the third indicates the controlling and guiding role assumed by the GP in the consultation. Below the factor solutions in table 4.2 the factor scores for each GP are shown as well. In the computation of these scores we have checked by means of a t-test whether or not the pre- and post-test figures differ significantly for these factor scores.

It appears from this analysis as well that the training has had the biggest effect on the empathic behaviour of the GPs (factor 2). Each GP has a higher post-test factor-score (significant for the GPs 2 and 6), which makes factor 2 the only factor that shows a significant change for the whole group. In sum: it appears that training has had indeed some effect on the GPs behaviour. The biggest changes are to be found in the so-called 'empathic' behaviour of the GPs, this being the type of behaviour which occupied a central position in the training. Particularly in the care of two GPs (Nos 2 and 6) these changes must be considered to be remarkable.

Table 4.1 Pre- and post-training interview profiles per GP and per group

	GP 1		GP 2		GP 3		GP 4		GP 5		GP 6		Total	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
1 Closed question	3	3	4	5	9	3	1	13	5	11	2	1	4	6
2 Direct question	24	33	31	29	68	38	37	31	49	60	46	44	42	38
4 Placing events in time/ sequence/place	2	9	4	14	17	9	8	2	14	19	9	9	9	10
5 Relating to previous experience	4	5	4	8	6	5	5	3	2	7	2	4	4	5
7 Open question	6	4	5	12	4	7	9	10	5	10	7	5	6	8
8 Exploring	12	15	15	36	27	26	15	16	17	26	14	18	16	23
9 Seeking patients ideas	0	2	5	6	3	6	2	9	4	2	2	6	3	5
10 Encouraging	19	23	23	60	16	14	20	48	15	7	6	40	16	31
12 Reflecting	2	2	2	10	8	9	2	4	3	3	0	6	3	5
13 Offering observation	0	4	1	2	9	6	2	4	2	2	3	4	3	4
14 Offering of feelings	3	18	5	19	10	12	5	8	8	10	3	12	5	13
16 Indicating understanding	55	88	58	208	76	70	69	117	67	83	33	112	57	112
17 Repeating patient words for affirmation	3	9	5	11	14	5	14	13	11	9	7	12	9	10
21 Apologizing	1	5	2	2	5	5	3	8	4	8	1	10	3	6
24 Directing	53	65	63	9	92	61	52	64	71	63	63	64	64	61
25 Giving convincing information or opinion	15	16	13	17	13	22	23	25	8	19	12	33	14	23
26 Suggesting	12	12	18	21	33	28	14	15	18	14	13	33	17	20
27 Reassuring	8	9	14	8	12	9	2	6	6	11	4	16	7	9
28 Advising	8	11	10	10	11	13	11	11	11	12	8	24	10	13
29 Giving neutral information or opinion	33	42	40	49	53	42	36	38	34	35	31	82	37	46
30 Clarifying	14	25	16	16	20	21	16	21	18	12	15	43	16	22
31 Answering patient question	29	24	43	32	32	33	32	41	21	20	23	78	29	36
32 Accepting patient ideas	4	8	17	15	8	13	7	11	9	7	4	12	7	11
33 Using patient ideas	2	3	2	2	3	3	2	0	3	3	1	2	2	2
34 Suggesting or accepting collaboration	1	2	9	5	9	6	5	2	3	2	2	10	4	4
36 Summarizing to close off	2	2	4	3	4	1	3	5	4	2	0	5	3	3
37 Indirect terminating	8	9	7	10	8	8	7	5	7	9	6	10	7	8
39 Confused noise	1	1	5	3	6	6	11	4	0	2	0	2	4	3
40 Not-interested 'yes', 'yes' utterances	6	3	7	2	4	4	4	11	1	4	2	5	4	5
41 Interrupting jumbled speech	11	4	5	2	18	5	13	11	5	8	4	2	9	6
42 Ignoring patient/not listening	11	12	14	10	11	9	13	18	6	12	13	14	11	12
46 Expressing satisfaction with patient	1	5	2	5	5	4	4	1	1	2	1	6	2	4

Significant  $P \geq 0.05$



Table 4.2 Factor analysis pre- and post-test factor loads and factor scores

Factor 1 Informative behaviour			Factor 2 Empathic behaviour			Factor 3 Directive behaviour		
Giving convincing information	0.66		Exploring	0.62		Closed question	0.39	
Suggesting	0.52		Seeking patient ideas	0.57		Direct question	0.76	
Reassuring	0.44		Encouraging patient	0.67		Placing events in time/sequence/place	0.55	
Giving neutral information	0.62		Reflecting	0.68		Exploring	0.42	
Clarifying	0.55		Offering of feelings	0.43		Repeating for affirmation	0.63	
Answering patient question	0.77		Indicating understanding	0.78		Directing	0.57	
Accepting patient ideas	0.42							
(var. 62.5% Eigenvalue 5.75)			(var. 21.1% Eigenvalue 1.94)			(var. 16.4% Eigenvalue 1.51)		
Factor scores	Pre	Post	Factor Scores	Pre	Post	Factor Scores	Pre	Post
GP 1	-0.07	-0.02	GP 1	-0.34	-0.07	GP 1	-0.50	-0.10
GP 2	0.31	-0.13	GP 2	-0.23*	1.10*	GP 2	-0.29	-0.18
GP 3	0.20	0.12	GP 3	-0.01	0.12	GP 3	-0.82*	-0.05*
GP 4	0.05	0.32	GP 4	-0.22	0.21	GP 4	-0.06	-0.25
GP 5	-0.31	-0.23	GP 5	-0.13	-0.11	GP 5	0.23	0.45
GP 6	-0.30*	1.27*	GP 6	-0.51*	0.06*	GP6	0.03	0.03
Total	-0.06	0.18	Total	-0.27*	0.21*	Total	0.02	-0.03

\* Significant difference pre- and post test  $P \leq 0.05$ .

### Question 2 Does the patient get more room in the consultation?

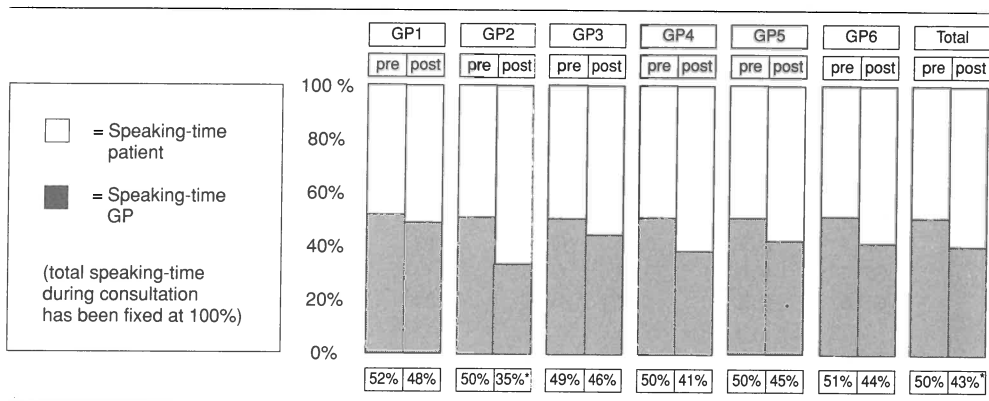
The variables referring to the room a patient gets in the consultation can be found in the figures 4.2 a, b and c. In figure 4.2 a the average duration of a consultation can be found and also the percentage of this time during which the practitioner looks at his patient. In figure 4.2 b we have calculated the proportion of conversation-time of the practitioner and his patient. Further, the observer's assessment concerning the practitioner's attention can be found in figure 4.2(c).

Figure 4.2 a Room-for-the-patient variables: consultation-time and looking-time

	GP1		GP2		GP3		GP4		GP5		GP6		Total	
	pre	post	pre	post	pre	post	pre	post	pre	post	pre	post	pre	post
Average consultation time (in seconds)	227	346	325	447	418	398	296	383	254	285	208	538*	285	392*
Average looking time (in % of consult-time)	24%	30%	14%	29%	28%	37%	36%	30%	29%	29%	22%	44%*	26%	32%*

\* Significant difference pre-test and post-test  $P \leq 0.05$ .

Figure 4.2 b Room-for-the-patient variables: speaking-time ratio GP/patient



\* Significant difference pre-test and post-test  $P \leq 0.05$ .

Figure 4.2 c Room-for-the-patient variables: scores for attention, interest and calmness

		GP1		GP2		GP3		GP4		GP5		GP6		Total	
		pre	post	pre	post	pre	post	pre	post	pre	post	pre	post	pre	post
Attention-score	Somatic fragments	3.1	4.0*	2.9	4.3*	3.1	3.7*	3.5	3.1	3.3	3.0	2.9	4.3*	3.1	3.7*
	Psychological fragments	3.5	4.3	3.0	4.3	3.6	4.5	3.9	3.9	4.0	3.4	3.0	4.0	3.5	4.2*
Interest-score	Somatic fragments	3.2	3.4	2.8	3.7*	3.3	3.4	3.0	2.8	3.1	3.2	2.8	3.5*	3.0	3.3*
	Psychological fragments	3.7	4.0	2.5	3.8	3.6	4.0	3.2	3.2	3.7	3.5	2.9	3.7	3.3	3.7*
Calmness	Somatic fragments	2.9	3.4*	3.0	3.8*	3.3	4.0*	3.0	2.8	2.9	2.8	3.0	4.1*	3.0	3.4*
	Psychological fragments	3.7	4.0	2.5	3.9	3.5	4.4*	3.4	3.3	3.3	3.3	3.0	4.3*	3.3	3.9*

\* Significant difference pre-test and post-test  $P \leq 0.05$ .

With regard to the latter variables we distinguish between conversations about somatic matters, the so-called somatic consultation-fragments, and conversations about psychosocial subjects, called psychosocial consultation-fragments. By means of a two-tailed t-test we have checked again which variables show significantly different scores in the post-measurement compared to the pre-measurement. It appears that interview training for GPs produces a considerable amount of room for the patient. All variables show a significant post-test difference, at least as far as the group average is concerned. The GPs show more attention, interest and calmness in the consultation, they look at their patients more often and talk less themselves. As a result of this the patient starts to talk more and the average consultation lasts longer. However, this change does not hold for all GPs equally and therefore it will be interesting to consider the - sometimes considerable - individual differences between the GPs.

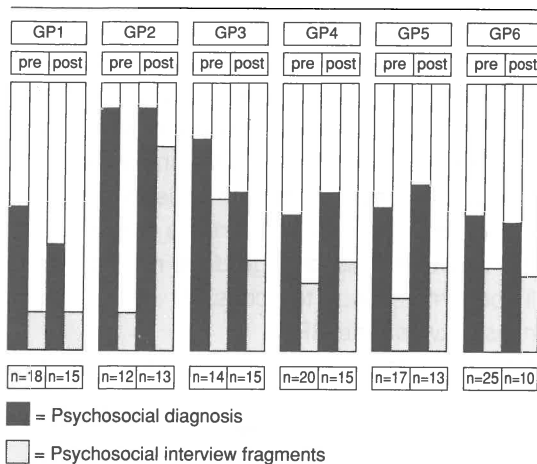
Starting with the consultation-time we perceive that this has increased for GPs except for GP 3. This is the one who shows less 'directive behaviour' in the post-measurements (factor 3) and who is consequently more attentive and calmer and looks more often at his patients. Evidently not every positive change in the GP's behaviour is by definition more 'time-consuming'. Studying the post-test figures we perceive that the GPs 2 and 6 are the ones who look at their patients significantly more often. For all GPs the proportion of conversation-time between GP and patient has changed in the same direction: the post-test figures show that the patients speak more often and longer. It should be noted that this change has been effected in different ways: a few GPs are more attentive and more interested, some look at their patients more often or behave calmer during the consultation, and other practitioners actively encourage their patients to talk more.

### ***Question 3 Are psychosocial problems discussed more often after the training?***

Now that it is evident from the post-test figures that the patients receive more room after the training, it will be interesting to find out whether psychosocial problems are discussed more often after the training than before. The results are shown in figure 4.3.

The number of psychosocial conversation-fragments is herewith used as a measure. These fragments should be regarded in relation to the number of psychosocial diagnoses the practitioner makes. First of all it is striking that GPs diagnose a case more often psychosocial than they discuss these matters with their patients. In all cases there are less psychosocial conversation fragments (to the right) than psychosocial diagnoses (to the left). With regard to the pre- and post-measurement it is striking that the relative number of consultations in which the complaints of the patients are judged as psychosocial has not substantially changed for any of the practitioners (what we do find here are enormous differences between the practitioners).

Figure 4.3 Percentage of consultations with a psychosocial diagnosis and with psychosocial interview fragments



In this connection it is disappointing to discover that the percentage of consultations in which doctor and patient discuss the psychosocial aspects of a complaint together has hardly increased in the post-test figures. The ratio has remained practically the same for all GPs with the exception of GP 2. Evidently the fact that the patient is given more room does not automatically imply that the patient really uses this room to discuss psychosocial matters (as we have seen earlier, the patient starts to talk more, but this only regards the pure medical aspect of his complaint). All in all we may conclude that the training appears to have had little effect on the measure in which the physician observes psychosocial aspects and no more on the measure in which psychosocial problems are actually discussed. It seems that the patient does not just use the offered room for slicing his problems.

### An illustration: GP 6

The previous sections contain numerous figures which form the basis for many conclusions. Many readers may well question the validity of these figures. What do they stand for? Do they present a true picture of what is actually going on in surgery? Moreover, do the postulated changes reappear in the consultations? In order to answer these questions we have been looking for adequate illustrative material in the raw video-data. We chose GP 6 because he showed the most changes across the board. Earlier we saw that this GP had a larger number of older patients in the post-test than in the pre-test. In order to eliminate this factor we looked for comparable types of patients in the pre- and post-test figures. We found two women, aged 30 and 35, who both presented complaints concerning feelings of general malaise. First we shall present the core figures for both consultations. These are as follows:

**Pre-test**

Time of consultation	= 5'20"
Looking-time GP	= 11%
Speaking-time GP	= 76%
Speaking-time patient	= 24%
Attention GP (5-point scale)	= 3
Interest GP (5-point scale)	= 2.5
Calmness GP (5-point scale)	= 3

**Interest profile**

Total number of utterances by GP in this consultation	= 30 (100%)
Number utterances factor 1 (i.e. 'informative behaviour')	= 8 (27%)
Number utterances factor 2 (i.e. empathic utterances)	= 1 (3%)
Number utterances factor 3 (i.e. directive behaviour)	= 16 (54%)
Other utterances	= 5 (15%)

**Post-test**

Time of consultation	= 13'35"
Looking-time GP	= 42%
Speaking-time GP	= 44%
Speaking-time patient	= 56%
Attention GP (5-point scale)	= 4
Interest GP (5-point scale)	= 4
Calmness GP (5-point scale)	= 4

**Interest profile**

Total number of utterances by GP in this consultation	= 79 (100%)
Number utterances factor 1 (i.e. 'informative behaviour')	= 21 (27%)
Number utterances factor 2 (i.e. empathic utterances)	= 37 (46%)
Number utterances factor 3 (i.e. directive behaviour)	= 15 (19%)
Other utterances	= 6 (8%)

According to these core figures the post-test behaviour of the GP in question differs markedly from his pre-test behaviour in that he leads less and is more empathic. The patient is given considerably more room. As regards the consultations proper, these were recorded as follows.

### *Pre-test consultation fragments of GP 6*

- The patient is a woman of 30
- Pt. = I feel absolutely terrible
- GP = Still? (Does not look up)
- Pt. = Yes, and my head is still, you know, it's still there. And I am terribly tired, and I still feel as if I could fall apart any minute.
- GP = We'd better check your blood pressure and have a look at your sinuses.  
Could you step inside there, please?  
(GP looks up and points to the examination room)
- GP = Do you have a temperature?
- Pt. = No...
- GP = But do you have dizzy spells?
- Pt. = Yes
- GP = Could you open your mouth and say 'ah' please...? Could you clear your nose please...?  
Lift your arms, would you?
- Pt. = Whenever I do anything I'm completely exhausted afterwards.
- GP = But did you allow yourself to shake off your illness?
- Pt. = I got up only yesterday.
- GP = Could you stand up for a moment, please? Do you have a cough?
- Pt. = Not really, sometimes, but nothing serious.
- GP = That looks quite all right really. Surely headache isn't as bad as it was, is it?
- Pt. = Sorry?
- GP = Is your headache not a bit better?
- Pt. = Yes, it's gone down.
- GP = Because it looks quite clear up there.
- Pt. = Yes, it's gone down, but I still have it though. Of course I still have a nightjob and I'm still on sickness benefit.
- GP = I'll give you some dihydroergot to relieve the dizziness and tiredness, and I will also give you some vitamin B complex. I would like you to go to my assistant to check for possible anaemia.
- Pt. = All right, doctor.
- GP = And eh, we'll just see for a week how it goes on, and stay off work for the time being.
- Pt. = All right. Did you say I should stay off work?
- GP = That's right.
- Pt. = Oh, I see ... but then I'll have to .. because I got one of those forms you know ...
- GP = I would simply give in if I were you and have lots of sleep. Somebody who's been ill, it really affects your body and it needs time to recover from the illness. You shouldn't force it. But your blood pressure is a bit on the low side so that could be the cause as well. That's why I want to check whether you're anaemic. Don't hesitate to come back if you're not all right by next week.
- Pt. = All right, doctor.  
Consultation ends.

### ***Post-test consultation fragments of GP 6***

The patient is a woman of 35

Pt. = Well doctor, this is not exactly what I expected.

GP = (Looks up) Oh, how's that?

Pt. = Well I'm feeling absolutely terrible and it's getting worse.

GP = (nods)

Pt. = I feel really ill, do you know that?

GP = Do you?

Pt. = The funny thing is I couldn't tell you where it hurts.

GP = H'm.

Pt. = I have a headache though.

GP = H'm.

Pt. = In the afternoon, dear oh dear, every step is an effort.

GP = H'm, h'm.

Pt. = And yesterday afternoon, I was doing the hoovering. I had been sitting for a while and then I got up to take the hoover and ... whoops ... there I went, I nearly keeled over.

GP = (nods)

Pt. = So when I really stoop down or get up quickly, everything sort of falls away.

GP = (nods)

Pt. = And I get it in the afternoon too. It feels as if I'm just about to faint all the time, not really fainting you know, but feeling like

GP = (nods)

Pt. = I'm really fed up with this. Sunday morning my eye was completely shut and all blue and yellow underneath.

GP = (nods)

..... (and later)

GP = What about sleeping? Do you sleep all right?

Pt. = Oh, well, I wake up regularly, but I've no difficulty in falling asleep again. So that's no problem really. When I go to bed I just fall asleep after a while, so that's not bad.

GP = It doesn't sound as if you're completely happy about it though.

Pt. = (silence) ... Well, I can't say I am of course. I mean I'm happy enough whenever I can go to bed ... I suppose ...

..... (and later)

Pt. = What about the dizziness? What could that be?

GP = The blood pressure of yours is bound to fall occasionally when you get up. You simply can't keep it at the required level. For us that's an indication of over-tiredness. And of course, being on the go all the time, or having been, without stopping. We might have a look at your sinuses to see if they're infected perhaps and we could check for possible anaemia. It's a possibility, but we won't know until the middle of next week.

Pt. = Oh, and I've been using nasept .. do I have to keep taking that.

GP = Well, that doesn't seem to be doing a lot of good, does it? When you keep having trouble, you might as well stop taking that.

(After some more appointments the consultation ends).

It is almost too good to be true: the GPs post-test behaviour shows a real difference from his pre-test behaviour (validity!). And moreover, his post-test behaviour is a perfect reflection of what he has learned in training. However, in reality we see here what the figures in the last paragraph already suggested: the result of the consultation is exactly the same in both cases. The GP doesn't choose another form of treatment, since in both cases X-rays are taken, blood-samples are taken and the doctor decides to wait and see. It is true that the patient is given more room but the net result is exactly the same. The only positive thing the patient may be left with (but we do not know, for we did not ask it) is the feeling that somebody has been really listening to what she had to say.

## Discussion

What do we learn from all this? First that it appears to be possible to teach general practitioners different habits by means of interview training, habits that were not only observable during the training, but also afterwards in his daily general practice routine. This is the kind of positive result that is certainly not found in every piece of evaluation research. The training especially aimed at unlearning active forms of behaviour and acquiring passive and empathic forms. From the results we can see that the empathy factor has in fact increased for all GPs, whereas the 'directive behaviour' factor, at least for some subjects, has decreased in the post-test figures. The first factor ('informative behaviour') increased for some GPs and decreased for others. It also appears from the post-test figures that more room was given to the patients by the GP to discuss what was bothering them. For practically all GPs the consultations lasted longer and the patients spoke longer both in absolute and relative terms. Also the GPs were calmer, they looked at their patients more often and in other ways too, they paid more attention to and were more interested in their patients.

In short, the doctors have changed by training; not all doctors changed equally much (the GPs 2 and 6 obviously being exceptional), but nevertheless they all changed and, without exception, they changed in the direction aimed for in the training. However, what is striking and in a sense disappointing, is the fact that psychosocial problems were not discussed more often (with the exception of one GP). Creating more room for the discussion of psychosocial problems in a consultation does not automatically mean that those problems will be discussed. Of course we must not forget that the training never was intended for teaching therapeutic skills. It has been a training course in listening and in empathy, with the aim of increasing the GPs' (psycho)diagnostic skills. And this, the training did achieve, but no more than that. The conclusions that must be drawn are that those elements of behaviour which are explicitly aimed for in the training, are in fact changeable, but this does not imply that all sorts of other changes of behaviour automatically follow. In fact we did expect this.

For in a situation of psychotherapeutic assistance Roger's empathic attitude really appears to stimulate the client to discuss emotional and psychosocial problems.



We run up against an interesting phenomenon here: apparently a theoretical concept from social (psychological) sciences won't work in a medical setting.

A possible explanation for this might be the different role expectations in both situations. In psychotherapeutic situations patients know that they are expected to talk about their problems. This is not always so in a medical setting. Perhaps, patients in the medical setting need time to change their expectations of their doctor and as a consequence need time to change their behaviour in the consulting room. If the doctor continues to act in the more empathic way he/she now acts, patients may learn over many consultations to introduce psychosocial problems, but this will not happen as soon as the doctor gives the first opportunity. And thus the doctor will need to continue to use these new behavioural techniques in order slowly to encourage his patients to divulge these problems to him.

Although the results of the consult hardly seem to have changed, we can speculate about another benefit of the training. It seems acceptable that the patients are more satisfied and more at ease about their illness (not quantified in our experiment) now that they have had the opportunity to discuss their problems completely, whether they are psychosocial or not. As a result of this, the consultation rate per patient per year may decrease. But this is very tentative because ironically the contrary might also appear: when patients are so satisfied with their doctor, they may visit him more often. Further research on this topic will be necessary.

If we cease our speculations here and take a look at the clean results of research, we can finally make the following remarks. If we want doctors to adopt different methods in the therapeutic phase of their consultations, then specific attention must be paid to such methods in training. The results of this study indicate that this conclusion should be regarded as a serious recommendation, since otherwise the 'benefits' would seem negligible in view of the fact that consultations often last twice as long and surgeries run over time, but that the net result is exactly the same.

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## 5 Doctor-patient communication and the quality of care<sup>\*</sup>

### Abstract

In this article a comparison is made of three independent sources of assessment of medical consultations. A panel of 12 experienced general practitioners rated 103 consultations with hypertensive patients on the quality of psychosocial care. There was a wide consensus between the judges, resulting in a high reliability score. Two contrast groups were formed: consultations that were rated high and those rated low in quality of psychosocial care. A comparison was made between this general assessment of the quality of psychosocial care and a more detailed assessment of the same consultations on nine much used communication variables. This last assessment was made by trained psychologists. Knowledge about doctor-patient communication proved to predict very well as to which quality group the consultations belonged. A very high percentage (93%) was predicted accurately, solely on the basis of these nine communication variables. Affective behaviour, and especially non-verbal affective behaviour had the strongest predictive power. In the last part of the study a third source of assessment, i.e. patients' satisfaction is compared with both other sources. Much lower relationships were found, although most were in the predicted direction. Affective behavior seems to be the most important in determining patient's satisfaction, too. The implications of these findings are discussed.

### Introduction

Since Michael Balint challenged the medical world with his statement: "*The Doctor is the Drug*"<sup>1</sup>, many researchers have found themselves in the unruly but rich and relevant research area of doctor-patient communication. This has resulted in a steady flow of publications ever since. Generally speaking, however, the state of the art of assessing the **quality** of physician communication is not well developed. Information on communication skills is mostly derived from studies on patient **knowledge**, patients' **compliance** and patient **satisfaction**<sup>2-4 a</sup>. Whilst patients

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\* Reprint from: Bensing, J.M., Doctor-patient communication and the quality of care. Social Science & Medicine, 1991 (in press).

undoubtedly are a relevant source of information on certain aspects of care, Lebow<sup>8</sup> advises caution in the use of patient assessments since these do not correlate highly with what he calls 'objective', i.e. physician defined, measures of care, a result that is confirmed by DiMatteo and DiNicola<sup>9</sup>. In this article on doctor-patient communication, we focus on (physician defined) quality of care. In doing so, we hope to meet the often heard criticism *"that the results of much research on doctor-patient communication have no face validity for clinicians and, consequently, are not readily used to change physician's behaviour in a desired direction"*<sup>5</sup>. As the changing of physicians behaviour is the ultimate goal of our research program<sup>10</sup>, it is relevant to explore the relationship between provider-defined quality of care and the concepts, used in this research program<sup>10-13</sup>. If it were possible to identify a set of doctor-patient communication variables that has great power of discrimination between consultations that are rated high in quality and consultations that are rated low in quality, this would give a clear indication as to which types of behaviour are to be trained in medical education or postgraduate education.

In line with the recommendations of Dimatteo we have classified the quality of physicians' conduct on three dimensions:

- 1 a traditional technical dimension which involves technical knowledge, skill, etc.
- 2 a nontraditional technical dimension which involves concern for psychosocial aspects of care
- 3 an 'art'-dimension which involves the interpersonal behaviour of the physician, his or her personal qualities and in general how the care is delivered<sup>9</sup>.

Whilst not in any way underestimating the relevance of the other dimensions, we restrict ourselves in this article to the second dimension: the quality of **psychosocial** care. Psychosocial care is an underdeveloped area that needs specific research effort. It is puzzling that on one hand there is a growing insight that psychological and social factors (psychosocial factors) influence the development and severity of nearly any disease and the recovery and even survival of very many patients<sup>14 15 16</sup>, whilst on the other hand the implications of this knowledge are reluctantly and scarcely translated in every day practice, in medical education programs, or in the formulating of explicit criteria in quality assessment programs<sup>14 17 18</sup>. As Kerr White<sup>14</sup> stated in his fascinating report of 'the Wickenburg Conference', entitled 'the Task of Medicine':

*"In the face of this evidence .....we need to ask why medicine has been so slow in acting to implement and increase this knowledge. Why do we continue to behave as if it did not exist?"*

Psychosocial care is important in all medical practice, but especially in general practice: not only in the detection and treatment of psychiatric, psychological and social problems but also (and perhaps even more because of the disguised influence of psychosocial factors) in most of the somatic problems that are presented in primary care: the major killers as well as the self-limiting diseases, the

chronic conditions as well as (many) acute problems, clear diagnoses as well as not-understood vague complaints.

There is yet another reason for concentrating on the quality of psychosocial care. Many concepts in doctor-patient communication research (e.g. 'affective behaviour' or 'empathy') originate from psychological theories (e.g. Rogers's theory of 'unconditional positive regard' <sup>10 19</sup>). From this we may hypothesize a strong relationship between the quality of psychosocial care and these communication variables.

To stay in line with other publications in this field, but also to get some idea of the relevance of Lebow's caution in the use of patient assessments, we also included a measure of patient satisfaction in this research project. Many authors argue that patients' assessment of the efficacy of their physicians' medical treatment (and hence their satisfaction) will be based on the perceived practitioners' affective behaviour (rather than on his instrumental behaviour) and on his attitude toward the patient as a human being <sup>20-25</sup>. From this we may hypothesize (despite Lebow's advice, but in line with some research findings <sup>22-30</sup>) a positive relationship between patient satisfaction on one hand and provider-assessed quality of psychosocial care, respectively doctor's affective behaviour in doctor-patient communication on the other.

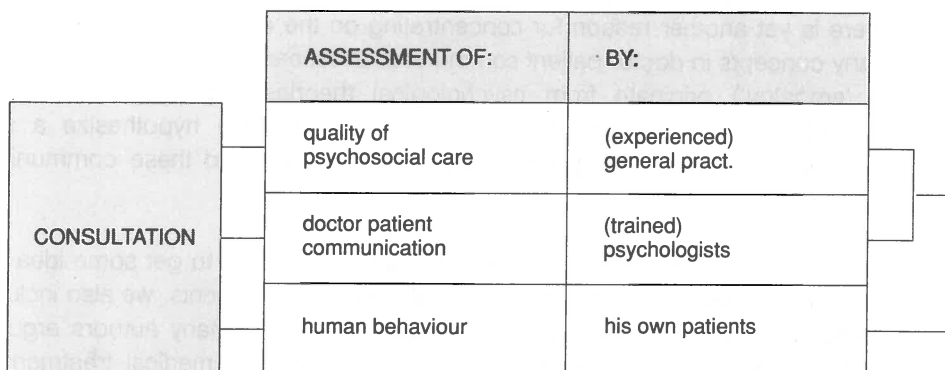
## Research questions

This leads us to two main research questions:

- 1 Is it possible to develop a reliable measure of the 'quality of psychosocial care', and, if this is so:
- 2 Is it possible to predict which consultations will be rated high - respectively low - on the quality of psychosocial care from ratings on certain aspects of doctor-patient communication (variables to be specified later on)? And: what is the relation between quality of care, doctor-patient communication and patient satisfaction?

In this last research question we compare three kinds of assessment of the same consultation (figure 5.1):

Figure 5.1 Research design



- a the assessment of the quality of psychosocial care by experienced general practitioners
  - b the assessment of doctor-patient communication by trained psychologists, and
  - c the assessment of the consultation and the GP in general by the patient himself.
- This procedure can be considered as a mutual crossvalidation of the three measures.

## Study I: Assessing the quality of psychococial care

### Methods

#### *Selections of the Consultations*

To assess the quality of care we used video recordings of real doctor-patient consultations. These are considered to produce the most valuable information for assessing the quality of care in general practice<sup>2 5 31</sup> and especially the quality of psychosocial care, because these video recordings enable us to assess non-verbal as well as verbal behaviour<sup>5</sup>. We selected the consultations for this study from videotaped doctor-patient consultations we had collected and observed in previous research projects<sup>12 13</sup>. These observations have been computerized to enable further analyses; besides, the tapes are ready for new observations (see for more information about this collection of video recordings Bensing, 1983<sup>32</sup>).

Carter and Inui<sup>5</sup> concluded that the heterogeneity of consultations is one of the big problems facing current physician-patient interaction research. That is why we decided to select consultations which had a common diagnosis. We preferred a diagnosis with a high medical relevance level. We looked for the kind of problem that evidently includes both medical and psychosocial aspects. In order to be able to do the necessary statistical analyses, it had to be a diagnosis with a high frequency level in general practice.

Hypertension (and other blood pressure problems) proved to meet all these requirements. The medical relevance of blood pressure problems is unchallenged,

as hypertension is a known risk factor for cardiovascular diseases: mortal enemy number one. It is generally considered to be serious by general practitioners. Hypertension also appears to be a condition in which both medical and psychosocial aspects are considered to be relevant by general practitioners. Grof<sup>33</sup>, Verhaak<sup>34</sup> and, in a slightly different way, Link et al.<sup>35</sup> made use of this characteristic of the problem 'hypertension' by using 'hypertension' as an item in a rating scale to measure the so-called 'psychosocial orientation' of a general practitioner. That fact that patients are aware of the psychosocial aspects of hypertension too, was illustrated by a nationwide research project run by the Netherlands Consumer Association<sup>36</sup>, results which are in line with a survey conducted in 1973 by the National Institute of Mental Health in the U.S.A.<sup>37</sup>.

A general look in the vast collection of literature on 'hypertension' shows us remarkable differences in the amount of attention paid to the psychosocial aspects of this condition. In the epidemiological literature there is a widespread acceptance of the influence of social and psychological factors<sup>38-40</sup>, even of the evident influence of a wrong diagnosis 'hypertension' on the mental state of a priori healthy people<sup>36,41</sup>. But in the literature about the (medical education of) the treatment of hypertension, there is a remarkable lack of attention to the growing body of knowledge that shows that the onset, severity, and treatment of hypertension is influenced by psychosocial factors. A striking example of this is given to us by Dove's review of sets of explicit criteria for the diagnostic work-up of hypertension (cited by Donabedian, 1982): more than 60 criteria have been formulated by different groups of physicians, and not one of these criteria has to do with psychosocial factors<sup>18</sup>! Hypertension proves to be an eminent example of Kerr White's lamentation; "*Why do we continue to behave as if this knowledge did not exist*"<sup>14</sup>. Hypertension seems to be a suitable case for treatment in this research project.

From one file in our video store (n=1569), we selected all the consultations involving hypertension or other blood pressure problems (ICPC-codes K85-K87). We found 103 consultations that met the rigorous demands of technical quality (6.6%). This figure is to be expected from a random sample of consultations in general practice<sup>42</sup>. The age-sex distribution of the patients is given in table 5.1 and is much similar to distributions found in morbidity research in general practice<sup>43</sup>. These 103 consultations have been used in this article.

Table 5.1 Age-sex distribution of patients with hypertension or other blood pressure problems in videotaped consultations, compared with figures from the british second national morbidity survey<sup>28</sup>.

sex age	man	woman	total	total NMS
< 45	11	10	21 (20%)	(10%)
45 to 64	10	23	33 (42%)	(47%)
65 to 74	11	14	25 (24%)	(29%)
> / 75	3	11	24 (14%)	(14%)
total	35 (34%)	68 (66%)	103 (100%)	(100%)
NMS	(35%)	(65%)	(100%)	

### Procedures

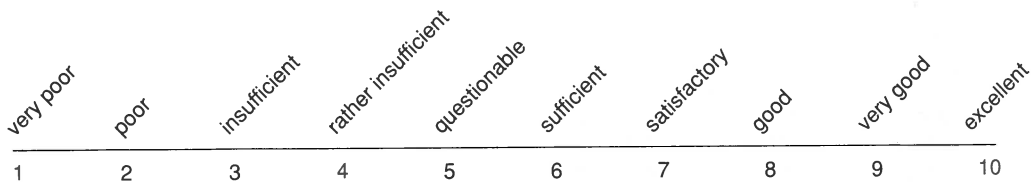
Twelve general practitioners (further to be called 'judges') were asked to rate the selected consultations (n=103). The judges were all experienced general practitioners with a minimum of five years in practice. Their ages varied from 30 to 70. Four of them were women. They had no knowledge of the previous observation sessions.

The judges were given a set of written instructions as to how to assess the different dimensions of the quality of care (technical-medical, psychosocial and the management of the doctor-patient relationship). 'Psychosocial care' was defined as 'receptiveness for and treatment of the (aetiological and consequential) non-somatic aspects of the presented health problem'. In their assessment of the quality of psychosocial care the judges were asked to give **one general assessment on the total consultation**, considering the GPs:

- \* sensitivity to the patients' verbal and non-verbal cues that may hint at non-somatic aspects of the health problem
- \* active explorations of the patients' possible psychosocial problems
- \* informativeness about the relationship between psychosocial problems and physical sensations or manifestations
- \* type of counselling: passive (supporting, comforting, reassuring) or active (intention to insight-promotion or behavioral change)
- \* undue attention to psychosocial aspects (too much or uni-directional attention can be as bad as too little!).



As with Dutch school report marks, their ratings could vary between 0 and 10.



The judges got a short training-program to become familiar with the method and the concepts used. In order to avoid their mutually influencing one another, the judges worked individually. To avoid bias from earlier ratings, consultations involving the same doctor (there were 27 different GPs on the video) were spread over the videotapes. One of the researchers was always at hand to answer questions. Sometimes it happened that a judge knew a particular general practitioner on the video. To avoid bias, he did not rate these consultations.

### **Results**

The assessment procedure proved to be feasible; the judges had no apparent difficulties in assessing the videotaped consultations in conformance with our instructions. The scale showed a good range of ratings: all the judges used 6 to 9 values of the 10-point scale. The judges were not afraid to give low ratings as well as high ratings. The average mean of the total group is 6.0, with individual means ranging from 5.3 to 8.1.

Table 5.2 Correlation matrix of the ratings of 12 independent judges

judge 1											
judge 2	.32*										
judge 3	.26#	.49*									
judge 4	.44*	.35*	.32*								
judge 5	.30#	.50*	.45*	.31#							
judge 6	.47*	.50*	.50*	.43*	.53*						
judge 7	.50*	.41*	.46*	.37*	.46*	.72*					
judge 8	.44*	.15	.40*	.40*	.30#	.55*	.62*				
judge 9	.40*	.26#	.49*	.50*	.15	.49*	.42*	.34*			
judge 10	.45*	.31#	.30#	.41*	.29#	.52*	.55*	.42*	.38*		
judge 11	.17	.35*	.40*	.31*	.22	.36*	.53*	.23	.32*	.28#	
judge 12	.60*	.28#	.39*	.47*	.45*	.64*	.65*	.56*	.34*	.38*	.39*
	1	2	3	4	5	6	7	8	9	10	11

one-tailed significance: # p < .01 \* p < .001

minimum pairwise n of cases = 74

In table 5.2 the correlations between the twelve judges are given. Most of the correlations (92%) are significant. Moreover the interassessor-reliability, measured by Cronbach's Alpha, is high: .88. Cronbach's alpha did not rise when any of the judges was excluded from the analysis. So, it is possible to use the mean as a psychosocial quality measure. However, interassessor reliability is just one and perhaps not the most important condition to develop an adequate instrument for quality of care. Another condition is intercase reliability, which means that a high score on one consultation of a GP goes along with a high score on other consultations of this same GP. We performed an intercase reliability-test on those doctors from our file who had five or more videotaped consultations. The results of these analyses for doctors are presented in table 5.3.

Table 5.3 Intercase-reliability of doctors with 5 or more consultations

Number	Cronbach's Alpha	Number	Cronbach's Alpha
Doctor 411	.81	Doctor 420	.66
Doctor 415	.85	Doctor 423	.85
Doctor 416	.87	Doctor 426	.77
Doctor 419	.91	Doctor 427	.90

average .83

The reliability figures are high with an average Cronbach's alpha of .83. A oneway analysis of variance shows larger differences between GPs than within ( $F = 12.67$ ;  $p < .0001$ ). These results give additional weight to the instrument and warrant its use as a psychosocial quality measure.

Figure 5.2 Frequency distribution of the psychosocial quality ratings

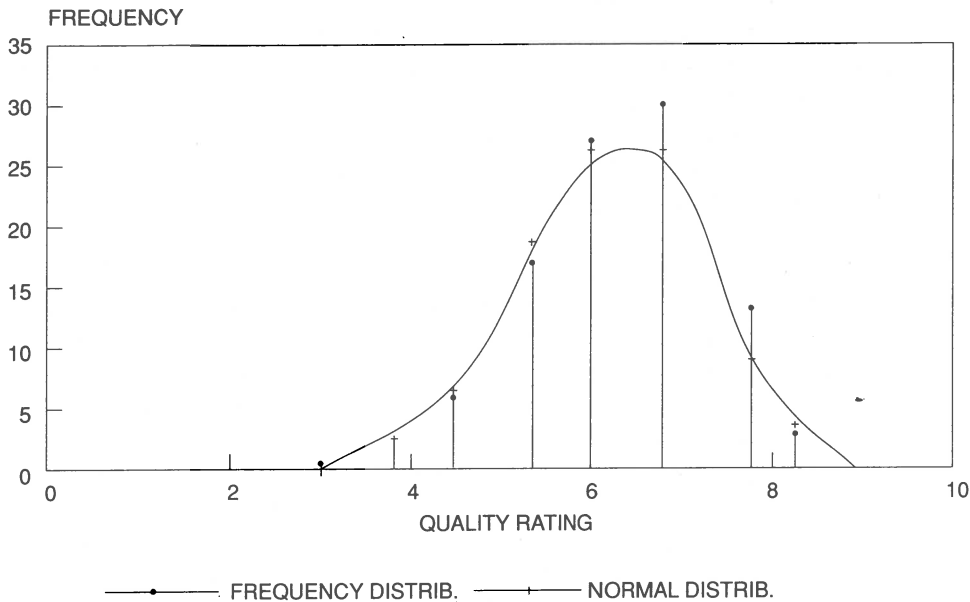


Figure 5.2 shows the distribution of the ratings on this quality measure. The lowest rating is 3.3, the highest 8.0. The mean is 6.2, the median 6.3. The standard deviation is .96. The distribution has a slight positive skewness, but is a reasonable approximation of a normal distribution. In the second study the ratings on this quality measure are used in the analyses. When it was necessary for some specific analyses to compare contrast-groups, all consultations with ratings 'questionable' or less ( $< 5.9$ ) were grouped - as in Dutch classrooms - in the 'negative' category ( $n=36$ , this is 35 % of all consultations); in the same way all consultations with ratings 'satisfactory' or more ( $> 7.0$ ) were classified as 'positive' ( $n=25$ , this is 24 % of all consultations).

## Study II: Doctor-patient communication, patient satisfaction and the quality of care

### Methods

#### *Doctor-patient communication*

For the data on doctor-patient communication we made use of the data-collection and observations of a previous study carried out by our research group. The methods and reliability figures have been published elsewhere<sup>12 13 34</sup>. Note that these observations of doctor-patient communication were done by psychologists, whilst the quality assessment in the first part of this study was done by general practitioners (and at a different time). There is no contamination in the observation of the independent and dependent variables in this study.

Three groups of doctor-patient communication variables have been used:

1 **Affective behaviour.** The concept 'affective behaviour' (which includes attentive, listening, empathic behaviour and the ability of the physician to communicate concern, warmth and interest in the patient as a whole person) originates from psychological theories, especially Roger's theory of 'unconditional positive regard'<sup>44</sup> but has since long made its introduction into the medical world (with Balint<sup>1</sup> as its famous pioneer). Now it is by far the most popular concept in doctor-patient communication research<sup>3 7</sup>. To summarize the major findings: affective behaviour proves to be related to patients' compliance<sup>20 21 26 45 46</sup> and patients' satisfaction<sup>22 23 25-30</sup>. It seems also to be related to the doctor's ability to detect psychiatric illness<sup>13 47-49</sup>. Gask et al.<sup>47</sup> found an increase in affective behaviour after a training course to improve psychiatric interviewing styles, together with a significant improvement in the trainee's ability to identify psychiatric illness accurately.

In this study affective behaviour has been operationalized in four variables<sup>12 13 34</sup>:

- 1 shown interest (5-point scale)
- 2 non-verbal attention (proportion of time GP looks at patient)
- 3 encouraging (utterances/minute)
- 4 verbal empathy (utterances/minute)

2 **Systematic and purposive behaviour.** This group of variables is derived from a popular 'school' among Dutch general practitioners, called 'the methodical approach' (developed by the Netherlands College of General Practitioners; see for an overview of this development since 1976: Sluys and van der Leden, 1988<sup>50</sup>). It refers to the active dimension in the GPs behaviour. From our own previous research we learned that a passive, empathic attitude is perhaps a necessary, but not always a sufficient condition to elicit information from the patient about more personal or emotional topics<sup>10 11</sup>, a view that is shared by others engaged in interview-training in primary care<sup>47</sup>. By active interventions (for instance the introduction of new topics) the general practitioner can show his

willingness to discuss psychosocial aspects of the presented problem. This is all the more important in general practice where patients are not always conscious of the multifaceted nature of their problems, and not always sure of their doctor's interest in non-somatic matters. Knowing that patients do not always present their main problems on the first occasion, the general practitioner should ask himself with every new patient "Why has **this** patient come to **me** with **this** specific problem at **this** specific moment in time? Clarifying the reason for the encounter is one important feature of 'systematic and purposive behaviour', the systematic structuring of the consultation if more than one problem is presented, another. To sum up, the variables in this subgroup are the following:

- 1 clarifying (proportion of complaints for which the reason for encounter is discussed)
- 2 structuring (proportion of consultations with a structured approach)
- 3 purposive probing (introduction of new topics)

3 **Patient-centered behaviour.** Since Byrne and Long published their classical 'Doctors talking to patients'<sup>57</sup>, there has been a growing interest among researchers in doctor-patient communication in terms of one of their main concepts: patient-centered behaviour (as opposed to doctor-centered behaviour). Byrne and Long introduced the so-called power-shift model: in general practice, and especially when non-somatic aspects are part of the problem, it is necessary to use the knowledge of the patient (himself an expert on his own feelings) in understanding the origin of the problem and trying to find possible ways of solving it. Barsky et al.<sup>52</sup> also formulated several reasons for a patient-centered structure for the medical interview in primary health care: They state that the interview itself involves negotiation and consensus seeking, rather than interrogation, inquisition and prescribing. Speedling et al.<sup>53</sup> follow a similar line of reasoning in their plea for a yardstick that goes beyond the one dimensional concept of the 'friendly physician'. They state that for a consultation to be effective the patient has to get involved in medical decision-making 'which may involve a great deal of hard work and include periods of conflict and need for compromise'. Trying to involve the patient in medical decision-making is the more important in primary care, where the physician manages symptoms and disability as much as he cures biological diseases, and where it is the patient himself who actually has to carry out the plan of management and treatment. Following Byrne and Long<sup>51</sup>, we use a 5-point scale to measure the degree of influence the patient gets in a consultation. And like them we make a distinction between the diagnostic phase and the therapeutic phase. The operationalisations are:

- 1 patient-centered behaviour in the diagnostic phase (5-points scale)
- 2 patient-centered behaviour in the therapeutic phase (5-points scale)

### Patient Satisfaction

For the data on **patient satisfaction** we also make use of previous work. At the time of the video-recordings, immediately after the consultation, the patients were asked to fill in a questionnaire with a Patient Satisfaction Scale. This scale was developed by Verhaak<sup>34</sup>; it is a shortened and slightly modified version of the patient satisfaction scale of Cassee<sup>54</sup>, a much used scale in the Netherlands. The scale consists of a questionnaire with 6 items of a five-point Likert rating format<sup>b</sup>. The items are similar to items used in other patient satisfaction questionnaires<sup>53-60</sup>. They reflect Ware's dimension of 'humaneness'<sup>59 60</sup>, or what other authors describe as 'affective satisfaction'<sup>56</sup> or 'evaluation of expressivity'<sup>57</sup>. The scale has a moderate reliability of .72 (Cronbach's alpha). The scale has one clear dimension: a factor analysis showed one factor with an Eigenvalue of 2.7 and 46 % explained variance. The factorscores are further used in this study.

### Results

We want firstly to link the quality of psychosocial care with different aspects of doctor-patient communication. To be more specific: we want to know if and to what extent certain much used variables in research on doctor-patient communication can predict whether a consultation will be rated high or low in terms of the quality of psychosocial care. Thereafter, we will examine the interrelationships between the quality of care, doctor-patient communication and patient satisfaction, therewith linking the results of this study with others from the literature.

Table 5.4 Communication variables in consultations with a high, respectively low psychosocial quality assessment

variable	positive		negative		difference	
	$\bar{x}$	(s.d.)	$\bar{x}$	(s.d.)	t	p
<b>affective behaviour</b>						
interest	4.0	(.7)	2.9	(.7)	6.48	<.000
non-verbal attention	.63	(.2)	.27	(.2)	8.12	<.000
encouraging	3.9	(2.2)	1.9	(1.2)	4.27	<.000
verbal empathy	.59	(.58)	.14	(.19)	3.85	<.001
<b>purposive structuring</b>						
clarifying	1.2	(.3)	1.3	(.4)	-.47	n.s.
structuring	2.5	(.7)	2.4	(.8)	-.15	n.s.
purposive probing	1.5	(1.5)	1.1	(1.1)	1.23	n.s.
<b>patient-centered beh.</b>						
diagnostic phase	3.4	(.9)	2.4	(1.0)	3.85	<.000
therapeutic phase	3.0	(.9)	2.3	(1.1)	2.76	<.008
total	n=41		n=32			

In table 5.4, the mean and standard deviation are given of the communication variables for the consultations that have positive, respectively negative ratings for the quality of psychosocial care. The differences between the two subgroups (measured by the t-test) are given in the last column. We see that there are significant differences between the positively and negatively rated consultations for all the variables of the subgroup 'affective behaviour' and all the variables of the subgroup 'patient-centered behaviour'. This means that in positively rated consultations, the general practitioner shows more interest in the patient, has more eye-contact, shows more empathy (by reflecting upon the words of the patient or paraphrasing what he says), and encourages him more by semiverbal nonspecific utterances (like hm-hm, ah etc.). In these consultations he is also more patient-centered, whereas in the negatively rated consultations he is more doctor-centered. This applies both to the diagnostic and the therapeutic phase. The variables from the subgroup 'systematic and purposive behaviour' do not yield significant differences between the two subgroups.

A discriminant analysis was performed in order to get a better understanding of the independent contribution of the nine communication variables to the discrimination between positively and negatively assessed consultations (see table 5.5).

Table 5.5 Stepwise discriminant analysis and classification table with quality as dependent and nine communication variables as independent variables

step	entered	Wilk's lambda	significance
1	non-verbal attention	.558	.000
2	interest	.384	.000
3	patient-centered beh. in diagnostic phase	.334	.000
4	verbal empathy	.296	.000
5	clarifying	.274	.000
6	purposive probing	.267	.000

95 % correct classifications

1 canonical discriminant function with an EIGEN value of 2.75

actual group	(n)	predicted group membership	
		high quality	low quality
high quality	(26)	25 (96%)	1 (4%)
low quality	(36)	2 (6%)	34 (94%)
total	(62)	27	35

An impressively high percentage of the consultations (95 %) can be predicted correctly as belonging to the positively - respectively negatively - rated, group of consultations. A stepwise variable selection shows that 'non-verbal attention', that is the amount of eye-contact, has the strongest predictive power, followed by 'shown interest' (also non-verbal). Other variables that have a significant independent influence ( $p < .000$ ) on the chance of a consultation being rated positively or negatively by independent judges are 'patient-centeredness in the diagnostic phase', 'verbal empathy', 'clarifying' and 'purposive probing'. Summarizing the results, we may conclude that the judges let themselves be guided in their rating of the quality of psychosocial care mainly by the 'affective behaviour' of the GP in question (and especially the non-verbal affective behaviour: shown interest and eye-contact), and - somewhat less - by the more verbal (and active) ways a GP tries to get patient's involvement in the consultation: by clarifying the reasons for encounter, purposive probing and giving the patient influence in the diagnostic phase of the interview.

In the last part of this study we want to examine the relationship between the ratings of the judges on the quality of psychosocial care, the communication variables and the expressed satisfaction of the patient. As stated before, we hypothesize a positive relationship between the satisfaction of the patient and the ratings of a panel of independent general practitioners. We also hypothesize a positive relationship between the satisfaction of the patient and the communication variables of this study; this hypothesis is enforced by the fact that these communication variables prove to be highly related to the ratings of the panel judges. In table 5.6 the results are presented.



Table 5.6 Correlationmatrix of patients' satisfaction, physicians' quality rating and observed doctor-patient communication

	factorscore on the Patient Satisfaction Scale	quality rating independent judges
quality rating of independent judges (GPs)	.19 #	
assessment of doctor-patient communication		
<b>-affective behaviour</b>		
*interest	.25 #	.60 **
*non-verbal attention	.06	.66 **
*encouraging	.03	.42 **
*verbal empathy	.24 #	.39 #
<b>-purposive structuring</b>		
*clarifying	.00	.03
*structuring	-.02	.04
*probing	.23 #	.16 *
<b>-patient-centered beh.</b>		
*diagnostic phase	.12	.39 **
*therapeutic phase	.04	.30 **

# =  $p < .05$

\* =  $p < .01$

\*\*  $p = < .001$

In the first column the correlations are presented between patients' satisfaction on one hand and the panel's assessment of psychosocial quality, respectively the observed doctor-patient communication on the other. In the second column the correlations are presented between between the panel's assessment of psychosocial quality on one hand and the observed doctor-patient communication on the other to make a comparison possible of the relative contribution of the different sources.

Patient's satisfaction on the 'humaneness' or 'the affective aspects' of the consultation has a barely significant ( $p = .045$ ) and not very high (.19) correlation with the panel-assessed quality of psychosocial care. Of the communication variables three variables have a slight relationship ( $p < .05$ ) with patients' satisfaction: 'shown interest', 'verbal empathy' and 'purposive probing'. The other correlations are low to very low. A discriminant analysis with patients' satisfaction as dependent and the nine communication variables as independent variables (analogue to the discriminant analysis of the quality rating, described above) showed 77 % correct predictions (see table 5.7), which is only 27 % more than chance (with two groups about 50 % of the consultations would have been

predicted correctly by chance). The variables with an independent (albeit small) influence on patients' satisfaction were (in this order):

- 1 non-verbal attention
- 2 verbal empathy
- 3 encouraging
- 4 purposive probing

Table 5.7 Stepwise discriminant analysis with patients' satisfaction as dependent and nine communication variables as independent variables

step	entered	Wilk's lambda	significance
1	non-verbal attention	.87	.028
2	verbal empathy	.78	.014
3	encouraging	.64	.002
4	probing	.54	.000

77 % correct classifications

- 1 canonical discriminant function with an EIGEN value of .850

## Conclusion and discussion

This study has produced some interesting results.

First, it proved to be possible to develop a reliable instrument for the assessment of the quality of psychosocial care (interassessor alpha = .88; average intercase alpha = .83), using a method that is primarily based on implicit criteria: the judges were not asked to score explicit criteria, but to weigh up the different aspects of psychosocial care (according to a written definition and operationalization) into one final assessment, thereby following Donabedian's advice *"for the assessment of those cases that do not conform to the more strictly medical criteria"* <sup>18</sup>. In the discussion about the relative merits of assessment procedures using implicit criteria versus those using explicit criteria, the supposed low reliability of the former is considered to be a major reason for refraining from quality assessment based on implicit criteria. This is a serious problem for researchers in primary health care (as well as those engaged in medical education in this field), as explicit criteria are seldom completely satisfactory for the assessment of consultations that do not conform to the more strictly medical criteria - which is very common in primary health care. In this light the relatively high reliability figures in our study come as a welcome surprise. However, the high reliability of the used procedure in our Study is probably caused by the size of our panel (n=12), which proved to be large enough to cancel out random fluctuations. Caution is still needed when using smaller sized panels and with this study we certainly do not want to open the door

for 'singlehanded' implicit quality assessments, as often is done in medical-education literature, where one- or two-people panels are no exception.

The reliability tests showed another interesting result: the intercase reliability proved to be high, which means that a high score on one consultation of a GP goes along with a high score on other consultations of this same GP. As we have spread the consultations of the GPs over the video tapes to minimize the so-called 'Halo-effect' on the judges, we can assume that 'quality of psychosocial care' is a doctor's characteristic as well as a consultation's characteristic. This means that observing about five consultations of a certain GP handling patients with the same health problem (in this case hypertension) can give a fairly good impression about his general performance with these patients.

Having found a satisfactory answer to the reliability-question, we now want to turn to the always much more complicated question of the validity of our measures. The limitations of this study just make it possible to draw conclusions about concurrent validity; no predictive validity can be assessed as we have no actual measure of the quality of care, such as outcome of treatment or health and functional status of the patient. Nevertheless, within these limitations some interesting results can be reported. We found a remarkably powerful relationship (95 % correct predictions in a discriminant analysis) between the panel's psychosocial quality assessment on the one hand, and a set of much used communication variables on the other. In consequence, the study certainly establishes what it is that experienced general practitioners view as quality visits. Appreciating the consistency with which these criteria are applied (as reflected by the correlations among judges) it can be argued that the quality ratings are a reflection of common conceptions and norms of practice among physicians, and thus build a good case for the (face) validity of the communication skills under study, particularly 'affective behaviour' and 'patient-centered behaviour'. As a result, this study provides us with indications as to what types of behaviour are useful for training purposes in medical and postgraduate education. Gask et al.<sup>47 48</sup>, Hornsby et al.<sup>61</sup> and Bensing et al.<sup>10</sup> demonstrated the possibility to train such behaviour and to evaluate the effects of such a training program.

The results of this study particularly enforce the relevance of 'affective behaviour' for an adequate medical interview, as many authors have stressed before<sup>7 20-30 46-50 61</sup>), but contradict the research results of other authors<sup>62-65</sup> who doubt this major influence. For that matter, the results can also shed some light upon a possible explanation for these contradictory findings in literature, for we found that especially the **non-verbal** aspects of affective behaviour (eye-contact and shown interest) had a strong predictive power on the quality rating of psychosocial care. The researchers that press the importance of more instrumental types of behaviour (e.g. 'task-oriented' behaviour) over 'socioemotional' behaviour - the later being more or less comparable with our concept of 'affective behaviour'), like Roter et al.<sup>64</sup> and Wolraich et al.<sup>63</sup> use audiotapes as observation instruments and only code verbal behaviour. In these studies the non-verbal aspects of affective behaviour are

necessarily neglected. It seems wise to maintain a distinction between the verbal and the non-verbal aspects of affective behaviour and, as Inui and Carter have stated<sup>5</sup> *"to complement systems that categorize and analyze a single type of interaction (e.g. verbal statements only) by other analytic approaches, to capture and characterize other means of communication (e.g. gesture and non-verbal communication)"*. The present controversies in literature on this point could possibly be resolved, if the much used observation protocols of Bales, Roter, or Stiles, that completely rely on verbal behaviour, would be enlarged with non-verbal measures. This links up with a pivotal statement made by Davis<sup>66</sup>, in which she states that most doctors know how to talk in a warm and friendly way, without being really patient-centered or really interested in the patients' problems or wishes. She stresses that it is much easier to control your verbal behaviour than your non-verbal behaviour. More research is necessary, but this study again stresses the relevance of non-verbal behaviour, also in determining patient satisfaction!

Another point worth discussion, however, is the much weaker relationship between the quality ratings and the communication variables on one hand, and the patient satisfaction scores, on the other. We did find a significant ( $p < .05$ ) correlation between patient satisfaction and panel-assessed psychosocial quality, but one of a modest magnitude (.19). This means that only 3.6 % of the variance in the quality assessments can be explained by patients' satisfaction. Of the nine observed communication variables the GPs 'shown interest', his verbal empathy and purposive probing have a significant (but equally modest) correlation with patient satisfaction. We did not expect this modest relationship, because the way the satisfaction questions were formulated (see Appendix A) is close to the operationalisation of many of our communication variables. But the results are in line with Lebow's cautions in the use of patients' assessments<sup>8</sup> and the comparable results in some other studies: DiMatteo found low correlations (average  $r = .10$ ) between physicians and patients as rating source<sup>9</sup>, Comstock found that physician empathy correlated with patient satisfaction only weakly, while physical attention (e.g. eye contact) did not correlate with satisfaction at all<sup>58</sup>, Wolraigh found the interesting result that physician's relational behaviour correlated with physician's estimate of patient satisfaction, but not with patient satisfaction as verbalized by the patient himself<sup>63</sup>, a result that was also found by Merkel<sup>67</sup>. Stewart found nonsignificant correlations between patient satisfaction and several modes of patient-centered behaviour<sup>68</sup>. Significant meaningful correlations are sometimes found in studies which use analogues instead of real patients<sup>64</sup>, while the doctor-patient communication is not measured independently from patients' satisfaction<sup>69</sup>. One possible explanation for this modest relationships could be, that patients are, on the whole, very satisfied with their general practitioner. The range of the scores is very short. In the case of some questions on the Patient Satisfaction Scale in our study the lowest score (on a 5-point scale) is the neutral one. Transformed to a 100-point-scale, as carried out by Ware and Hays in a comparative study on different satisfaction measures<sup>70</sup>, the mean responses on the 6 items vary between .66 and .95. However, this problem is well-known in patient satisfaction research. A

close inspection of the data of other research projects reveals that the data distribution of patient satisfaction scores is always very positively skewed. Mean satisfaction figures on that same 100-point scale are seldom lower than .80 and often above .90, especially the figures about satisfaction on 'humaneness' or 'affective behaviour',<sup>56-58 70-73</sup>. This could mean that the small differences that exist, probably say more about different answering tendencies than about differences in satisfaction. There is one additional finding that underlines this supposition: even doctors that only got positive quality ratings had patients with different satisfaction scores; and (perhaps even more important) doctors that only got negative quality scores had patients that were very satisfied. Another (methodological) explanation could be that in our Study the patient satisfaction scale while specific to communication by the doctor, is non-specific as to the particular communication of the consultation, whereas the GP and psychologists' ratings are of the particular consultation and the communication skills displayed therein. Some ground for this argument can be found in Verhaaks's research (using the same patient satisfaction scale), who found a relationship between patient satisfaction, patients' willingness to discuss psychosocial problems with their GP and the GPs sensitivity to psychosocial problems on the doctor's level, but not on the consultation level<sup>34</sup>. In our study the average number of consultations per GP is too small to test this hypothesis. However, as we have shown above that the same lack of relationship is found in studies in which specific satisfaction scales are used, this methodological question can hardly be a sufficient explanation for the modest relationship between patient satisfaction on the one hand and panel-assessed quality of care, respectively observed communication skills on the other. Nevertheless, further research into the most adequate level of analysis is recommended.

## NOTES

- a. See for a review over this latter group of publications till 1983: Inui and Carter (5), and for a description respectively meta-analysis on 61 of these studies till ca. 1986: Roter, Hall and Katz (6,7).
- b. Items of the patient satisfaction scale (5-point scale)
  - 1 My doctor knows exactly what is wrong.
  - 2 My doctor keeps his patients at a distance (-).
  - 3 My doctor is interested in me as a person.
  - 4 My doctor is good at handling problems.
  - 5 My doctor talks about non-medical problems as well.
  - 6 My doctor allows enough time for me.

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## 6 Who is to say that it was a good consultation?\*

### Summary

This article describes the assessment of 103 hypertension consultations from three different sources. Following each consultation, the GPs own patient completed a questionnaire indicating his satisfaction with it and giving an assessment of the functional breadth of the GPs activities. The consultations, recorded on video, were assessed by 12 GPs in terms of a number of quality aspects and the degree to which the GP manifested a general practice orientation. Trained psychologists scored the consultations using the NIVEL observation protocol. In those consultations which were assessed positively by colleagues, the GP seemed to demonstrate more affective behaviour, in particular, of the non-verbal variety. The GP also showed a greater degree of general practice orientation in these consultations. Strangely enough, patient satisfaction related only to the quality of the doctor-patient relationship. On a number of aspects initial consultations were assessed differently from repeat sessions.

### Introduction

This article describes research into the way in which a number of specific GP consultations are assessed by various types of assessors. The article is entitled 'Who's to say that it was a good consultation?' The research was undertaken because of our need to further validate the observation instrument for doctor-patient communication developed by the NIVEL. The NIVEL observation system was developed, in the first instance, in order to study the psychosocial assistance given by the GP. It is supported principally by psychological theories, in particular by those of Rogers. In a number of research projects, it has been demonstrated that the NIVEL observation system really does provide useful information on psychosocial assistance. We have learned for example that the observation system is able to differentiate between consultations, showing that particular types of behaviour arise more often in consultations which discuss not only somatic, but

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\* Translated reprint from: Bensing, J.M. Wie zegt dat dit een goed consult is? Huisarts en Wetenschap 1991, 34, 1, 21-29.

also psychosocial matters<sup>1</sup>. We know that it is possible to specify each GP's 'style of communication' with the help of this system, i.e. characteristic behaviour that remains relatively constant for each GP, but in which there are considerable differences between one GP and another<sup>2,3</sup>.

We also know that it is possible to capture differences in behaviour on the part of GPs who have followed a particular course of training in oral consultation with the help of this observational system<sup>4</sup>. We had always implicitly assumed that a GP using Rogers's communication techniques, by definition, also produced consultations that were qualitatively good in the eyes of other GPs. Actually we do not know whether this is the case, or not. We do not know whether a 'good' consultation, from the perspective of psychological theory, is also regarded as a good consultation in terms of contemporary views of general practice. Thus far, the analyses have been descriptive and correlational and there are as yet no relations with external measurements of outcome. The research described in this article is intended to remedy this deficiency. For that reason - in addition to doctor-patient communication registered on the NIVEL observational protocols - we have studied two external sources<sup>5</sup>:

- \* a panel of 12 experienced GPs
- \* the patients of the GPs involved.

The choice of peer review was made because this is the most common form of quality assessment in training courses and testing projects<sup>6,7</sup>, the doctor's own patients were chosen because they are often used as a measure of outcome in research (in particular in research into doctor-patient communication)<sup>8,9,10</sup>.

In this article we examine the measuring instruments that are used with each of the three sources, and we also examine the relations among the assessments from the various sources. The research can be seen as a test of the cross validity of the various judgments. None of the sources is regarded as a pre-determined 'gold standard'.

## Method

### *Selection of the consultations*

The consultations, which were videorecorded, come from a research project on the 'interpretation and treatment of psychosocial complaints in general practice' that was published in a dissertation with the same title by Verhaak<sup>2</sup>. The dissertation gives an account of the selection of the random sample. For this study, a further selection was made from that particular random selection. This was done to prevent heterogeneity (an often misunderstood problem in research in doctor-patient communication<sup>11</sup>). This selection was made on the basis of the following criteria:

- An attempt was made to find consultations which dealt with common health problems.
- The problem had to have a sufficiently high frequency to allow statistical analysis.

- Furthermore there had to be an **important** medical problem, a problem in which the quality of care could be expected to have consequences for the outcome of the care (N.B. very many health problems in general practice tend to go away, whatever the GP does or neglects to do).
- In order to justify the characteristic general practice response to quality in terms of the biopsychosocial model, a problem was sought which involved psychosocial aspects in addition to somatic ones.

Hypertension appeared to meet all of these requirements. The GPs that took part in the project on the 'Interpretation and treatment of psychosocial problems' noted - in addition to other things - all health problems that arose in the consultation. Trained coders coded the health problems in terms of the classification system currently used in general practice, and known as: the International Classification of Primary Care (ICPC)<sup>12</sup>. This made it possible to select all consultations involving hypertension and other blood pressure problems (ICPC-codes K85-K87) (n=103) from the total inventory (n=1569). The age and sex of the patients was in keeping with expectations on the basis of the data from the larger scale morbidity research program<sup>a 13 14</sup>). The majority of the consultations (76%) involved a repeat visit; this was also what was expected - hypertension is a chronic complaint. By way of comparison: in the British Second National Morbidity Survey the figure was 63%<sup>13</sup>; in the Rotterdam Monitoring project, 95% of hypertension consultations and 59% of consultations for high blood pressure were repeat consults<sup>15</sup>). In the greater part of the consultations other health problems were also involved in addition to the blood pressure problem : if we look at the records of the GPs, in 39% of the consultations only one health problem was presented (hypertension); if we look at the video tapes this is the case only in 19% of the consultations.

Co-morbidity is a well-known factor in general practice<sup>16</sup>. GPs generally deal with several health problems during a consultation and even more than their actual records show<sup>17</sup>. In the consultations we had selected, we do not deviate from the average hypertension consultation. We may, on the basis of this data, conclude that the video consultations selected by us provide a reasonable reflection of hypertension consultations as these arise in general practice and, as such, they form suitable research material for this study.

### *Source of assessment 1: GPs-colleagues*

For the purpose of this study, 12 practicing GPs, with considerable experience of practice, were recruited. The 12 GPs each gave an independent general assessment of the QUALITY of the consultations. In these assessments three dimensions were distinguished:

- the technical-medical dimension
- the psychosocial dimension
- the doctor-patient relationship

This tripartite division derives from Dimatteo, who points to the deficiency in the commonly used dichotomy of 'instrumental-affective', or 'somatic-psychosocial', because it omits the factor of the successful doctor-patient relationship which is completely different from detecting and adequately treating psychological problems and vice versa<sup>18</sup>. In the observation instrument, known as, PREVARA, developed by the Nijmegen University Institute of General Practice (NUHI), a comparable tripartite division is to be found<sup>19</sup>. The GP-observer receives written instructions and a short period of training in order to standardize the assessment as far as possible. An indication is given, in the written instructions, as to which aspects per dimension the observers must involve in their assessment of quality. In reference to the **medical quality**, this is a summary of the NUHI-protocol on the detection and treatment of hypertension, in addition to some general aspects of quality, such as: the avoidance of superfluous treatment, and being alert to patients who have been incorrectly designated healthy but also those who have been incorrectly labeled as sick. In the assessment of **psychosocial quality** the observers were asked to pay attention, among other things, to the degree to which the GP is receptive to, and himself investigates, the non-somatic aspects relating to the complaint, which should not only concern psychosocial problems as such, but also the background to the complaint and the problems which are caused by it or the treatment. Concern on the quality of the **doctor-patient relationship** was exclusively with the manner in which the doctor dealt with the patient, in particular the degree in which he was successful in creating an open, secure and workable relationship with the patient.

The observers were, intentionally, not asked to tally all of these aspects separately, or to assess them, but to arrive at a total assessment after having assessed the various aspects against one another per dimension. They were allowed to express their assessment in a numerical grade (i.e. from 0 to 10). This approach was chosen because numerous publications reveal that detailed protocols (including those on hypertension) appear to be very far removed from today's reality<sup>20 21</sup>, and that even after conclusion of the testing project up to 50% of the treatments which were regarded as 'obligatory' in a consensus conference were not actually carried out in practice<sup>22</sup>. By asking the GP-observers to pay attention to the various aspects of quality, but to set them off against other aspects in a total assessment, we hope to avoid some of the problems reported in the literature. Of course, it all depends on the reliability (consistency) of the judgments of the various observers.

The observers appear to be able to use this method successfully. The subdivision of GP behaviour into three dimensions (technical-medical, psychosocial, management of the doctor-patient relationship) did not appear to cause any problems. An analysis of variance did not reveal differences in the three measures of quality among the observers, but did reveal them among the consultations. The reliability was good: Cronbach's alpha for the three measures of quality, was .79, .88 and .88 respectively. On the basis of this data it was decided to use an average score per quality assessment for the rest of the analyses.

The scoring range on the resulting 10-point scale showed a reasonable spread, the average assessment of the quality of the technical-medical treatment varied between 4.6 and 7.6 ( $X=6.5$ ; s.d. = .55); the psychosocial treatment received scores of between 3.3 and 8.0 ( $X=6.2$ ; s.d. = 9.6), and the quality of the doctor-patient relationship between 3.8 and 8.1 ( $X=6.6$ ; s.d. = .90).

The 12 GPs were also asked to make a statement on the **general practice orientation** of the doctor. A measuring instrument, comprising 7 five point scales, was used for this purpose; it derived from the typology of the 'clinical-GP' dimension, which was developed by Verhaak on the basis of a study of the literature<sup>2</sup>, and was somewhat modified for the purpose of this study<sup>b</sup>. This instrument also turned out to be reliable with inter-assessor alphas of between .77 and .93. When aggregated for all assessors, the 7-item scale provided a Cronbach's alpha of .93. A factor analysis for this aggregated scale produced one clear factor with an Eigen value of 4.96 and (when skewed) 70.9% explained variation. On the basis of this analysis it was decided in the further analysis to use the average score on this scale as a measure for the general practice orientation of the doctor concerned.

#### Source of assessment 2: the doctor's own patient

Each of the patients filled in a questionnaire on conclusion of the video recording. The questionnaire contained six items, derived from Cassee<sup>23</sup>, in which the satisfaction of the patient was ascertained; and 7 items (derived from Crebolder<sup>24</sup>) on the functional breadth assigned by the patient to the doctor's role ('what sort of problems do you take to the doctor?'). The satisfaction scale provided a reliability score of .73 (Cronbach's alpha). On the basis of this it was decided to include the aggregated score in the analysis as a measure for satisfaction.

Table 6.1 Factor-analysis functional breadth (patient assessment)

	Factor 1 psychosocial care	Factor 2 social welfare care for the aged
- educational problems	.67*	.18
- marital problems	.79*	.18
- to the home for the aged	.10	.65*
- loneliness	.56*	-.15
- domestic assistance	.02	.78*
- terminal support	.02	.74*
- sex education	.57*	.03
Eigen value	1.99	1.40
% explained variance	28,4%	20,0%

The functional breadth scale provided a reliability score of .57, which is too low to allow calculation of the aggregated score. On the basis of this, a factor analysis was carried out on this scale. The factor analysis provided two interpretable factors which together explain a good 48% of the variance (see table 6.1): factor 1 refers to the functional breadth in the 'psychological' area; the second factor, functional breadth in respect of the (welfare aspects of) care for the aged. Patients clearly make a distinction here. Both factor scores were used in further analyses.

### **Source of assessment 3: the NIVEL-observation instrument**

We made use of the observations of video consultations - carried out earlier in the context of Verhaak's dissertation - for the psychologist's assessments. The observational instrument used here derived both from psychological theories, in particular the theory of Rogers, and from more recent general practice insights, including, among others, those from the Methodical Approach. The variables and measuring procedures have been described extensively elsewhere<sup>2</sup> so that a concise summary will be sufficient here. For this study, we selected variables which, as earlier research had shown, together form a style of communication that was both highly doctor specific and on the basis of which doctors could be distinguished one from another<sup>2 3</sup>. This style of communication comprises nine variables that can be subdivided conceptually in three groups:

- 1 **affective behaviour.** This comprises the degree to which the doctor has eye contact with the patient (expressed as a percentage of time), the interest that he expresses (a five-point scale), his a-specific encouraging noises (throat clearing, ums and ahs, etc.), expressed in the number of utterances per minute; and finally the number of expressions of empathy per minute (paraphrases and reflections). This category of behaviour reflects what is regarded in psychological theories as the basic attitude required in any caring relation<sup>25</sup>.
- 2 **methodical approach.** This comprises three variables: is there a clarification of problem? Is structure introduced into the consultation? And how often are factors outside the complaint, in its narrower sense, investigated?
- 3 **patient-oriented behaviour.** This comprises two variables, deriving from Byrne and Long<sup>26</sup>, which give expression to the degree to which the GP allows the patient to influence the consultation in the diagnostic and therapeutic phase. Both variables are scored on a five-point scale.

The test-retest reliability varies between .44 and .88; the inter-assessor reliability between .35 and .89. The variables for which the specific behaviours have to be tallied were (as has been described elsewhere<sup>27 28</sup>) scored more reliably than the variables in which a subjective assessment was asked of the observers. Where the



reliability was low, a check was carried out for observer effect. In no single case did differences between doctors disappear after this observer effect, in part because the consultations by the various doctors were equally distributed among the observers (see further Verhaak, 1984<sup>29</sup>). In the analyses, scores for each of the nine communication variables were recorded separately.

## Results

### *Internal consistency among the assessments of GP-colleagues*

Table 6.2 Interrelationship between doctor-assessments

<b>Quality</b>			
1 technical-medical			
2 psychosocial	.68 **		
3 doctor-patient relationship	.67 **	.88 **	
<b>Orientation</b>			
4 general medicine	.53 **	.90 **	.81 **
	1	2	3

\* p < .01

\*\* p < .001

Three assessments relating to the quality of the technical-medical treatment, the psychosocial treatment, and the management of the doctor-patient relationship showed a high degree of internal consistency (see table 6.2). Where a GP was assessed as good in one of these areas, his behaviour in other areas was also assessed as good in a considerable number of the consultations. The general practice orientation of the doctor also showed a high correlation with the assessment of quality; mostly with the quality assessment of the psychosocial treatment and least with technical-medical treatment.

*Consistency between the assessments of GP-colleagues and the GPs own patients*

Table 6.3 Correlation, GP assessments with patient assessments

GP assessment/(own) patient	satisfaction	functional breadth psychological care	functional breadth social care welfare for the aged
Quality - technical-medical	.03	.10	-.12
Quality - psychosocial	.19 <sup>▼</sup>	.34 <sup>*</sup>	-.01
Quality - doctor-patient relationship	.30 <sup>*</sup>	.30 <sup>*</sup>	.04
General practice orientation	.16	.36 <sup>*</sup>	-.05

▼ p < .05

\* p < .01

\*\* p < .001

Table 6.3 shows a remarkable result: The satisfaction of the patient does **not** relate to the quality of the technical-medical treatment, **nor** to the psychosocial treatment, but only to the way the GP manages the doctor-patient relationship. When a patient is satisfied with his GP, this appears to relate more to the GPs bedside manner and less to his primary role as a doctor. It is also striking that when a patient allocates a broad functional role in the psychosocial area to the GP that the quality of treatment in that area is also rated 'good'. In such cases the GP also more often has a general practice orientation according to his colleagues. When a patient allocates a broad functional role to his doctor in relation to the social welfare side of care for the aged, this often does not relate or even relates negatively - though not significantly - to the assessed quality and the general practice orientation.

*Consistency between the assessments of GP-colleagues and the NIVEL observation protocol*

Table 6.4 Correlation, GP assessments and psychologists assessments

Assessments psychologists/GPs	Quality			Orientation GP
	med.	psychosoc.	d-p rel.	
<b>Affective behaviour</b>				
1 non-verbal attention	.39**	.66**	.55**	.69**
2 interest	.56**	.60**	.56**	.49**
3 a-specific attention	.26*	.42**	.39**	.48**
4 Empathy (verbal)	.20 <sup>†</sup>	.39**	.35**	.43*
<b>Methodical approach</b>				
5 clarifying the issue	-.03	.03	-.00	.07
6 introducing structure	.08	.04	.14	.02
7 targeted question	.22 <sup>†</sup>	.16 <sup>†</sup>	.09	.08
<b>Patient-oriented behaviour</b>				
8 in diagnostic phase	.11	.39**	.38**	.44**
9 in therapeutic phase	.04	.30*	.28*	.37**

<sup>†</sup> p < .05  
 \* p < .01  
 \*\* p < .001

Table 6.4 shows the interrelationships between the GP assessments and observations using the NIVEL observational protocol. It is primarily the **affective behaviour** of the GP, and, the non-verbal forms of affective behaviour (eye contact and demonstrated interest) in particular, which relate strongly to the three assessments of quality; again highest with the quality of psychosocial treatment, and the lowest with technical-medical treatment. Affective behaviour also relates to the assessment of the general practice orientation of the doctor.

A **methodical approach** on the part of the doctor, at least in the degree to which he clarifies the problems and introduces structure into a consultation, does not show any relationship with the various assessments of quality given by GP colleagues.

Targeted questions relate slightly to the assessment of quality on medical-technical and psychosocial treatment.

When the GP gives **the patient considerable influence** in the diagnostic or therapeutic phase of the consultation, the consultation can expect to get a good grade from the GP assessors, at least as far as the quality of the psychosocial treatment and the management of the doctor-patient relationship is concerned. It has no relation with the technical-medical quality. Although the video-doctors in

these consultations do demonstrate a general practice orientation in their colleagues' view.

To gain further insight into the pattern, a series of multiple regression-analyses were carried out with the nine communication variables as independent variables and the quality assessments on technical-medical treatment, psychosocial treatment and management of the doctor-patient relationship respectively as the dependent variables (see table 6.5).

Table 6.5 Multiple Regression and the quality assessments as dependent variables and the communication variables as independent variables

	medical quality ass.		psycho-social quality ass.		doctor-patient relation ass.		assessment orientation	
	$\beta$	T	$\beta$	T	$\beta$	T	$\beta$	T
non-verbal attention	.22	2.28 <sup>▼</sup>	.35	4.15 <sup>*</sup>	.32	3.34 <sup>*</sup>	.42	5.05 <sup>**</sup>
interest	.50	5.13 <sup>**</sup>	.42	5.44 <sup>**</sup>	.40	4.29 <sup>**</sup>	.28	3.51 <sup>**</sup>
a-specific	.07	.68	.20	2.49 <sup>▼</sup>	.18	1.88	.22	2.67 <sup>*</sup>
empathy	-.02	-.17	.07	.82	.15	1.64	.13	1.53
clarification of the issue	-.02	-.15	-.03	-.39	-.06	-.65	-.04	-.46
introducing structure	.03	.37	-.07	-.91	.04	.47	-.09	-1.18
targeted questions	.06	.62	.05	.65	-.10	-1.06	.01	.13
patient-oriented behaviour (diagn.)	-.00	-.09	.22	2.83 <sup>*</sup>	.23	2.48 <sup>▼</sup>	.26	3.40 <sup>*</sup>
patient-oriented behaviour (ther.)	-.02	-.18	.11	1.32	.10	.96	.17	1.96
Multiple R	.60		.77		.65		.77	
Adjusted R <sup>2</sup>	.34		.58		.40		.58	
F (significance)	21.24 (p<.001)		28.21 (p<.001)		17.95 (p<.001)		27.64 (p<.001)	

- ▼ p<.05
- \* p<.01
- \*\* p<.001

Here too, all three quality assessments demonstrated the dominance of the GPs non-verbal affective behaviour, i.e.: the degree to which the doctor maintained eye contact with the patient, and the degree of interest he revealed. In other aspects, the proportions of explained variance between the three assessments of quality differ considerably: the communication variables together explain about 34% of the variance in the assessment of the technical- medical quality, as against 58% on the assessment of psychosocial quality and 40% of the assessment on the quality of the doctor-patient relationship. The judgment of GPs on the degree to which the doctor

manifested a general practice orientation in the video consultations also seems to be exclusively predicted by the communication variables, in particular the affective non-verbal behaviour of the GP. The percentage of explained variance here is 58%.

It might be contended that in chronic complaints like hypertension, 'initial consultations' and 'repeat consultations' differ so much from one another that the observers would give another weighting to their quality assessments. For this reason (in table 6.6) the correlations have been recalculated for both sub-groups: 'initial consultations' (n=25) and 'repeat consultations' (n=70). It should also be noted that the assessors were not previously informed of the fact that the consultation was an initial consultation or a repeat.

Table 6.6 Correlation, GP assessments with psychologist assessments

Assessments psychologists/GPs	Initial consultation (n=25)			repeat consultations(n=70)				
	Quality med.	psycho- social	d-p rel.	General orient.	Quality med.	psycho- social	d-p rel.	Gener. orient.
<b>Affective behaviour</b>								
1 non-verbal attention	.16	.43 <sup>▼</sup>	.38 <sup>▼</sup>	.58 <sup>*</sup>	.41 <sup>**</sup>	.69 <sup>**</sup>	.58 <sup>**</sup>	.70 <sup>**</sup>
2 interest	.80 <sup>**</sup>	.56 <sup>**</sup>	.52 <sup>*</sup>	.29	.50 <sup>**</sup>	.59 <sup>**</sup>	.55 <sup>**</sup>	.52 <sup>**</sup>
3 a-specific	.57 <sup>**</sup>	.52 <sup>*</sup>	.41 <sup>▼</sup>	.43 <sup>▼</sup>	.13	.35 <sup>**</sup>	.36 <sup>**</sup>	.47 <sup>**</sup>
4 Empathy (verbal)	.30	.64 <sup>**</sup>	.66 <sup>**</sup>	.64 <sup>**</sup>	.18	.37 <sup>**</sup>	.33 <sup>*</sup>	.40 <sup>**</sup>
<b>Methodical approach</b>								
5 clarifying the issue	.38 <sup>▼</sup>	.42 <sup>▼</sup>	.32	.29	.02	.08	-.01	.12
6 introducing structure	-.04	-.02	.06	.18	.09	.02	.12	-.05
7 targeted questions	.32	.19	-.14	.06	.20 <sup>▼</sup>	.17	.19	.11
<b>Patient-oriented behaviour</b>								
8 in diagnostic phase	.10	.29	.18	.34	.07	.38 <sup>**</sup>	.38 <sup>**</sup>	.43 <sup>**</sup>
9 in therapeutic phase	.10	.26	.14	.40 <sup>*</sup>	.06	.32 <sup>*</sup>	.32 <sup>*</sup>	.39 <sup>**</sup>
▼	p<.05							
*	p<.01							
**	p<.001							

Indeed we do see remarkable differences between both types of consultation. In the initial consultations the assessed quality is determined less by the degree to which the GP allows the patient to have influence on the course of the consultation and the treatment. On the other hand, a methodical approach is more valued in these consultations: the degree to which the GP clarifies the patient's problem relates to the assessed quality in the technical-medical and the psychosocial areas.

*Consistency between the assessments of the doctor's own patients and the NIVEL observation protocol*

Patient satisfaction correlates moderately with the doctor-patient communication as this is scored using the NIVEL observation protocol (see table 6.7). Patients are more satisfied about their GP when he is probing purposively into factors (other than the obvious) which might play a role in the patient's health problems ( $r = .32$ ;  $p < .01$ ). In addition, manifest GP interest and (verbal) empathy appear to relate to patient satisfaction. The 'functional breadth scale' proved to be a better predictor of patient satisfaction. Where the patient has allocated a broad functional role to his GP in the psychosocial field, it means his GP has displayed considerable affective behavior (verbal and non-verbal) and that the patient made a major contribution in the diagnostic phase of the consultation. A multiple regression-analysis with the communication variables as independent and the various patient assessments as dependent variables shows that none of the communication variables makes an independently significant contribution to the relevant patient assessment.

Table 6.7 Correlation patients assessments and psychologists assessments

Assessments psychologists/GPs	total			initial consultation			repeat consultations		
	A	B	C	A	B	C	A	B	C
<b>Affective behaviour</b>									
1 nonverbal attention	.01	.26 <sup>▼</sup>	.08	-.28	.47 <sup>▼</sup>	-.06	.07	.21	.09
2 interest	.19 <sup>▼</sup>	.25 <sup>▼</sup>	-.13	.42 <sup>▼</sup>	.00	-.42 <sup>▼</sup>	.22	.26 <sup>▼</sup>	-.09
3 a-specific	-.05	.16	-.09	-.33	.12	-.57 <sup>*</sup>	.07	.14	.04
4 empathy (verbal)	.21 <sup>*</sup>	.31 <sup>*</sup>	.03	.29	.47 <sup>▼</sup>	-.30	.22	.27 <sup>▼</sup>	.13
<b>Methodical approach</b>									
5 clarifying the issue	.04	.12	.11	.41 <sup>▼</sup>	.06	.35	.03	.15	-.01
6 introducing structure	-.01	.24	-.04	-.04	.34	-.10	-.00	.28	.07
7 targeted questions	.32 <sup>*</sup>	-.10	-.06	.47 <sup>▼</sup>	-.07	-.20	.31 <sup>*</sup>	-.11	-.05
<b>Patient-oriented behaviour</b>									
8 in diagnostic phase	.03	.32 <sup>*</sup>	.04	.10	.31	-.10	.06	.34 <sup>▼</sup>	.08
9 in therapeutic phase	-.04	.24 <sup>▼</sup>	-.03	.04	.12	.08	-.04	.36 <sup>*</sup>	-.10

▼  $p < .05$   
 \*  $p < .01$   
 \*\*  $p < .001$

A = satisfaction  
 B = patient assessment functional breadth 'psychological'  
 C = patient assessment functional breadth 'social/welfare'

As the second and third part of table 6.7 reveals, the type of consultation also seems to make a difference here: in the initial consultations the patient is particularly satisfied when the GP clarifies the problem (methodical approach), shows interest and asks directly about other problems that play a role in the visit to the surgery; in subsequent consultations only the latter seems important. In subsequent consultations it also seems important for the GP to allow the patient influence discussing his health problem and the planned treatment; in these cases, the GPs functional role in the psychological domain is assessed broader by the patient. We should, because of the small number of initial consultations in our random selection, be careful with the interpretation of these relationships. For this reason too it does not make sense to make a multivariate analysis per sub-group.

## Discussion

The research under consideration was undertaken to investigate the extent to which the NIVEL observational system was able to reveal differences in quality, as these are defined by those concerned. In reflecting on the results, we should, first of all, be aware that a degree of relativization is necessary. Research was carried out on a select group of consultations, i.e. consultations involving hypertension patients. We have shown that our consultations in this connection give a good reflection of the average hypertension consultation in everyday general practice (they are representative in terms of age and sex distribution; there are many repeat consultations and considerable co-morbidity). However they are not representative of **general practice consultation** as such. In the case of hypertension, concern is with chronic problems, which make different demands on doctor-patient communication from acute problems. The results of this study have therefore a limited validity.

Further investigation is required in the way in which **quality** is measured in this research. We chose a measuring procedure in which the assessing GPs gave a total assessment in the form of a numerical grade for each dimension of general practice treatment (technical-medical, psychosocial and management of the doctor-patient relationship). They were asked to include a number of aspects of quality (which were written down) in the assessment and to weight these in respect of one another in order to reach an all embracing total assessment. The advantage of this approach is that total judgment of this type gives a holistic image of the consultation; the disadvantage is that one is dependent on subjective impressions and there is a threat of a relatively low level of reliability, particularly when the observers all consider different aspects of quality as important. This does not however appear to have been the case in this study; the twelve observers present a relatively consistent picture of 'good' and 'bad consultations. A warning is however necessary here. We worked with a relatively large panel in this project, which means that the influence of chance is automatically reduced. This is particularly important when - as in the study under consideration - use is made of subjective

impressions instead of quantifiable units of behaviour. It would therefore not be appropriate, on the basis of this study, to determine that it is possible to arrive at a reliable assessment of the quality of a consultation on the basis of asking two or three experienced GPs to give a quality assessment based on fairly broadly framed instructions. It should also be pointed out that this measure of quality has its value, first and foremost, as a global 'outcome measure' and only a limited relevance for (re)training purposes. After all, the measure does not give information on specific aspects of care which are worse or better assessed, thereby providing concrete starting points for improvement.

This suggests an interesting path for future research, i.e. where data from the type of measurement of quality presented in this study is compared with traditional data, in which detailed categories of behaviour are tallied or assessed by using operationalized protocols. In the description of the method, we have seen that this last approach sometimes presents data that is difficult to interpret. What does it mean when, after a test project, a doctor has only carried out half of the procedures described as 'obligatory'<sup>22</sup>? Does this mean that we are looking at qualitatively sub-optimal care? Or does it relate to the fact that the protocol is, in fact, '*a composite list of requirements for all diagnosticians and practitioners*'<sup>30</sup>, in which the concept of quality is maximized? Or are the protocols too far from everyday practice, since in everyday practice there are seldom 'pure' hypertension consultations? Or does the problem reside in the methods of analysis or measurement (generally frequencies of behavioural categories), described by Wasserman as '*trying to understand the game of tennis by merely counting the number of serves, slams, lobs and volleys*'<sup>31</sup>? A comparison of both methods of measurement may give more insight into these problems. Perhaps it will be seen that a holistic description of the quality of a consultation (as was the case in this study) provides a good supplement to a more detailed (but also more fragmented) measurement of quality. This type of analysis can, for example, provide further information on the actual question of the circumstances in which inter-doctor variation should be seen as a lack of quality, or as the precise phenomenon, the creative effect of which must be emphasized<sup>32 33</sup>. More research would seem desirable.

This is also true for what we have measured as **general practice orientation**. The measuring instrument developed on a basis of the study of the literature appeared to give a reliable score. The high level of correlation between the assessment of quality and the affective and patient-based parts of the observational protocol also give an initial indication of the validity of the measuring instrument. It would seem worthwhile to test this measuring instrument further. A warning should be given however about the use of the 'clinical-general medicine' axis as it is used in the literature at present. In opposing these terms one to another we might generate a misunderstanding to the effect that general practice is not a clinical subject. When using the term general practice orientation, it might be preferable to refer to the 'specialist versus generalist' dimension. This type of description is also closer to the terminology used in the measuring instrument we developed.



Let us return to the main problem addressed in this study. When we first looked at the relationship between the assessments of the doctor-patient communication on the basis of the NIVEL observational instrument and the various assessments of GP-colleagues, the first thing that caught the eye was the positive relationship between the '**affective behaviour**' measured by the psychologists and **all** judgments of quality expressed by colleagues: affective behaviour seems to be assessed positively in medical consultations, not only in respect of psychosocial aspects of care, but also in connection with technical-medical care. A high correlation was also found between affective behaviour and the degree of general practice orientation perceived by colleagues in the consultation. Affective behaviour is a core concept in all sorts of psychological theories, in particular in Rogers's theory. In terms of this theory, affective behaviour is a necessary requirement for building a relationship based on confidence with the patient. As such it has gradually been incorporated in the thinking of virtually all schools of psychotherapy. It is regarded as one of the 'non-specific factors' shown, by a synopsis of research into effect, to play a role in virtually all forms of psychotherapy<sup>34</sup>. The research presented here shows that affective behaviour would appear to be regarded as a basic requirement for good care, not only in mental health care, but also in general practice. This is true in particular in respect of **non-verbal** affective behaviour: eye contact and showing interest. This important role of non-verbal affective behaviour was also pointed out early by Dimatteo et al.<sup>35</sup>, Strecher<sup>36</sup>, and Friedman<sup>37</sup>, among others.

Doctor-patient communication, as it is portrayed with the help of the NIVEL observational instrument, not only plays a role in the three judgments of quality: only one third of the variance in medical quality judgment is explained by it as against nearly 63% of the variance in the judgment of the quality of psychosocial treatment. In this respect the NIVEL-observation instrument would appear to be adequate for determining the quality of psychosocial treatment ( and also the quality of the management of the doctor-patient relationship), but it is not sufficient to describe the quality of technical-medical treatment adequately. This is not all that surprising in itself. The observation instrument was developed to provide increased insight into psychosocial care given by the GP, and, for the greater part, this is provided via the medium of doctor-patient communication. Perhaps however a greater proportion of the quality of technical-medical treatment can be determined with the assistance of observational instruments from a more instrumental tradition, such as those developed by Hall<sup>38</sup> and Roter<sup>39 40</sup>.

The disappointingly low correlations between the **methodical approach** and the various assessments of quality encouraged us to make further analyses. On the basis of the assumption that a methodical approach is primarily important in the initial consultations when the nature of the problem and the treatment have not yet been completely established, a number of analyses were carried out separately for 'initial consultations' and for 'repeats'. Although the number of consultations in the

first group in particular was relatively small (and for that reason we have been careful about drawing conclusions from them), the assessors do, in initial consultations, seem to incorporate different aspects in their assessments from those in the repeat consultations. It seems that in initial consultations a technical/methodical approach by the GP is valued (by the patient too), whereas for longer periods of care it seems more important that the GP gives the patient considerable influence in discussing the exact nature of his health problem and the course of the planned treatment. Various types of consultations seem to demand different types of doctor-patient communication. We must therefore view these results as a warning against mixing various types of consultation when assessing their quality. If research into the assessment of quality were limited to 'pure' consultations (initial consultations in which no other problem than the one intended was presented) it would have only limited relevance for everyday reality in the practice. This too could provide a subject for further investigation.

## Notes

### a. Background data on the hypertension consultations

age	man	woman	total	total NS <sup>14</sup>	total NMS <sup>13</sup>
< 45	11	10	21 (20%)	(14%)	(10%)
45 - 64	10	23	33 (42%)	(44%)	(47%)
65 - 74	11	14	25 (24%)	(27%)	(29%)
≥ 75	3	11	14 (14%)	(14%)	(14%)
	35	68	103 (100%)	(100%)	(100%)
total	(34%)	(66%)	(100%)		
total NS	(37%)	(63%)	(100%)		
total NMS	(35%)	(65%)	(100%)		

NS = National Survey of Morbidity and Interventions in the Netherlands

NMS = National Morbidity Survey in the United Kingdom

b. Measuring instrument for 'General Practice Orientation'

What is your impression of the general orientation of the doctor during this consultation?

- |  |                  |  |                     |
|--|------------------|--|---------------------|
| - Is the doctor more 'care' or 'cure' oriented   | care             | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | cure                |
| - Is the doctor more natural science or more behavioural science oriented  | natural science  | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | behavioural science |
| - Does the doctor treat the patients in a businesslike way or personally   | business-like    | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | personally          |
| - Does the doctor choose a safe path or does he take risks   | safe             | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | risks               |
| - Is the doctor patient-oriented or complaint-oriented   | patient-oriented | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | complaint-oriented  |
| - Does the doctor choose a biological or psychotherapeutic approach with psychological problems                  | biological       | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | psychotherapeutic   |
| - Is the doctor more concerned with guiding and supporting the patient (maintenance) or intervening and changing | guiding          | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | intervening         |

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## 7 Instrumental and affective aspects of doctor-patient communication\*

### Abstract

In a semi-replication study 103 videotaped real life general practice consultations with hypertensive patients were observed with Roter's Interaction Analysis System (RIAS). RIAS consists of a detailed category system meant to measure each verbal utterance of physician and patient (distinguished in task-related behavior and socio-emotional behavior), and a set of global affect-ratings. In this article only GP-behavior is studied. GP's behavior is related to two types of outcome measures: (1) panel-assessed quality of care on three separate dimensions (technical-medical, psychosocial and the management of the physician-patient relationship), and (2) patient satisfaction.

A remarkable high percentage of the variance in the quality assessments (ranging from 59 % to 70 %) was explained by RIAS. The global affect-ratings proved to have the strongest influence in all quality assessments. Besides: task-related behavior seems to be more important in medical technical behavior, whereas socio-emotional behavior, and especially Roger's categories like reflecting, paraphrasing, showing agreement etc., seems to be more important in the other quality measures. The correlations of RIAS-behaviors with patient satisfaction were much lower, showing that patient satisfaction was mainly correlated (negatively) with the negative behaviors and affect-ratings, suggesting a malfunctioning physician-patient relationship in some consultations. The results are compared with Roter's studie; similarities and differences are discussed in the light of adjustments in the methodology.

### Introduction

In medical communication two types of behavior are thought to be important: instrumental behavior and affective behavior<sup>1-11</sup>, corresponding with the two main purposes of the medical consultation; i.e.: information exchange, necessary for solving the medical problem<sup>7 12-22</sup> and creating a therapeutic relationship, necessary

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for managing the psychosocial aspects of patient's health problems and gaining patients confidence<sup>2 3 5 23-31</sup>. The reason why these two types of behavior are both so important in general practice (and, probably in all medical practice) is that patients when seeing a doctor have two different types of needs that have to be met<sup>32-34</sup>: as Engel<sup>32</sup> stated: "*the need to know and understand*" (to know what is the matter with him, what causes the pain, and how this can be stilled), and "*the need to feel known and understood*" (to know that he is accepted by the doctor as a person, that he is not seen as a malingerer). While most people agree about the relevance of both types of behavior, there is considerable debate about the relative importance of both. In relating communication behavior to outcome measures such as patients' satisfaction, some claim that affective behavior is predominant, that patients cannot distinguish between both types of doctor's behavior and base their assessment on the doctor's affective qualities<sup>2 5 35</sup>. Others claim that patients can and do discriminate between both types of behavior, and that instrumental behavior plays the most important role in patients assessment of his doctor's performance<sup>7 8 36</sup>. In an earlier study (of chapter 2) we suggested that the differences in opinions (based on differences in research results) could probably be explained by differences in the theoretical background of the researchers involved<sup>34</sup>. We found that in doctor-patient communication research there are two distinct theoretical schools, that - until recently - hardly had any influence upon one another: the instrumental school, based on problem-solving theories (the researchers belonging to this school found their inspiration in Bales<sup>37</sup>), and the affective school, based on psychotherapeutic theories (Rogers<sup>38</sup> and Balint<sup>23</sup> are the leading theorists here). The research programs of both 'schools' are not only characterized by different theoretical frameworks (albeit mostly implicit), but also by different observation instruments (audio versus video), methodology (counting behavior versus assessing behavior) and - as a consequence - different results: researchers who started their work in the instrumental tradition continue to find a preponderance of instrumental behavior, even when they have supplemented their observation with affective measures. And, similarly, researchers belonging to the affective tradition find cumulative evidence to strengthen their point of view<sup>34</sup>.

In order to gain more insight in the contradictory results found in the literature, a study was designed in which observation instruments from both theoretical traditions were used on the same research material. For this study Roter's Interaction Analysis System was chosen as a typical representative of the problem-solving tradition. Roter's system is well documented<sup>39</sup>, widely used<sup>7-8 19 40-45</sup>, and relatively favorably judged in a comparison study<sup>43</sup>. Moreover, it has been shown to provide some interesting results about the relative contribution of affective and instrumental behavior to the quality of care ('medical proficiency') and patient satisfaction. In this article, the results are presented of a study into the relationships between Roter's Interaction Analysis System (RIAS) and two outcome measures:

- the quality of the process of care, as assessed by a panel of experienced GPs, and
- patient satisfaction



The same kind of analyses on the same material has been done with data from an observation instrument, which has its roots in the affective research tradition (the NIVEL observation instrument)<sup>31 46</sup>, which makes a comparison possible<sup>47</sup>.

## Methods

### *Sample*

For this study, videotaped GP-consultations were used from a previous study into the relationships among the NIVEL observation system, panel assessed quality of care and patient satisfaction respectively<sup>31 47</sup>. The tapes comprise 103 consultations with hypertensive patients; these were all the hypertensive patients from a larger sample (n=1569) of videotaped consultations with consecutive, 'real-life' GP-patients<sup>30 48-49</sup>. This figure (6.6 %) is to be expected from a random sample of consultations in general practice<sup>50</sup>. The age-sex distribution of the patients is fairly similar to distributions found in morbidity research in general practice<sup>31 51</sup>. The rationale behind the choice of hypertensive patients was the need for a homogeneous sample<sup>44</sup>, with a health problem considered serious enough to deserve special medical attention, and a problem requiring a biopsychosocial approach. The latter is thought to be important because in general practice health problems seldom demand a somatic solution alone<sup>31</sup>.

### *Dependent variables: quality of care*

In terms of Donabedian's useful distinction (structure-process-outcome)<sup>52</sup>, the focus in this study is on the process of care. Quality of care was measured by a threefold assessment by a panel of 12 experienced GPs of:

- quality of GP's technical-medical behavior
- quality of GP's psychosocial behavior
- quality of GP's management of the doctor-patient relationship

The GPs, who made their assessments independently from one another, rated the GP performance (as in the Dutch school grading system) on three ten-points scales. They were asked to make global assessments weighing up for themselves the different elements thought to be important in each type of behavior. These were summarized in a paper they had to hand during the assessments. For instance, the panel-members were provided with an overview of the major elements of the NUHI Hypertension Protocol as a guide in assessing the technical-medical quality; in addition they were asked to pay attention to some general aspects of quality of care in general practice, such as the avoidance of superfluous treatment and a correct designation of patients as ill or healthy. In the assessment of psychosocial care the panel-members were asked to pay attention -among other things- to the degree to which the GP was receptive to these non-somatic aspects relating to the complaint; these were not only to involve psychosocial problems as such, but also stress-related factors in the origin of the hypertension and the problems caused by it and

by its treatment. Concern in the quality of the doctor-patient relationship was exclusively with the manner in which the GP dealt with the patient, in particular the degree to which he was successful in creating an open, secure and workable relationship with the patient. These global assessments proved to be reliable with Cronbach's alpha's of .79, .88 and .88, respectively. Moreover the scores showed a wide range; the judges were not afraid to give low scores as well as high scores. An analysis of variance did reveal differences in the three measures of quality among the consultations, but not among the observers. The 12 observers' scores were averaged to get a single measure for the quality of care for each of the three dimensions distinguished<sup>31</sup>.

To get an integrated assessment of the quality of care, the judges were also asked to rate GP behavior on seven 5-points scales, representing different dimensions of a 'generalistic orientation', as opposite to a biomedical approach, which is thought adequate for general practice (of chapter 6, note a). In a former study<sup>31</sup>, this scale also proved to be reliable with inter-assessor-alpha's of between .77 and .93 and an inter-item alpha (using the summated score for each item) of .93. A factor-analysis on this summated scale showed one clear factor which explained 70.9 % of the variance. The scale's sumscore is used in the analyses.

#### ***Dependent variables: patients satisfaction***

Immediately after the consultation, the patients were asked to fill in a questionnaire. A Patient Satisfaction Scale<sup>48</sup> was used, that proved to have a reliability of .73 (Cronbach's alpha)<sup>31</sup> in our sample. At the time the consultations were recorded, the NIVEL-studies focused primarily on GP's affective behavior and were not designed to include measurements of instrumental behavior. As a consequence, the satisfaction scale was designed to capture the humanistic side of medicine, and therefore does not contain items with regard to the more instrumental aspects of GP behavior. As it was neither possible nor useful to obtain additional information on patient's satisfaction long after the original recordings, the result is a one-sided satisfaction scale. This can mean a drawback for this study, to which we will return in the discussion.

#### ***Independent variables: doctor-patient communication***

Doctor-patient communication was measured by Roter's Interaction Analysis System (RIAS)<sup>\*</sup>, i.e. Roter's modification of Bales' process analysis scheme<sup>37</sup>. The unit of analysis for this scheme is a verbal utterance, defined as the smallest distinguishable speech segment to which a coder can assign a classification. This

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\* We would like to thank Debra Roter for her enthusiastic cooperation in helping us with the application of her observation instrument in our study.

may be a single word, a clause, or a complete sentence. All utterances are assigned to mutually exclusive categories. The system is described in detail in several publications<sup>7-8 19 39-42</sup>, sometimes with minor adjustments. The latest version<sup>39</sup> is used in this study; one additional refinement has been made in this study by splitting up the information, question and counseling categories in: 'medical', 'feelings' and 'lifestyle'. This has been done, because we are not only interested in the technical-medical aspects of GP-consultations, but also in the psychosocial aspects and the way the GP manages his relationship with the patient. This interest of ours is also reflected in the threefold quality rating (see before). The result is an observation system consisting of 35 distinct categories to be filled in for GP and patient, separately. In this article only GPs behaviors have been analyzed.

In addition to Roter's Interaction Analysis System, five global affect-scales were rated for GP and patient, separately. The same 6-point scales were used by Roter<sup>39</sup>, although not in the publications about the relative relevance of task-related and affective behavior. The affect-scales were meant to assess the following types of affect:

- anger/irritation
- anxiety/nervousness
- dominance/assertiveness
- interest/concern
- warmth/friendliness

To avoid interpretation problems, neither the behavioral categories nor the manual with full instructions were translated, but instead the original documents were used. The application of the observation system was facilitated by the availability of six audiotaped American consultations and their complete transcripts in which the correct codes were noted. These were used for training purposes. After the training, all 103 consultations were coded by one observer. Twenty five of these were also coded by a second observer to test the reliability of the observations.

Thanks to the detailed instructions and many annotated examples in the manual it was not very difficult to code the verbal utterances of GP and patient in the behavioral categories of the RIAS. Yet, it proved to be a time-consuming effort: Application of the RIAS system took us about 3 hour per consultation (average consultation length was 9.5 minutes), which is much longer than reported by Roter<sup>39</sup> and Inui et al.<sup>43</sup>. The reliability of the observations proved to be high, with inter-observer correlations (Pearson's Product Moment Correlation) between .76 and .99 for the GPs categories and between .67 and .99 for the patient's categories. As can be expected from rating scales<sup>7-8 29 43 48 53-54</sup>, the reliability of the global affect scales was a bit lower, but apart from the assessment of GP's dominance (Pearson's Product Moment Correlation:  $r=.47$ ), the figures are acceptable (ranging from .73 to .91). Dominance is excluded from the analyses.

## Data analysis

The principal efforts in data analysis were (1) to provide a more detailed picture of the behaviors within the socio-emotional cluster (2) to explore the internal relationships between the three main groups in the observation system: task-related behavior, verbal socio-emotional behavior (which together form Roter's Interaction Analysis System) and the global affect ratings, (3) to compare the relative strength of process-outcome associations across these main groups. For the preliminary analysis (first research question) a principal components analysis was computed with varimax rotation of the resulting factors. Pearson's product-moment correlations were computed for the two other research questions. Additionally, a series of stepwise multiple regressions were performed for the last research question, which treated the distinct measures of doctor-patient communication as independent variables and encounter outcome (panel-assessed quality of care quality of care and patient satisfaction) as dependent variables. For reasons described by Inui<sup>43</sup>, the 'explanatory power' of a given dependent variable is reported as the Adjusted  $R^2$ , which is a conservative estimate of total  $R^2$ . It gives the maximum amount of explained variance, when the total explained variance is adjusted for the number of independent variables entering. Actual values for independent variables in all analyses were frequencies (counts), since treating independent variables as proportions did not substantively alter results in other studies<sup>43</sup>, a result also found in our previous research<sup>48</sup>.

## Results

### *Preliminary analyses*

Our version of RIAS consists of 35 behavioral categories, which makes it necessary to reduce them to meaningful clusters within the two main groups of the system: task-related or instrumental behavior and socio-emotional or affective behavior.

### *Instrumental behavior (RIAS)*

The following task clusters were formed by Roter<sup>7-8</sup>:

- information: all information statements related to medical condition, therapeutic regimen, lifestyle, feelings, other.
- questions: all open-ended and closed-ended questions as well as asking for understanding, clarification or opinion.
- counseling: all persuasive statements related to medical condition, therapeutic regimen, lifestyle and feelings.
- directions: all statements that guide the patient through the consultation ("sit down", "I'll have a look first", etc.).

In this study these task clusters are used in the analyses. Additionally, the first three clusters have been split up in 'medical' and 'psychosocial' (combining 'feelings' and 'lifestyle').

### **Affective behavior (RIAS)**

Roter's socio-emotional cluster was formed on the basis of a factor analysis (principal components analysis) of **all** the behavioral categories; she found "no clear socio-emotional factor, although one of the rotated factors did contain substantial loadings for personal remarks and laughs, and loadings for statements of approval and agreement that were higher than the loadings of all but one other content analysis item on that factor. These four variables were consequently averaged to form a positive socio-emotional cluster"<sup>7</sup>. Because of Roter's low correlations between this socio-emotional cluster and medical proficiency, or patient satisfaction<sup>7-8</sup>, which, as has been shown in the Introduction to this article, is contrary to other research results, special attention has been paid to the content of the socio-emotional part of Roter's Interactional Analysis System. Instead of a factor analysis on all the RIAS-items, a factor analysis has been carried out on the socio-emotional items alone. The only negative socio-emotional item: 'disagree' was also excluded from this analysis. This principal components analysis on the **positive socio-emotional** behavioral items produced three clear, distinguishable factors, explaining 55 % of the variance (see table 7.1).

Table 7.1 Factor Analysis (PCA) positive socio-emotional behavior (n=103)

	Factor 1 'verbal attentiveness'	Factor 2 'showing concern'	Factor 3 'social behavior'
Agreement	.88	-.03	-.04
Paraphrases	.80	.08	.01
Empathy	.62	.14	-.03
Partnership	.72	.07	.04
Legitimize	.65	.13	.13
Worry	.12	.75	.13
Reassurance	.12	.79	-.07
Personal Remarks	-.01	-.15	.86
Jokes	.35	.30	.44
Approval/Compliment	-.05	.34	.45
Eigen Value	3.09	1.38	1.05
% explained variance	30.9%	13.8%	10.5%

The first factor, explaining 30,9 % of the variance, comprises all typical Rogers's categories<sup>38</sup>: showing agreement, paraphrasing and reflecting patient messages, legitimizing patient behavior or feelings, and showing partnership. It gives information about the degree to which the GP is attuned to what the patient volunteers to tell; it is called 'verbal attentiveness'. The second factor, explaining 13,8 % of the variance is comprised of categories that show GPs concern and involvement in the patient's health problem: shows worry, and gives reassurance. It

is called 'showing concern'. The third factor (explaining 10,5 % of the variance) can be considered as a social factor: the GP makes personal statements, jokes, and gives compliments and signs of approval. Note that this last factor is much alike Roter's socio-emotional factor: it has a very high loading for 'personal statements' and moderate loadings for 'jokes' and 'approvals'<sup>7</sup>.

As a result of this analysis, four socio-emotional clusters are distinguished in this study instead of one: the categories loading high on one of the factors have been summated to form three socio-emotional clusters: verbal attentiveness, showing concern and social behavior. GPs statements of disagreement are included in the analyses separately, because this is the only negative socio-emotional behavioral category.

### Relations between GP's task and socio-emotional behaviors

In table 7.2 the correlations are shown between the task clusters and the socio-emotional clusters of Roter's Interaction Analysis System.

Table 7.2 Relationships (Pearsons' R) between task-related behaviors and socio-emotional behaviors (n=103)

	verbal attentive- ness	showing concern	social behavior	disagree- ments
Information	.47**	.40**	-.02	.44**
medical .53**	.35**	-.01	.46**	
psychosocial	.02	.07	-.18	.19
Questions	.48**	.06	.11	.24*
medical .21	.06	.13	.21	
psychosocial	.32**	-.03	.01	.02
Counseling	.52**	-.01	.12	.51**
medical .41**	.08	.11	.52**	
psychosocial	.33**	-.11	.07	.18
Directions	.48**	.26*	-.04	.26*

\* p < .01

\*\* p < .001

**Verbal attention** is strongly correlated with all four task clusters. However, when the topic of the conversation is taken into account, some refinements of the overall picture can be shown. Doctors who show their attentiveness by paraphrasing the patient, reflecting or legitimizing his feelings and showing agreement or partnership,

are also likely to give more medical information (but not more psychosocial information); they tend to ask more psychosocial questions but not more medical questions. They also do more counseling, regardless of the topic. **Showing concern** by reassuring the patient or showing worry is correlated with giving information (especially medical information) and directions, only. **Social behavior** (the cluster that was much like Roter's socio-emotional cluster) has no significant relationship with any of the four task clusters, not even when the topic of the conversation (medical or psychosocial) is taken into account. Strikingly, the negative socio-emotional category '**showing disagreement**' has a positive relationship with all task clusters, especially with counseling and giving information. This is largely restricted, however, to conversation on medical topics.

### *Relationships between RIAS' task and socio-emotional clusters and the global affect-ratings*

In table 7.3 the correlations are presented between the RIAS-clusters on the one hand, and the global affect ratings on the other.

Table 7.3 Relationships between Rias' task and socio-emotional clusters and the global affect ratings (Pearsons' product moment correlation; n=103)

Task cluster	anger	anxiety	interest	warmth
Information	.06	-.02	.23 <sup>o</sup>	.22 <sup>o</sup>
medical .06	.02	.19 <sup>o</sup>	.21 <sup>o</sup>	
psychosocial	.28*	-.04	-.03	-.08
Questions	-.17 <sup>o</sup>	-.18 <sup>o</sup>	.32**	.32**
medical .01	-.11	.16	.17 <sup>o</sup>	
psychosocial	-.27*	-.26*	.34**	.32**
Counseling	-.04	-.10	.20 <sup>o</sup>	.20 <sup>o</sup>
medical .05	-.06	.13	.12	
psychosocial	-.11	-.09	.17 <sup>o</sup>	.17 <sup>o</sup>
Directions	-.11	-.01	.30*	.26*
Socio-emotional Cluster				
verbalattentiveness	-.26*	-.23 <sup>o</sup>	.33**	.36**
involvement	-.11	.00	.16	.15
socialbehavior	-.23*	-.13	.26*	.32**
disagreements	.31**	.25*	-.03	-.07

<sup>o</sup> p<.05  
 \* p<.01  
 \*\* p<.001

An irritated GP asks few questions during the consultation, (especially few psychosocial questions). He is also not very attentive in his verbal behavior and has no inclination to socialize with his patient. On the contrary: he often disagrees with him. Together these results point to a malfunctioning relationship between the doctor and his patient. The same (but in a somewhat lesser degree) can be said of an anxious or nervous-looking doctor.

The mirror-image of the irritated and anxious doctor is formed by the interested GP who exudes warmth. These doctors are verbally attentive, display much social behavior and ask many questions, especially psychosocial questions. But there is more: An interested doctor who radiates warmth seems to be active in **all** four task clusters; he also gives much information (especially medical information) and does much counseling (especially psychosocial counseling). On the other hand, no relationship with his disagreements has been found.

### *Relations between GPs behavior and the quality of care*

In table 7.4 the correlations are given between the observed behavior and panel-assessed quality of care, distinguished into technical-medical care, psychosocial care and the management of the GP-patient relationship. The degree to which the GP displays a 'generalistic orientation' (as opposed to a biomedical orientation) is the fourth quality measured in these analyses.

The original four **task clusters** (giving information, asking questions, counseling and giving directions) all show positive correlations with each of the three quality measures. But when split up into a medical and a psychosocial component, some differentiation arises: medical information seems to be important for all quality ratings, no matter the domain of care. On the other hand, psychosocial information has no significant relation with any of the three quality-ratings, not even with the quality-rating for psychosocial care. Counseling and questioning show the expected relationships: medical counseling and questioning correlate with the quality rating for technical-medical care (and not with the other two quality ratings); psychosocial counseling and questioning correlate with both the quality of psychosocial care and the quality of the GP-patient relationship, but not with the quality of medical care.

When the GP displays a 'generalistic' orientation during the consultation, as opposed to a biomedical orientation, he seems to display many activities, especially in the psychosocial area.

Of the **socio-emotional** clusters, verbal attentiveness has the strongest relationships with all quality-ratings, as well as with the GP's generalistic orientation. A GP who shows concern in his patients' health problems by showing worry or giving reassurance is positively evaluated, too, be it in a more moderate way. Social behavior (the category that is most alike Roter's socio-emotional cluster) only



counts for the quality-rating on the way the GP manages the doctor-patient relationship.

The strongest correlations with the quality of care, however, can be found among the global **affect-ratings**. Especially the positive affects (interest and warmth) show a very high correlation with all three quality-ratings, as well as with the GP's generalistic orientation.

Table 7.4 Relationship between GPs task and socio-emotional behavior and affect ratings and the quality of care (Pearsons' R; n=103)

		Quality of care			generalistic orientation
		medical	psychosocial	relationship	
<b>Task behavior</b>					
Giving information	<b>total</b>	.35**	.33**	.25**	.25*
	medical	.41**	.32**	.30**	.22
	psychosocial	.02	.14	.02	.20
Counseling	<b>total</b>	.22	.26*	.18	.27*
	medical	.23*	.10	.06	.06
	psychosocial	.07	.28*	.20	.34*
Questioning	<b>total</b>	.22	.29*	.20	.24*
	medical	.21	.05	.03	.01
	psychosocial	.06	.34**	.24*	.34**
Directions	<b>total</b>	.46**	.29*	.22	.14
<b>Socio-emotional behavior</b>					
	verbal attentiveness	.38**	.53**	.42**	.55**
	showing concern	.25*	.22	.25*	.17
	social behavior	.14	.16	.31**	.23
	disagreements	.20	.15	.01	.16
<b>Affect ratings</b>					
	anger	-.26*	-.45**	-.46**	-.41**
	anxiety	-.22	-.27*	-.30**	.65**
	interest	.69**	.77**	-.30**	-.27**
	warmth	.58**	.71**	.76**	.65**

\* p<.01

\*\* p<.001

### *The relative relevance of different types of behavior for the quality of care*

To determine the relative influence of the different types of behavior on the three quality ratings as well as the assessed rate of generalistic orientation, several stepwise multiple regression analyses have been carried out, with the quality ratings successively as dependent variables and different subsets of behavioral categories and affect-ratings as independent variables. Table 7.5 gives an overview of the results in terms of a list of the behavioral categories (in order of importance) that have an independent influence on that specific quality measure, and the amount of variance that is explained by these variables (in percentages). As the revised version of the task-clusters (which distinguishes between medical and psychosocial topics in information-giving, questioning, and counseling) proved to be fruitful in the previous analyses, only the revised task clusters are presented.

The total observation system consists of three main groups of variables: task related behavior, socio-emotional behavior (together forming RIAS), and global affect-ratings.

In the upper part of table 7.5 the combined influence of all three main groups on the distinguished quality ratings are presented. It is demonstrated that a high proportion of variance in the quality ratings is explained by the observation system:

- 60 % of the variance in the assessment of technical-medical quality is explained by the observation system; mainly by interest (one of the global affect-ratings) and giving medical information (belonging to the task-related behaviors). Other task-related behaviors with a small but independent influence on the quality of technical-medical care are: 'asking psychosocial questions' (this has a negative predictive value) and 'giving directions or instructions'. The socio-emotional behaviors have no independent influence on the quality of medical care.
- 70 % of the variance in the assessment of psychosocial quality can be explained by the observation system. Here too, interest (a global affect-rating) has the strongest predictive power, followed by verbal attentiveness (from the socio-emotional behaviors). Task-related behavior also has an independent influence on the assessment of the quality of psychosocial care, but only in relation to the topic discussed: the quality of psychosocial care is valued better when the GP gives a lot of psychosocial information and asks few medical questions.
- 59 % of the variance in the assessment of the way the GP manages his relationship with the patient is explained by the observation system. Task-related behavior does not have any influence on this particular quality assessment. It is totally predicted by affective measures, partly from the global affect-ratings (warmth) and partly by the verbal socio-emotional behaviors (verbal attentiveness).
- 63 % of the variance in GPs generalistic orientation is explained by the observation system, mainly by affective measures (interest, verbal attentiveness and warmth). From the task-related behaviors, giving directions has a small

negative independent influence, whereas giving psychosocial information has a small positive influence.

Summarizing these results it can be concluded that the different quality ratings (all being predicted fairly well by the observation system) do show a different communication profile. Global affect seems important in all of them, albeit different types of affect in different quality-ratings. Besides: task-related behavior seems to be more important in technical-medical behavior, whereas socio-emotional behavior, and especially verbal attentiveness seems to be more important in the other quality measures.

Table 7.5 Summary stepwise multiple regressions with several subsets of doctor-patient communication variables as independent and several quality measures as dependent variable (percentage explained variance (adj:R<sup>2</sup>); independent variables in order of relevance)

	Quality of care			generalistic orientation % expl. var. variables
	medical % expl. var. variables	psychosocial % expl. var. variables	GP-patient rel. % expl. var. variables	
I Task related beh. + socio-emot. beh. + affect ratings	60% interest med. info psy. quest. (-) directions	70% interest attentiveness psy. info med. quest. (-)	59% warmth attentiveness	63% interest attentiveness directions (-) psy. info warmth
IIa Socio-emot. beh. + affect ratings	51% interest disagree	67% interest attentiveness	59% warmth attentiveness	54% interest attentiveness
IIb Task-related beh. + socio-emot. beh.	24% directions med. info	30% attentiveness psy. quest.	25% attentiveness social beh.	46% attentiveness social beh. psy. info med.couns. (-) psy. quest.
IIIa Task-related beh.	24% directions med. info	21% psy.quest. med. info psy. couns.	12% med.info psy. quest.	19% psy. quest. psy. couns. med. info
IIIb Socio-emot. beh.	16% attentiveness concern	28% attentiveness	25% attentiveness social beh.	34% attentiveness social beh.
IIIc Affect-ratings	48% interest anger (-)	58% interest	57% warmth	44% interest warmth

The relative relevance of the three main groups can be made visible by the successive removal of one or two of the main groups from the multiple regression analyses.

In the second box of table 5, all task-related behavior is removed from the analysis (row II.a) in order to demonstrate the influence all affective behavior (verbal socio-emotional behavior, as well as global affect-ratings) has on the respective quality measures. Not much explained variance is lost by this operation, ranging from none of the variance in the quality of the GP-patient relationship to 9 % of the variance in the technical-medical quality and the generalistic orientation. When the global affect-ratings are removed from the multiple regression analyses (row II.b), in order to demonstrate the influence of the bare RIAS-system, containing all verbal behaviors, the loss of explained variance is more dramatic: RIAS alone explains less than half of the variance that is explained by the total observation system for each of the quality measures: 24 % of technical-medical quality, 30 % of psychosocial quality and 25 % of the quality of the GP-patient relationship. Only the generalistic orientation is still predicted fairly well by the bare RIAS-system (46 % explained variance). Removal of the global affect-ratings brings one socio-emotional behavior in the open, whose influence was masked by the overwhelming influence of the global affect-ratings: this is social behavior (which is much like Roter's socio-emotional cluster) which now has an independent influence on the quality of the GP-patient relationship and on GPs generalistic orientation, but not on the quality of medical care, nor the quality of psychosocial care.

In the lower part of table 7.5, the relative influence of each of the three main groups apart is demonstrated (task-related behavior, verbal socio-emotional behavior and global affect ratings). Moreover, this analysis shows the relative relevance of the different types of behavior **within** each main group.

Comparing the influence of task-related behavior with verbal socio-emotional behavior (III.a. and III.b.), it is again demonstrated that the task clusters are more important in explaining the variance in the medical quality, whereas the socio-emotional clusters are more important in explaining the psychosocial quality, the quality of the GP-patient relationship and the generalistic orientation. Medical information proves to be the most important task-related behavior: it has an independent influence on all of the quality measures; of the socio-emotional behaviors, verbal attentiveness is the most important in all types of care.

However, of all individual clusters, the global affect-ratings do have the highest predictive power, especially interest and warmth.

Table 7.6 Relationships between GPs task and socio-emotional behavior and affect ratings and patient satisfaction

		patient satisfaction		
		total	consultations with disagreement	consultations without disagreement
<b>Task behavior</b>				
Giving information	<b>total</b>	-.16	-.30	.04
	medical	-.10	-.16	-.05
	psychosocial	-.38*	-.61**	.22
Counseling	<b>total</b>	-.08	-.11	-.05
	medical	-.09	-.06	-.19
	psychosocial	-.03	-.09	.23
Questioning	<b>total</b>	-.05	-.11	.02
	medical	-.07	-.12	.01
	psychosocial	.11	.11	.11
Directions	<b>total</b>	.05	.04	.05
<b>Socio-emotional behavior</b>				
	verbal attentiveness	.03	.01	.07
	showing concern	-.08	-.22	.20
	social behavior	.11	.13	.08
	disagreements	-.23 <sup>o</sup>	-.37*	-
<b>Affect ratings</b>				
	anger	-.23 <sup>o</sup>	-.33	-.08
	anxiety	-.09	-.15	.01
	interest	.18	.15	.20
	warmth	.18	.20	.15
<b>Quality of care</b>				
	medical	.03	-.03	.10
	psychosocial	.19 <sup>o</sup>	.01	.39*
	GP-patient relationship	.30*	.19	.43**
	generalistic orientation	.16	.00	.38*

<sup>o</sup> p<.05  
\* p<.01  
\*\* p<.001

n=59

n=44

### *Relations between GPs behavior and patient satisfaction*

In table 7.6 the correlations are shown between GP's behavior and patient satisfaction. Along the whole line these are much lower than the correlations between GP's behavior and the quality of care. Most striking, however, is the fact that the only significant correlations have a negative sign. There is for instance a negative correlation between giving information (especially psychosocial information) and patient satisfaction. In table 7.4 we saw that psychosocial information did not have a relationship with any of the three quality-ratings; we now see, that it has a negative relationship with patient satisfaction. But before jumping to conclusions, it is necessary to look at the lower part of the table. This shows, that patients are also less satisfied, when their GP often disagrees with them, and shows his anger or irritation. As GP's disagreements are strongly (and positively!) correlated with giving information it is plausible, that the correlations between patient satisfaction and the task clusters have been influenced by the overall negative undertone of some consultations (doctors, bargaining or even quarreling with their patients, showing their irritation). To test this hypothesis we split up the consultations into a group without disagreement between GP and patient (n=44), and a group in which at least one of the partners openly disagrees with the other (n=59). As can be seen in the last two columns of table 7.6, this is certainly the case, to a degree at least. In consultations where there is disagreement between GP and patient, there is virtually no relationship between patient satisfaction and the quality of care, whereas in the more harmonious consultations such relationships exist for the quality of psychosocial care, the quality of the GP-patient relationship and GPs generalistic orientation.

### **Discussion**

The results presented partly corroborate those from the previous studies in which Roter's Interaction Analysis System was used, but they also shed new light on the controversies found in the literature about the relative relevance of instrumental versus affective behavior. Let us first summarize the major similarities and differences in both studies.

In Roter's study as well as in ours, the quality of technical-medical care ('proficiency') was better explained by RIAS task-clusters than by RIAS socio-emotional clusters. In Roter's study, as well as in ours, 'giving information', and especially 'giving medical information' proved to be important in the assessed quality of care. And in Roter's study as well as in ours, patient satisfaction with a humane approach did not correlate, or sometimes had even a negative relationship with GPs task-related behavior and -perhaps more surprisingly- also with his verbal socio-emotional behavior.

Thus far the similarities. But there are also some important differences. In the first place: in our study socio-emotional behavior did correlate substantially with each of the task-related clusters; this was especially true for 'verbal attentiveness'. This

specific component of the GP's socio-emotional behavior also has strong correlations with panel-assessed quality of care and the degree to which the GP shows a generalistic orientation (as opposite to a biomedical orientation). Another major difference in the results of both studies is the importance of the global affect ratings. In our study, these proved to be very important indeed: in multivariate analyses, the global affect-ratings proved to have the greatest predictive power in all three quality-assessments (the assessment of technical-medical quality, too!) as well as in the panel's rating of the GP's generalistic orientation. A last major difference was the much lower correlations in our study between task-related behavior and patient satisfaction.

Roter's overall conclusion, that task-related behavior (probably because it is in itself affect-laden) is more important in medical consultations than affective behavior cannot be corroborated by the results of this study. On the contrary: just as in our previous publications on the same material, (using another observation system and other observers) affective behavior, and especially non-verbal affective behavior, seems to be the most important in determining panel-assessed quality of care<sup>31 47</sup>. An explanation is necessary.

In the last of her two papers about the relative relevance of instrumental or task-related behavior on one hand, and socio-emotional or affective behavior on the other, Roter called on other researchers "*to replicate her findings through different methodologies and in the natural setting*"<sup>8</sup>. This call was based on two possible weaknesses of her study: the use of simulated patients instead of real patients, which raises questions about the generalization of the results, and the use of audiotapes instead of videotapes, which limited the possibility to register non-verbal affect to vocal-tone only. Our study can be seen as such a replication: it has taken place in the natural setting (real general practitioners with real hypertensive patients) and has used partly different methodologies (video instead of audio, which makes it possible to register visual cues as well vocal cues). In addition some refinements have been made in RIAS in order to get a more detailed picture of GP's socio-emotional behavior. It is relevant to consider the differences found in the results of both studies in the light of our adaptations in design, methodology and data analysis.

First the GP's socio-emotional cluster is considered more closely. Roter found no relationships between the GP's socio-emotional behavior and his task-related behavior, nor with several outcome-measures, like medical proficiency or patient satisfaction. The latter is confirmed in our study, but we did find significant relationships between GPs socio-emotional behavior and panel-assessed quality of care. We also found significant relationships between GPs socio-emotional behavior and his task-related behavior. The differences can be explained because in this study, GPs socio-emotional behavior, while based on exactly the same observation instrument, is considerably different from the original socio-emotional cluster. Roter worked with **one** socio-emotional cluster, based on a (rather unsatisfactory) factor

analysis of all RIAS behavioral categories. In this study **three** socio-emotional clusters were distinguished on the basis of a factor analysis of the (positive) socio-emotional behaviors only, each representing a clearly different concept within the socio-emotional domain:

- **'verbal attentiveness'**, which provides information about the degree the GP is attuned to what his patient volunteers to tell him. This factor represents the therapeutic concept of an unconditional positive regard, originally formulated by Rogers<sup>38</sup>, but now by most theorists considered as the non specific factor ('factor X') that is the agent in therapeutic processes, regardless of the specific therapeutic school<sup>3 55</sup>. It is indeed this factor that in this study proved to be responsible for the relationships between socio-emotional behavior and panel-assessed quality. A doctor who shows in his verbal behavior that he is attuned to what his patient volunteers to tell him (by paraphrasing or reflecting what he says, showing agreement or partnership, etcetera) is considered a 'good doctor' in all domains of medical care: technical-medical, psychosocial and in the management of the GP-patient relationship. With the exception of 'showing agreement', none of the distinct categories that make up this socio-emotional behavior are used in Roter's concept of socio-emotional behavior.
- **'showing concern'** which provides information about the degree to which the GP shows his concern with the emotional aspects of patients' health problem by giving reassurance or showing worry. By this behavior the patient can get an idea about the seriousness of his health problem. It should guide him in his labeling himself as ill or healthy, which is important in promoting compliance on the one hand and prevention of somatic fixation on the other. Although the relationships are less clear, 'showing concern' is also associated with high quality ratings, especially for medical care and the management of the GP-patient relationship. Of all positive socio-emotional behaviors, this has the strongest relationship with patient satisfaction, at least in the harmonious consultations ( $r = .20$ ).
- **'social behavior'** which provides information about the degree to which the GP indulges in social conversation that has no particular function in the consultation, apart from establishing rapport with the patient. This concept is much alike Roter's socio-emotional cluster<sup>7-8</sup>. It is also much alike Wolraich's concept of 'social amenities'<sup>45</sup>. As in Roter's study, social behavior did not correlate with the quality of medical care, nor with GPs task-related behavior, nor with patient satisfaction. In fact, it proved to be related primarily to the quality of the GP's management of his relationship with the patient.

Part of the riddle has been solved: Roter's original socio-emotional cluster is in fact a social cluster, fitting perfectly in Bales' problem-solving theory in which socio-emotional behavior is only important to ease the relationship in order to facilitate the primary purpose of the conversation: problem-solving<sup>37</sup>. Medical consultations, however are more than a problem-solving enterprise. They are also therapeutic encounters, in which affective behavior is necessary to create a warm and trusting atmosphere. And this is a purpose in itself, a second purpose, beside the purpose



of problem-solving<sup>56</sup>. Our first socio-emotional cluster 'verbal attentiveness' (explaining 31 % of the variance in positive socio-emotional behavior) fits neatly in the psychotherapeutic theories, which claim to provide room for the patient to talk about his real worries<sup>47</sup>. In this study, it is shown to be important in medical consultations.

The second major difference (the degree of influence of global affect-ratings on the quality of care) can also be explained by differences in the methodology of both studies. Roter measured global affect by rating the affective quality of electronically filtered voice-tone in selected fragments of the audiotaped consultation<sup>7-8</sup>. Low correlations were found. In our study GP's behavior on the total videotaped consultation is rated on global affect-scales which makes it possible to register visual cues as well as vocal ones (see also Inui 1985)<sup>4</sup>. In this study global affect-ratings proved to be very important indeed. A possible explanation for the differences found is that affective behavior cannot always be heard. Simply looking at the patient has proven to be very important in medical consultations<sup>31</sup>. Just as silence can be a very powerful therapeutic weapon, at least when it is used in an adequate way. With audiotapes, one never can tell if a patient is looking at his records or at the patient. Or if a joke has an affective role in the consultation by easing the patient, or if it is meant to end (part) of the consultation, for example when the GP turns his head at the same time. Eye aversion is an important technique in controlling the interview<sup>57</sup>. Mehrabian (cited by Strecher<sup>58</sup>) concluded in a broad review of the literature that only 7 % of the emotional communication is transferred via verbal behavior; another 22 % is transferred by voice tone; but 55 % is only transferred by visual cues, eye contact, body positioning and so on. It is plausible that the better predictive results of our global affect-ratings can be attributed to the use of video instead of audio, partly at least.

The last major difference we want to discuss is the much lower relationships in our study between patient satisfaction and the different components of RIAS' observation system. A possible explanation that must be considered seriously is the restricted range of our Patient Satisfaction Scale, that was primarily designed to capture patient's satisfaction with the humanistic side of medicine. This possibility can only be ruled out by a new research project with a wider satisfaction scale. However, rather high correlations are generally found between 'humane satisfaction' and 'instrumental satisfaction' (Roter reports a correlation of .45<sup>8</sup>; other authors find correlations between .68 and .81<sup>53 59-60</sup>), which makes it useful to look for additional explanations. One such explanation is suggested by the results of this study, where patient satisfaction proved to be related primarily to GPs negative behavior (disagreements) and attitude (anger/irritation). Perhaps in real-life consultations 'dissatisfaction' is a stronger measure than 'satisfaction'. The important role of 'dissatisfaction' (over 'satisfaction') is also found by Woolley (1978)<sup>61</sup> and Like (1987)<sup>62</sup> who demonstrated that patients were least satisfied when their expectations were not achieved or their desires were not met. Dissatisfaction is

seen by Zastowny (1983) as an important predictor of subsequent utilization<sup>63</sup>. It seems that 'disagreements' (the only negative socio-emotional type of behavior in RIAS, not used in Roter's own study<sup>7-8</sup>) can provide information about disturbed relationships or dysfunctional consultations, a finding that was also reported by Davis<sup>17</sup> and Byrne and Long<sup>64</sup>. The rather high correlations between patient satisfaction and panel-assessed quality of the GP-patient relationship also suggest that patient satisfaction is a characteristic of the GP-patient relationship, rather than of the specific diagnostic or therapeutic qualities of the GP. In a later study Zastowny (1989) made a plea for a micro-analytic approach in which specific provider-patient dyades are studied, because the same 'setting' can produce satisfaction with one type of patients and dissatisfaction in another<sup>65</sup>. This suggestion is strengthened by the result of our former study in which GPs who had unanimously positive quality ratings by all of the panel-judges, nevertheless sometimes had dissatisfied patients, whereas GPs who had unanimously negative quality-ratings also had patients who thought very favorable of them<sup>31</sup>. As it was shown that in the more harmonious consultations (without statements of disagreement) meaningful relationships could be found between patient satisfaction and quality of care, 'showing disagreement' seems a relevant behavioral category in Roter's Interaction Analysis System.

The question remains as to why the patients in this study are primarily attuned to the affective qualities of the GP and not (as in Roter's study) to GP's task-related behavior. This could be due to cultural as well as to methodological differences between the two projects. A possible methodological explanation is that simulated patients, who have been instructed to present a particular circumscribed somatic problem (chronic obstructive pulmonary disease) will respond primarily to the technical-medical aspects of the consultations and hence GPs task-related behavior; simulated patients shall not feel the emotions and anxieties of being ill and going to a doctor like a real patient does (in Engel's words: they will primarily feel the need to know and understand, and not feel the need to be known and feel understood<sup>32</sup>). There is also little chance that a disturbed GP-patient relationship will evolve in a laboratory experiment with simulated patients as this takes time and a continuous relationship. This raises questions about the possible generalizability of the results of Roter's study, but also of those of our own study. It is a study of hypertensive patients with a long-lasting relationship with the medical system. In the Netherlands, which has a health system that is much alike the British health system, they have the same GP for all their visits and over a long period of time. GP and patient get to know each other fairly well. This makes it possible for communication patterns to evolve that are different from communication patterns for more incidental visits, communication patterns that are sometimes very valuable, but that can also have a harmful effect on the development of a warm and trusting relationship. In Zastowny's words: *"...some providers may have a care environment into which patients become socialized over time. In some cases the patient-environment fit is a good one from the patient's point of view whereas in others it is*

*problematic and conflicted, laying seeds for later dissatisfaction*"<sup>65</sup>. However, it is also possible that the differences must be attributed to differences between general practitioners in two different countries with different health care systems. Listening to the American audiotapes that we used for our training gave us the impression that American doctors have other communication patterns (more detached, more problem-related) than their Dutch colleagues. Whether these differences are caused by working with simulated patients versus real-life patients, or by cross-cultural differences between general practitioners and health care systems in different countries can only be determined in a new research project, in which real-life consultations from both countries are compared.

## Literature

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## 8 Conclusion

### Conclusion

The foregoing Chapters have provided us with much information about the main research problem to which this thesis is addressed:

*which elements of General Practitioners behavior provide good quality of care?*

Now it is time to take the balance: what can we learn from all this information; information that is partly derived from literature, and partly from original research in a series of consecutive research projects? Several topics deserve further discussion, many of them further research.

I shall explore the results from four perspectives:

- \* from a theoretical viewpoint
- \* from a methodological viewpoint
- \* from an educational viewpoint
- \* from a health policy viewpoint.

I shall conclude this discussion by making some speculative and perhaps provocative remarks about the role of patient satisfaction in determining the quality of care.

### Conclusions from a theoretical point of view

*"If your only tool is a hammer, you see every problem as a nail"* (Chapter 2). Using a psychotherapeutically based observation system, is not the way to learn about the active ingredients in GPs behavior with regard to the medical problem-solving process. Using an instrumental observation system, based on problem-solving theories, won't make you much wiser about the active ingredients of the therapeutic relationship necessary for managing the emotional and psychological aspects of patients' health problems. In more general (and in fact well-known) terms, it can be stated that the way a researcher on doctor-patient communication looks at his data is largely determined by the observation system that he uses, and this is for its part highly influenced by the system's underlying theoretical notions (Chapter 2). Formulated in this way, this seems to be a rather obvious statement, but in the heat

of everyday research practice, its importance is easily forgotten. However, in this thesis, it is clearly demonstrated again.

The NIVEL-observation system, with its roots in psychotherapeutic theories, has proven to be able to make accurate predictions about the chance that GPs behavior in a particular consultation will be rated high on psychosocial quality by a panel of independent general practitioners (Chapter 5). Panel-assessed quality of psychosocial care is mainly explained by the GPs affective behavior (especially his nonverbal affective behavior: his eye-contact with the patient, and the interest he shows), and the degree of influence that he grants the patient (Chapter 5, 6). These results can be understood within the psychotherapeutic frame of reference, in which affective behavior is seen as a core concept, a non-specific factor that must be considered one of the active ingredients of virtually all forms of psychotherapy, and - as is convincingly shown in this thesis - also of psychosocial care in general practice.

The effectiveness of the NIVEL-observation system in making accurate assessments of relevant communication-behavior in technical-medical care is less pertinent (Chapter 6). Again non-verbal affective behavior is considered important, but the total amount of explained variance in the panel-assessed quality of medical technical care is much lower than in the case of psychosocial care. This result can be explained by the fact that the NIVEL-observation system lacks instrumental measures, which are important in the problem-solving side of general practice.

The influence of psychotherapeutic theories in general practice is primarily focused on the diagnostic side of medicine: it teaches the general practitioner how to be receptive to patients stories about his own lifeworld. What to do next (the instrumental side) is much less explored, as is vividly demonstrated in the results of the evaluation of an interview training course for general practitioners (Chapter 4). And things that are not measured cannot provide us with results.

On the other hand, one of the other observation systems that is used in this thesis, - Roter's Interaction Analysis System (RIAS) - has its roots in the instrumental tradition. This observation system is an adaptation of Bales' Interaction Analysis System that was based on problem-solving theories, in which information exchange is thought to be *the* medium for solving problems. It is focused primarily on verbal task-related behavior, and in Roter's own research, this task-related behavior proved to be related to medical proficiency and patient satisfaction (actually more than affective behavior). In this thesis, a slightly adapted version of RIAS indeed proved to explain more of the panel-assessed quality of technical-medical care, than previous observations with the NIVEL-observation instrument on the same material (Chapter 7). However, this semi-replication (Chapter 7) also demonstrated that the minor role of affective behavior in Roter's research can be retraced to the way affective behavior is conceptualized and measured in Roter's study. Affective behavior is conceptualized within the problem-solving framework: in this theoretical framework, affective behavior has no end in itself; it is necessary for

the creation of a good atmosphere in which the problem-solving process is facilitated (for instance by social and friendly conversation) or hampered (for instance by many disagreements). This conceptualizing of affective behavior fits in perfectly within research projects that are targeted at the instrumental side of medicine, but it is too restricted to provide useful information about the psychotherapeutic side of general practice: about the management of the emotional and psychological sides of the patient's health problems, the anxieties and uncertainties, the influence of stress. Then other aspects of affective behavior have to be measured, for instance: attentiveness and empathy, the way a GP shows his patient that he is listening and understands what the patient says (for instance by paraphrases, reflections, verbal encouragement, nods and eye-contact). These types of behavior were not incorporated in the only socio-emotional behavior cluster that Roter used in her own research; moreover, by using audio-equipment instead of video, it was not possible for her to measure the non-verbal behavior, that is thought relevant in psychotherapeutic theories. And things that are not measured, cannot provide us with results.

The confounding problem is that the term 'affective behavior' is conceptualized in two totally different ways, in terms of totally different theoretical frameworks; this is masked by the fact that the same expression is used in both cases and, moreover, can be justified in both cases. This provides us with a serious warning against taking global concepts like 'affective behavior' at their face value, when studying the literature. 'Patient satisfaction' is another easy example.

These findings teach us something else too, namely that there must always be a strict relationship between the research question and the observation instrument. It has no use dreaming of one observation system that can capture all GP-behavior. It is neither possible, nor useful to put a lot of effort into an attempt to integrate all available knowledge about doctor-patient communication in The-One-And-Only Observation System (just as there is no question of 'One GP-Attitudinal Questionnaire', nor of 'One GP-Registration-Form'; but for one reason or another, that seems more obvious). Different research questions demand different observation systems. When the medical consultation is conceived as a problem-solving enterprise, different types of behavior have to be measured, from those in which the medical consultation is regarded as a therapeutic encounter. For other examples (not elaborated in this thesis), where the medical consultation is conceived as a power-struggle or as a market negotiation, still other observation systems, measuring other types of behavior are necessary to adequately capture doctor-patient communication.

## Conclusions from a methodological point of view

*"When you ask questions, you only get answers"* (Chapter 1). In addition to verbal communication, non-verbal communication plays an important role in doctor-patient communication. The English proverb 'hear-all, see-all and say-nothing' would not

be out of place in the GPs consulting room. As has been shown in this thesis (Chapter 2,5,6,7), affective behavior is mainly communicated by non-verbal behavior, and affective behavior is important in all general practitioner's behavior. To a greater or lesser degree, it determines the quality of the doctor-patient relationship, the psychosocial quality of care, and the technical-medical quality of care (Chapter 6). It is also related to patient satisfaction (Chapter 5,6,7). When we accept the fact that communication always has cognitive as well as emotional elements, it is important to record GPs verbal as well as his non-verbal behavior. Video is therefore preferable to audio-recording. This will probably be true for most research questions in research on doctor-patient communication.

While the foregoing is an easy plea, there are also some methodological topics that deserve discussion but do not result in such an unequivocal recommendation. One is the scoring format of communication behavior. Roughly speaking, the customary scoring format for instrumental observation systems is the counting of the raw frequencies of mutually exclusive behavioral categories, whereas the scoring format for affective behavior mostly consists of rating-scales. Both formats have their weak and strong points, in which the observation systems often are each other's opposites. Counting behavior in a comprehensive observation system makes certain, that every verbal utterance is measured; this is an objective procedure which can be performed in a highly reliable way (Chapter 2,7). The problem arises in data-analysis, for it is not always clear which unit of analysis is the most adequate. Sometimes (Chapter 2,7), the raw frequencies are taken in a (sometimes implicit) assumption of a linear relationship between that particular behavior and the chosen outcome measure. In other words: it is assumed that 'more' is 'better'. Sometimes a *relative* measure is chosen by relating the number of certain utterances to the total number of utterances, or to the length of the consultation (Chapter 5,6). A plausible line of reasoning is possible for both choices. One can argue that more utterances will cause the consultation to last longer. In this view, the length of the consultation is determined by GPs behavior (and of course the patient's behavior). For instance, when the GP provides the patient with more room by means of verbal encouragement, this will stimulate the patient to talk more freely about his problems, with consequences for the length of the consultation (Chapter 4). This viewpoint warrants the use of raw frequencies. However, one can also argue that a longer consultation will automatically produce more utterances, because the chance of a particular behavioral category will increase with the length of the consultation. Likewise, when a patient tells a lengthy story, the GP will automatically produce more semiverbal utterances, like 'hmm'. This would seem to encourage a *relative* choice of measure. The problem is a bit like that of 'the-chicken-and-the-egg'; it is difficult to determine what comes first. If the variability in the consultation time is considerable, the first view seems to gain the most weight. With fixed consultation times, it is more likely that the GP will have to set priorities within his behavior. Unfortunately, these will be different for the different general practitioners, and even differ from one consultation to another by the same general

practitioner, depending on its place in the appointment schedule and the length of the preceding consultations. Perhaps the best solution would be to use raw frequencies for those utterances that theoretically influence the length of the consultation, and relative measures for those behaviors that are thought to have a more mechanical relationship with the length of the consultation. Further research is recommended. A related problem has to do with the saliency of behavior. Sometimes, one carefully formulated question provokes more patient reaction than a whole routine battery of questions. However, weighing each utterance invokes a subjectivity-problem, and makes the observation-system and data-analysis unduly complex. A possible solution (to be investigated) can be the adding of one global quality-rating (over the whole consultation) for that particular type of behavior.

On the other hand, rating scales have other kind of problems. Rating scales involve normative judgments, that tend to have an inevitable subjective component. A generally somewhat lower reliability is the result (Chapter 2,3,6,7). In studies of this approach, this has not proved to be a serious problem. In the last study, in particular (Chapter 7), the inter-observer reliability was rather high, even for the global affect-ratings. However, this could be influenced by the common background of both observers (both clinical psychologists), and perhaps even more so by the mere fact that the global affect-ratings were made *after* the tallying of the utterances, which proved to be a very time-consuming affair: an averaged three-hour exposure to an average 10-minutes consultation gives a penetrating picture of that consultation; no word, no cue, no gesture remains hidden. It would be an interesting experiment to reverse the order of observation and see what happens to the reliability-figures. Further it must be recommended - because of the inevitable subjectivity of the ratings - that rating-scales never be considered as 'golden standard', but that researchers always try to link the ratings to more objective measures in order to test their validity.

## Conclusions from an educational point of view

*"The first great task of medicine is to create a relationship with the patients and the second is: to learn how to hear what that relationship reveals"* (Chapter 1). The results of this thesis make clear that creating a relationship with the patient indeed is a major aim in general practice. Of all panel-assessed quality measures, the quality of the doctor-patient relationship proved to have the strongest relationship with patient satisfaction (Chapter 6,7). GP's affective behavior (his warmth and interest) plays a dominant role in panel-assessed quality of the doctor-patient relationship, and - to a somewhat lesser degree - also in patient satisfaction (Chapter 6,7). But before jumping to the conclusion that a 'good' doctor is synonymous with a 'warm' doctor, two different warnings must be given.

The first is, that the quality of the doctor-patient relationship is not only related to affective behavior, but also to some instrumental types of behavior, not

incorporated in the NIVEL-observation system: the quality of the doctor-patient relationship is valued better when the GP gives the patient much medical information, and when he asks many questions outside the somatic realm (Chapter 7). While the latter is rather obvious, it is relevant to draw attention to the first conclusion: from the results of this thesis it becomes evident that giving medical information is a very important task for the general practitioner. It is the only instrumental type of *medical* behavior that is related to the quality of the doctor-patient relationship, and in fact the only instrumental behavior that is related to all quality measures. In other words: A 'good' doctor is a doctor who shows a lot of warm interest in the patient and his lifeworld, but who at the same time is very informative about the medical side of the patient's health problems. This statement can be regarded a general conclusion and is important in teaching communication skills.

The second warning has to do with a differentiation that seems necessary *within* the concept 'affective behavior'. In literature, this term is used for two distinct types of behavior: 'social behavior', necessary for creating a relaxed relationship, and 'empathic behavior', necessary for creating a therapeutic relationship. From the results of this thesis, it can be learned that these operational definitions of the concept of 'affective behavior' indeed represent two distinct types of behavior. Social behavior is useful in establishing a good doctor-patient relationship, but it is *not* a criterion for good psychosocial care (Chapter 7). This is a very important conclusion, indeed. Moreover, a warm and friendly doctor, who shows the patient his concern and understanding will no longer automatically provide psychosocial care of good quality: these behaviors seem to be necessary, but they are not sufficient for good quality psychosocial care (Chapter 3,4,7). The results of a training interview course for general practitioners focused on these passive types of behavior are a convincing illustration of this point (Chapter 4). The NIVEL-observation system has taught us, that in addition to showing affective behavior, good psychosocial care, also requires general practitioners to give their patients considerable influence in the course of the consultation and on the planning of treatment (Chapter 5,6). Furthermore, Roter's observation system has taught us that the general practitioner must also show active instrumental behavior by asking psychosocial questions, by counselling the patient on matters of stress and emotion, and (as was stated before) by giving a good deal of medical information. The simultaneous importance of *psychosocial* questioning and counselling on the one hand and giving a lot of *medical* information on the other can be explained by the fact that patients, when entering the GP's consulting room experience two different types of emotions: uncertainty (what is wrong with me? how will I get better?) and anxiety (have I got something serious? am I going to die or become an invalid?). Giving medical information is necessary in dealing with the first type of emotion, while affective behavior and psychosocial intervention are necessary for the second one. With somatizing patients (i.e. patients with many vague complaints for which no organic cause can be found) the situation is even more complex: they

tend to have two conflicting anxieties at the same time: the anxiety that there is something wrong with them, something that is so intricate that doctors cannot find it; and, at the same time they experience a fear that there is *nothing* wrong with them, that the doctor will regard them as malingerers. This places the general practitioner in a paradoxical position: dealing with one anxiety will automatically reinforce the second one. This is probably the reason why simple reassurance does not help with somatizing patients. A combination of affective and instrumental behavior in both medical and psychosocial areas seems indicated. Again, giving medical information incorporated within a really affective attitude seems to play a crucial role. However, how these types of behavior must be combined in everyday practice cannot be taught by psychotherapeutic theories alone: in psychotherapy, both parties know that they are going to deal with psychosocial problems; in general practice, there always is a somatic problem as well. Taking account of the many patients with psychosocial problems in general practice and the even larger hordes of somatizing patients who form a considerable part of the GP's workload, it is to be recommended that serious investment be made in the development of specific psychosocial techniques that are adequate in the particular setting of Dutch general practice.

Other types of behavior seem to be useful only for certain aspects of quality, or for certain types of consultations. For instance: it seems important for a general practitioner to work methodically, where a new medical problem is presented: in these consultations, clarifying the reason for encounter is found to be relevant by the GPs peers on the quality-panel, as well by his own patients. Interestingly, in repeat consultations, this is no longer the case for either party. It seems for instance to be more important in these consultations to give the patient a lot of influence in determining the course of the consultation and the planning of the treatment (Chapter 6). These results are found in an observation study of hypertensive patients. For the time being, we can only speculate about their generalizability; only new research with the same observation systems among different groups of patients could reveal this. But with the many chronically ill patients in general practice, this must be a warning against training communication skills with new patients only, as is easily done in laboratory-like situations. And whether considered as an advantage or as a disadvantage for general practice: the communication skills necessary in the continuing relationship between doctor and patient in general practice can not be taught in the hospital. Again a recommendation must be made for support of the ongoing research programs in this area in the different Institutes and for a further investment in developing communication skills within the general practice setting itself.

## Conclusions from a health policy viewpoint

*"The spoken language is the most important tool in medicine"* (Chapter 1). Last paragraph's recommendations for research and education programs, aimed at the

development of communication skills in general practice, with a special focus on the psychological and social aspects of patient's health problems and perhaps even more on the complex communication with somatizing patients, are in itself important for health policy, too, because these recommendations set priorities for research funds and could have implications for the length and the content of the vocational training for general practitioners. Besides, however, it is important to realize, that the structural and financial conditions within which general practitioners do their work can either facilitate or hamper the GPs possibilities as well as his inclinations to pay much attention to his communication with the patient. Especially the way doctors are remunerated forms an important prerequisite for the establishment of a therapeutic relationship. In this respect, the present situation in the Dutch health care system must be considered a rather favorable one: for the majority of their patients, the GP is paid according to a capitation-reimbursement system, which means that the GP is not rewarded for doing specific interventions, as is the case in a fee-for-service remuneration system. In the latter case - and certainly when there are specific fees for taking blood samples, doing diagnostic tests, minor surgery and injections, instead of a mere reimbursement or consultations and visits - the instrumental character of the consultation increases. 'Listening' and 'counseling' can not easily be conceived as remunerable elements of a consultation. Yet, as has been demonstrated in this thesis, these are perhaps the most important diagnostic as well as therapeutic tools. And it can be learned from experiences in other countries (Germany, Belgium, America) that in an instrumental-oriented fee-for-service system, physicians indeed perform more instrumental interventions than in capitation-fee systems like the Netherlands. There is a hint of jealousy in White's words, when he states that unlike the United States of America *"countries like ... and the Netherlands seem to be able to size their resources and manpower appropriately to meet the needs of the populations they serve"*. He points to the layered structure of the health care system, built on a strong primary health care, and to financial conditions: *"As long as the pecuniary rewards in medicine ignore such elements as time devoted to listening, observing and explaining, experience and wisdom in dealing with interpersonal, domestic, occupational and social stress, simple ambulatory management based on "wait-and-see" as a diagnostic or therapeutic manoeuvre, and a probabilistic, rather than a deterministic, approach to dealing with the patient's problem, it seems unlikely that a more inclusive theory of health and disease will find widespread acceptance."* The grass is always greener at the other side. While the Americans are trying to implement at least some of the elements of the Dutch health care system, in the Netherlands the policy-makers are planning to change their health care system, therewith risking to overlook the importance of some powerful elements of the present system. A strong recommendation from this thesis must be, that in the negotiations about an other remuneration system for general practitioners, no unduly attention must be paid to infrequent instrumental tasks, which only have a limited influence on patient flow in medical specialistic care, but



an effort must be made to stimulate medical and psychosocial conversation by financial incentives instead.

## Patient satisfaction and the quality of care

'Who is to say this is a good consultation?' In doctor-patient communication research, patient satisfaction is a common, probably the most commonly used outcome measure. In medical education literature, the peer review is the main source for an external opinion of the quality of the care delivered. Both sources produce different results, as is demonstrated in this thesis, research projects, as well as in the literature described (Chapter 5,6,7). There is virtually no relationship between panel-assessed quality of technical-medical care and patient satisfaction, and a significant but only weak relationship between the quality of patient satisfaction and psychosocial care ; only the panel-assessed quality of the doctor-patient relationship has a relevant relationship with patient satisfaction. How are these results to be interpreted?

First it can be argued that these weak relationships must be ascribed to the narrow range of the patient satisfaction scale in use. This scale was indeed primarily developed to capture the humanistic side of medicine, because NIVEL's interest in doctor-patient communication has traditionally been in the area of psychosocial care. It contains questions about the GPs understanding of the patient's health problems, the interest he demonstrates in personal and non-medical matters, the amount of time he allows the patient, and his skills in handling problems. Accordingly, a recommendation must be made for the development of patient satisfaction scales that capture a wider range of GP behavior, and also contain, for instance, questions about his more instrumental behavior. American literature can be a source of guidance, but the different settings of the Dutch and American health care system, especially with regard to the tasks and functions of general practitioners necessitate careful adaptation.

While the limited range of the patient satisfaction scale can explain at least part of the results, similar results in different projects using different patient satisfaction scales suggest that additional explanations are necessary. Some suggestions have been made in the contributions to this thesis (Chapters 5,7).

It is suggested that the small amount of variation in satisfaction scores (patients are in general very satisfied with their GP) probably says more about the tendency of patient response than about variance in GP behavior (Chapter 5). This would imply that only deviation from the normal (i.e. *d*issatisfaction) should be considered a relevant measure.

Another suggestion is that patient satisfaction is a more general assessment of GP behavior, based on several consecutive visits. In this view, the patient does not blame his general practitioner for being in a hurry, if usually he is very attentive to the patient. In a long-lasting relationship in particular (as in friendship, but also in

many Dutch doctor-patient relationships), one does not need to prove good intentions in each and every contact. When one door shuts, another opens. The high correlation between patient satisfaction and the quality of the doctor-patient relationship provides some grounds for this argument; other grounds have been found in literature (Chapter 5). The implication of this option is, that patient satisfaction must be taken seriously, and that only the observation of many consultations by the same general practitioner can give valid information about his general level in quality of care.

A third explanation in which the foregoing suggestions can be combined is that patient satisfaction, is indeed, a characteristic of the doctor-patient relationship rather than an indicator of the quality of care (technical-medical or psychosocial), but a characteristic that is mainly determined by negative behavior. We found that patient satisfaction was lowest when the GP frequently disagreed with patient's ideas (Chapter 7). In such consultations, the general practitioner was also more irritated and nervous. One could speak of a disturbed relationship, a finding that is also reported in literature (Chapter 1,7). Where two people disagree it is difficult to determine beforehand who is right and who is wrong. Sometimes, for the sake of patients' health, the GP *must* confront him with disagreeable information or prospects. Patients do not always like what they hear; this is true for psychosocial problems as well as somatic problems. Again somatizing patients are a difficult group in this respect. Patients also are not always willing to comply with nasty regimes or to change unhealthy lifestyles. On the other hand, sometimes they also want more or different things from the general practitioner, for instance a referral to a medical specialist which is not necessary from a medical point of view, or - even harder to accept - complementary care from a quack. The *positive* relationship between panel-assessed quality of technical-medical care and GP disagreements suggest that colleagues often tend to share the GPs opinion in these matters.

However, from these results it may not be concluded, that it is always the general practitioner, who is right when the two disagree. Natural alliances between the GP and his colleagues in the panel can mask quite legitimate pressures from the patient to acquire more influence in his own treatment. And, as is also shown in the literature (Chapter 5), patients sometimes have different views on the sort of care they need from the professionals who care for them. Which of the two should be given preference is not always clear. As consumerism in health care is only yet in its early stage, physicians still have to find a way to deal with it. Teaching general practitioners to handle disagreements is therefore an educational priority that has to be added to those in the last section. Moreover, it would seem unwise to maintain two separate circuits in quality research: one doctor-patient communication circuit in which general practitioner's behavior is primarily related to patient satisfaction, and one medical education circuit which primarily makes use of peer assessments. For then, there is a fair chance, that never the twain shall meet.

# Samenvatting

## Inleiding

Dit proefschrift gaat over arts-patiënt communicatie: over de wijze waarop huisartsen met hun patiënten praten. Het bestaat uit een aantal afzonderlijke artikelen die elk ingaan op de vraag welk gedrag van de arts van belang is voor een goede hulpverlening. Voor dat doel zijn in de spreekkamer van een aantal huisartsen video-opnamen gemaakt bij patiënten die daarvoor hun toestemming hadden gegeven. De videobanden zijn nauwgezet bekeken door enkele getrainde observatoren (psychologen) aan de hand van observatiesystemen die tot doel hebben elementen uit het gedrag van de huisartsen objectief vast te leggen. Een aantal van de op video opgenomen consulten is bovendien voorgelegd aan een panel van ervaren huisartsen om een oordeel te krijgen over de kwaliteit van het consult. Ook is gevraagd naar de tevredenheid van de patiënt. Al deze gegevens zijn in een aantal opeenvolgende projecten geanalyseerd. De resultaten daarvan zijn in dit proefschrift te vinden.

### *Het belang van arts-patiënt communicatie als onderzoeksthema*

Waarom is het zo belangrijk om arts-patiënt communicatie te onderzoeken? Als de aandacht in de populaire media of de verdeling van onderzoeksgelden als maatstaf wordt genomen, lijkt het veel belangrijker te investeren in nieuwe medische technologieën of de ontwikkeling van medicamenten tegen gevreesde ziekten. Dat zijn ook belangrijke investeringen, maar daarnaast is het goed zich te realiseren dat het overgrote deel van de gezondheidsproblemen van mensen, zo ze al onder professionele aandacht komen, uitsluitend door de huisarts wordt behandeld, en dat het gesprek daar een prominente rol in vervult. Zoals in feite ook al sinds de grijze oudheid bekend is, dat lichaam en geest elkaar beïnvloeden ("mens sana in corpore sano", een gezonde geest in een gezond lichaam) en Hippocrates al heeft geleerd hoe belangrijk een goede hulpverleningsrelatie is voor het herstel van de patiënt. Iedereen weet dat. En toch blijft de meeste aandacht uitgaan naar de verworvenheden van de biomedische wetenschap, met als rechtstreeks gevolg dat het lichaam meer aandacht krijgt dan de geest, en dat de wetenschappelijke waarde van biomedische waarnemingen overschat wordt (denk aan de bijna magische kracht van laboratoriumuitslagen), terwijl aan de andere kant onderschat wordt hoe belangrijk het verhaal is dat patiënten zelf over hun gezondheidsproblemen te vertellen hebben. De Amerikaanse arts Kerr White

concludeert in zijn inspirerende boek 'The Task of Medicine' dat van slechts 20 % van de therapeutische interventies onomstotelijk bewezen is dat ze meer goed doen dan kwaad. En hoewel veel mensen beter worden omdat klachten vaak uit zichzelf wel overgaan, kan een groot deel van de genezingsprocessen verklaard worden door twee verwante verschijnselen: het placebo-effect (waarmee de suggestieve werking bedoeld wordt, die uitgaat van de gedachte dat er een behandeling plaats vindt die werkt), en het Hawthorne-effect (veranderingen die optreden vanwege de extra aandacht die optreedt vanwege de deelname aan een speciaal project). Voor beide verschijnselen geldt dat hun werkzame kracht in de arts-patiënt relatie ligt en met name in de wijze van gespreksvoering:

*De eerste belangrijke taak van de geneeskunde is een goede relatie te leggen met de patiënt, en de tweede is: te leren luisteren naar wat die relatie ons openbaart (Stephens, 1988).*

Op grond van dit soort overwegingen beschouwde Balint (1956) de dokter zelf als medicijn. Wanneer we ons realiseren wat dit betekent wordt het belangrijk om na te gaan wat precies de werkzame ingrediënten zijn van dit medicijn: welke elementen uit het gedrag van de huisarts zijn verantwoordelijk voor een goede hulpverlening? Dit is de leidende onderzoeksvraag, de rode draad, door de verschillende artikelen heen.

### ***Belangrijke elementen in het gedrag van huisartsen***

In de literatuur over arts-patiënt communicatie worden meestal twee soorten gedrag onderscheiden: instrumenteel gedrag en affectief gedrag. Instrumenteel gedrag (ook wel 'taakgericht gedrag' genoemd) staat in het teken van het oplossen van medische problemen en is cognitief en rationeel van aard. Affectief gedrag is gericht op het scheppen van een werkzame arts-patiënt relatie en is emotioneel van aard. Beide soorten gedrag zijn elk op hun eigen manier van belang voor een goede hulpverlening. Ter illustratie geven we van beide typen gedrag een concreet consult uit onze video-collectie als voorbeeld.

#### ***Het instrumentele consult***

Een oudere vrouw komt de spreekkamer van de huisarts binnen. Ze klaagt over duizeligheid, en hoopt dat het niets ernstigs is. De huisarts vraagt haar uitvoerig hoe ze zich precies voelt, wanneer ze er last van heeft en of er nog andere verschijnselen zijn. Vervolgens onderzoekt hij haar uitgebreid (een aantal neurologische tests, oonderzoek, bloeddruk en pols). Intussen vertelt de patiënt van alles over haar oorarts, haar slechtzittend gebit, haar gymnastiekclubje en een recente operatie voor aangezichtspijn, die zij schuldig acht aan haar huidige klachten. Na beëindiging van het onderzoek gaat de arts zitten en deelt de resultaten mee: alles is goed; alleen de bloeddruk is aan de lage kant. Hij raadt haar aan abrupte bewegingen te vermijden en te kijken of het daarmee beter gaat. Bij het uitschrijven van recepten voor medicijnen die op zijn, blijkt dat de patiënte (buiten weten van de huisarts) nog steeds plaspillen gebruikt die haar ooit zijn voorgeschreven. De arts schrikt en deelt mee dat dit ook een oorzaak kan zijn van de duizeligheid. Hij stelt voor geleidelijk te stoppen en maakt hiervoor een concreet plan. De patiënte wordt gevraagd om twee weken later terug te komen.

Bij instrumenteel gedrag staat informatie-uitwisseling centraal. In allerlei onderzoeksprojecten is gezocht naar belangrijke elementen van die informatie-uitwisseling. In het diagnostisch proces is dat in de eerste plaats een goede vraagtechniek. Voor het stellen van veel diagnoses is niet meer nodig dan een zorgvuldige anamnese. Daarnaast is het van belang de patiënt op een heldere en begrijpelijke wijze informatie te geven over de klachten en de voorgenomen behandeling (inclusief eventuele alternatieven). Dit is zeker nodig bij gezondheidsproblemen waarbij de patiënt zelf het nodige moet doen om beter te worden (of zijn conditie niet te laten verslechteren). Dan wordt ook de pedagogische kant van het huisartsconsult belangrijk. Naast informatie geven is het dan belangrijk om alles duidelijk uit te leggen, de patiënt te motiveren en te overtuigen van het belang van het opvolgen van de instructies.

Van iets andere orde, maar eveneens instrumenteel van aard, is het 'methodisch werken', waarmee vooral bedoeld wordt: verheldering van de hulpvraag en het goed structureren van het consult. Dit laatste is met name van belang wanneer er meerdere hulpvragen aan de orde zijn. Het verhelderen van de hulpvraag kan voorkomen dat consulten mislopen, doordat de arts en de patiënt een verschillend verwachtingspatroon hebben of de klachten anders interpreteren; bijvoorbeeld: de patiënt is zich nog al eens bewust van allerlei psychosociale invloeden op de klacht, terwijl de arts zich vaak tot de lichamelijke kant beperkt. Wanneer de arts en de patiënt het met elkaar eens zijn over de aard van de klacht en de te volgen behandeling is de kans op behandelingsukses het grootst.

### **Het affectieve consult**

*Een vrouw van middelbare leeftijd komt de spreekkamer binnen. De arts begroet haar met de woorden: Goedemorgen, mevrouw X, U vereert ons niet vaak met een bezoek". De patiënt vertelt dat ze de dag tevoren met de fiets in de struiken gevallen is, waarna haar broer haar heeft aangespoord naar de dokter te gaan, omdat ze wellicht een hoge bloeddruk heeft. Haar moeder is "aan haar hart" overleden. De arts laat haar rustig praten. Patiënt vertelt ook dat ze de laatste tijd duizelig is, en niet weet waar dat van komt. Ze gebruikt weinig zout. De arts legt uit wat de oorzaken van hoge bloeddruk kunnen zijn. Na een kleine stilte, waarin de arts oogcontact houdt, antwoordt de vrouw dat ze zich wel eens nerveus maakt (wie niet?), maar dat er toch geen belangrijke problemen zijn. Ze wil graag weten waar de duizeligheid vandaan komt. De arts legt uit dat duizeligheid in 99% van de gevallen door spanningen, problemen of oververmoeidheid komt. De resterende procent kan gemakkelijk door lichamelijk onderzoek worden uitgesloten. Duizeligheid wordt nooit door hypertensie veroorzaakt. Nadat de arts heeft uitgelegd dat het ook kleine ergernissen kunnen zijn, die ze misschien moeilijk kan uiten, volgt een uitvoerig verhaal over de schoonfamilie die in het naastgelegen huis woont en zich te intensief met het huiselijk leven van de patiënt bemoeit. De arts leeft zichtbaar mee, verwoordt de gevoelens van de patiënt en steunt haar. Wanneer blijkt dat schoonfamilie binnenkort verhuist, sluit de arts het gesprek af met het voorstel nu de bloeddruk te meten, en een (lange) vervolgfpraak te maken voor de volgende week om lichamelijke onderzoek te doen en wat verder te praten. Aldus gebeurt.*

Affectief gedrag is vooral gericht op het tot stand brengen van een goede arts-patiënt relatie. Voor sommige onderzoekers is dit hetzelfde als 'goede manieren' en het scheppen van een ontspannen sfeer, bijvoorbeeld door over koetjes en kalfjes te praten, vriendelijke opmerkingen te maken, en de patiënt op zijn gemak te stellen. Psychotherapeutisch georiënteerde onderzoekers vinden dit niet voldoende. Zij vinden dat een arts-patiënt relatie pas goed is als er sprake is van een vertrouwensrelatie

tussen huisarts en patiënt. De arts kan dat bereiken door aandachtig en empathisch te zijn (dat wil zeggen, door te laten merken dat hij meeleeft met de patiënt en zijn emoties begrijpt), door respect te tonen, warmte uit te stralen en oprecht te zijn. Hij moet de patiënt ook in zijn waarde laten en accepteren zoals hij is. Een affectieve arts zal vaak passief zijn in het consult: hij zal luisteren, meeresoneren met wat de patiënt vertelt, en goed gebruik maken van stilte. Op deze wijze komen psychosociale problemen gemakkelijker aan de orde, en is er meer ruimte om te praten over de emotionele beleving van de klachten, de angsten, de onzekerheid. Een ander effect is dat op deze wijze gemakkelijker een meer gelijkwaardige relatie ontstaat tussen huisarts en patiënt. Affectief gedrag van de arts blijkt vaak te leiden tot tevreden patiënten, die niet gemakkelijk van arts veranderen.

## Onderzoeksvraag

De onderzoeksvraag die in dit proefschrift behandeld wordt is:

*welke elementen uit het gedrag van de huisarts zorgen voor een goede hulpverlening?*

Om deze onderzoeksvraag te kunnen beantwoorden zijn videobanden geobserveerd van huisartsconsulten. Daarbij is gebruik gemaakt van observatiesystemen, die deels door het NIVEL zelf zijn ontwikkeld op basis van de beschikbare literatuur (hoofdstuk 3 t/m 6), en deels in zijn totaliteit zijn overgenomen uit Engelse (hoofdstuk 4) en Amerikaanse (hoofdstuk 7) onderzoeksprogramma's. Bij de observaties is zowel gelet op affectief gedrag als op instrumenteel gedrag. Veel van de hiervoor genoemde gedragselementen komen in de artikelen voor, als onderdeel van een of meer van de observatiesystemen die zijn gebruikt. De volgende criteria worden gebruikt als indicator voor hulpverlening van goede kwaliteit:

- 1 praten over psychosociale problemen als die geacht worden een rol te spelen in de gezondheidsproblemen van de patiënt (hoofdstuk 3 en 4).
- 2 een kwaliteitsoordeel door een panel ervaren huisartsen op drie aspecten van het huisartsgeneeskundig handelen: de medisch-technische kwaliteit, de psychosociale kwaliteit en de kwaliteit van de arts-patiënt relatie; (hoofdstuk 5 -alleen psychosociale kwaliteit -, 6 en 7).
- 3 tevredenheid van de patiënt (hoofdstuk 5,6 en 7), en de mening van de patiënt over de rol van de arts bij psychosociale problemen (hoofdstuk 6).

De empirische artikelen benaderen de algemene onderzoeksvraag elk uit een ietwat verschillend perspectief. In de Slotbeschouwing worden de verschillende onderzoeksresultaten geïntegreerd en van commentaar voorzien. Maar eerst wordt een theoretische beschouwing gepresenteerd om meer zicht te krijgen op de vraag waarom sommige onderzoeksresultaten uit de literatuur op het eerste gezicht tegenstrijdig lijken te zijn.

## Impliciete theorieën in onderzoek naar arts-patiënt communicatie

Regelmatig wordt kritiek geleverd op het feit dat in onderzoek naar arts-patiënt communicatie weinig aan theorievorming wordt gedaan. Als gevolg daarvan lijkt de verzameling onderzoeksresultaten in de literatuur wel wat op een psychologische projectietest, die meer zegt over de persoon die er naar kijkt dan over de verzamelde kennis. Allerlei auteurs hebben op allerlei manieren en met meer of minder succes getracht lijn te brengen in de onderzoeksresultaten: bijvoorbeeld door overzichtsstudies, meta-analyses, of door de resultaten te plaatsen in één allesomvattende (systeem)theorie.

Het blijkt echter ook mogelijk de complexiteit van de onderzoeksresultaten drastisch terug te brengen door een simpele analyse uit te voeren. Voortbordurend op het aloude onderscheid tussen de 'twee gezichten van de geneeskunde': de kunst en de kunde (het humane en het technologische; de care en de cure), zien we dat de onderzoeksresultaten zonder veel moeite verklaard kunnen worden, door het artsgedrag dat - bijvoorbeeld - samenhangt met de tevredenheid van de patiënt onder te brengen in twee voor de gezondheidszorg vertrouwde hoofdgroepen: (1) affectief gedrag, en (2) instrumenteel gedrag. Daarnaast kan men nog een derde groep onderscheiden, te weten 'tegenmoet komen aan de verwachtingen van de patiënt', naar deze is eigenlijk van een ander niveau.

Hoewel de complexiteit van de onderzoeksresultaten op het gebied van de arts-patiënt communicatie door deze indeling aanmerkelijk wordt verminderd, blijven er toch nog vragen en tegenstrijdigheden over. Zo blijkt in sommige onderzoeksprojecten dat de tevredenheid van de patiënt vooral wordt bepaald door het affectieve gedrag van de arts, terwijl in andere projecten vooral taakgericht gedrag tot tevreden patiënten blijkt te leiden. Die tegenstrijdigheden worden begrijpelijk wanneer men zich rekenschap geeft van de (veelal impliciete) theoretische achtergrond van de onderzoeksprojecten waaruit de resultaten voortkomen. Affectief gedrag en instrumenteel gedrag blijken namelijk bestudeerd te worden in geheel verschillende onderzoekstradities met een verschillende theoretische achtergrond. Beide tradities werken met verschillende soorten observatiesystemen, waarin verschillende gedragselementen worden geobserveerd. Het is dan ook niet verwonderlijk dat de resultaten op het oog weinig samenhangend, en soms zelfs tegenstrijdig zijn.

In de instrumentele traditie heeft de sociaal-psycholoog Bales een toonaangevende invloed gehad met zijn meetinstrument dat gebaseerd is op probleem-oplossingstheorieën. Voor het oplossen van problemen (in de huisartspraktijk is dit: het oplossen van de gezondheidsproblemen van de patiënt) is vooral instrumenteel of taakgericht gedrag nodig, en met name informatieuitwisseling. Affectief gedrag is in deze theorieën geen doel op zichzelf, maar alleen van belang om het probleemoplossingproces aan de gang te houden; affectief gedrag bestaat daarom alleen uit gedragingen die wijzen op het al dan niet bestaan van spanningen die het probleemoplossend proces kunnen belemmeren, of juist vergemakkelijken. Veel onderzoekers op het terrein van de arts-

patiënt communicatie gebruiken het observatiesysteem van Bales of een observatiesysteem dat daarvan is afgeleid, waarmee ze (soms onbewust) ook in de theoretische voetsporen van Bales stappen. Doordat onderzoekers uit deze onderzoekstraditie zich vooral bezig houden met het gesproken woord, gebruiken zij audiomateriaal om gedrag vast te leggen. Iedere afzonderlijke gespreksuiting wordt vastgelegd in een meer of minder uitgebreid observatiesysteem van elkaar wederzijds uitsluitende categorieën. Geturfd wordt hoe vaak bepaalde uitingen voorkomen. Dat blijkt heel betrouwbaar te kunnen gebeuren. De achterliggende gedachte in het analyseplan is dat wanneer bepaald gedrag veel of juist weinig voorkomt, dit een indicatie is van (bijvoorbeeld) de kwaliteit van het consult, of de kans dat de patiënt tevreden zal zijn.

In de affectieve onderzoekstraditie zijn het vooral de klinisch psycholoog Carl Rogers en de psychiater Michael Balint geweest die hun sporen op het observatieonderzoek hebben gedrukt. Daarmee heeft de affectieve onderzoekstraditie een duidelijk psychotherapeutische achtergrond. In deze visie is het allereerst van belang een vertrouwensrelatie met de patiënt te scheppen, omdat ziekte, maar ook het naar de dokter gaan, bijna altijd met angst en onzekerheid beladen is. Om een vertrouwensrelatie te scheppen is affectief gedrag nodig: aandacht, empathie, en respect voor de patiënt. De patiënt moet het gevoel krijgen dat hij serieus genomen wordt. Woorden hebben slechts een beperkte betekenis in affectief gedrag. Veel belangrijker is het nonverbale gedrag: de houding van de arts, het oogcontact, de stiltes die hij laat vallen. Onderzoekers uit de affectieve onderzoekstraditie gebruiken dan ook meestal videomateriaal om gedrag vast te leggen. Zij zijn ook niet zozeer uit op het gedetailleerd turven van diverse gedragingen, maar op de globale indruk van het consult op relevant geachte dimensies. Weliswaar is dit vaak minder betrouwbaar dan turven van concreet gedrag, maar zij stellen daar tegenover dat er op deze manier in ieder geval **relevant** gedrag gemeten wordt. Zij meten de relevantie van het gedrag bijvoorbeeld af aan de vraag of de huisarts op deze manier eerder op het spoor komt van psychische problematiek, en of er vaker over psychosociale problemen gesproken wordt wanneer daar aanleiding voor is.

Beide onderzoekstradities hebben hun sterke en zwakke kanten. De instrumentele onderzoeksprojecten zijn vaak methodologisch beter opgezet, maar ze missen nogal eens klinische relevantie: de huisarts weet niet zo goed wat hij met de resultaten moet doen. De affectieve onderzoeksprojecten spreken de individuele huisarts veel meer aan (affectief gedrag is een belangrijk ingrediënt van veel interviewtrainingen), maar krijgen nogal eens kritiek te verduren vanwege hun zwakke methodologische opzet. Maar misschien is wel het belangrijkste, dat het in de instrumentele onderzoekstraditie niet goed mogelijk is om affectief gedrag (in de therapeutische betekenis van het woord) te meten, terwijl in de affectieve traditie geen inzicht verkregen wordt in het probleemoplossingsproces: Als je enige gereedschap een hamer is, maak je een spijker van elk probleem!



Toch zijn beide doelstellingen in de huisartspraktijk van belang: zowel het oplossen van problemen, als het scheppen van een vertrouwensrelatie. Soms is vooral het een nodig, soms vooral het ander, afhankelijk van de betrokken patiënt, afhankelijk van zijn gezondheidsprobleem, en afhankelijk van de fase in het hulpverleningsproces. Dat maakt duidelijk dat de keuze van een observatiesysteem nooit alleen ingegeven mag worden door zijn toevallige beschikbaarheid of bewezen meettechnische eigenschappen, maar afhankelijk moet zijn van de concrete inhoudelijke vraagstelling, waarop het onderzoek een antwoord wil geven. Dit betekent dat onderzoekers op het terrein van de arts-patiënt communicatie, naar analogie van het bekende motto van het 'methodisch werken', zich bij de keuze van hun observatiesysteem, moeten afvragen: *Waarom is dit type gedrag belangrijk bij dit type patiënt met dit type gezondheidsklachten en in dit type consult?* En waarschijnlijk betekent dat meestal, dat er een intelligente mengvorm van beide soorten observatiesystemen nodig is.

## Ruimte voor de patiënt

Lang heeft de huisartsgeneeskunde in een duidelijk dilemma verkeerd, en misschien is dit dilemma zelfs nu nog niet helemaal opgelost: men realiseert zich dat het biomedische model, waarin men is opgeleid, niet toereikend is om de typisch huisartsgeneeskundige problemen te lijf te gaan, omdat veel van de problemen waarmee patiënten hun huisarts bezoeken niet louter biologisch van aard zijn. Daar staat echter tegenover, dat ook psychologische hulpverleningsmodellen slechts een beperkte waarde lijken te hebben in de huisartspraktijk. Deze zijn immers ontwikkeld voor patiënten van wie vaststaat dat ze psychische problemen hebben, terwijl in de huisartspraktijk patiënten meestal met lichamelijke klachten komen, en de huisarts nog moet uitzoeken welk deel van de problematiek door lichamelijke en welk deel door psychosociale oorzaken wordt bepaald, en hoe dat allemaal op elkaar inwerkt. Bovendien heeft een psychotherapeut per keer meestal drie kwartier of een uur tot zijn beschikking, terwijl de huisarts gemiddeld niet veel meer dan tien minuten per consult kan uittrekken. Aan de andere kant geeft de continuïteit van de arts-patiënt relatie de huisarts weer een zeker voordeel tegenover de psychotherapeut: de huisarts kent zijn patiënten, en vroeger of later komt de patiënt weer bij hem terug. Ook het feit dat de huisarts vaak in een vroeg stadium bij problemen van zijn patiënten betrokken is, geeft hem een zeker strategisch voordeel.

Dit betekent dat de huisartsgeneeskunde de niet onaanzienlijke taak heeft om het medische model, dat niet langer voldoet, te integreren met gedragswetenschappelijke modellen die nog niet toereikend zijn. Dit betekent, dat de huisartsgeneeskunde wel gebruik kan maken van begrippen die ontwikkeld zijn in de psychologische hulpverleningspraktijk, maar dat deze begrippen eerst verder toepasbaar moeten worden gemaakt voor het werken in de huisartspraktijk. Hiervoor is begripsontwikkeling noodzakelijk.

In dit hoofdstuk wordt als kernbegrip gekozen: 'ruimte voor de patiënt', waarmee bedoeld wordt dat de patiënt de gelegenheid krijgt te vertellen wat hem werkelijk dwars

zit, inclusief zijn angsten en emoties, en inclusief zijn eigen ideeën over factoren die een rol hebben kunnen spelen bij het ontstaan van zijn gezondheidsprobleem. Dat is namelijk waar het klassieke biomedische model in tekort schiet, terwijl het voor een goede hulpverlening in de huisartspraktijk met zijn vele ambigue gezondheidsproblemen noodzakelijk is dat patiënten de ruimte krijgen om hun gezondheidsproblemen vertellend te ontdekken, echter binnen de grenzen van de dagelijkse strijd tussen tijd en aandacht.

Op basis van een literatuurstudie zijn meetbare (gedrags)elementen geselecteerd, die op een of ander wijze iets te maken hebben met het begrip 'ruimte voor de patiënt'. Zo kan men veronderstellen dat 'de duur van het consult' rechtstreeks samenhangt met de ruimte die een patiënt in het spreekuur krijgt. Ook de objectieve spreektijd van de patiënt lijkt een rechtstreekse relatie te hebben met de ruimte van de patiënt. Gedragselementen aan de kant van de huisarts zijn verder 'rust', 'aandacht', 'interesse', 'stimulerende', maar ook 'remmende opmerkingen'; gedragselementen aan de kant van de patiënt zijn 'spraakzaamheid' (verdeeld in het aantal keren dat een patiënt uit zichzelf een nieuw onderwerp aansnijdt, en het aantal keren dat hij langer doorpraat dan strikt genomen noodzakelijk is als reactie op de arts), en het 'aantal gepresenteerde klachten'. Tot slot mag verondersteld worden dat het oordeel van de huisarts over de aard en de ernst van de gezondheidsproblematiek van invloed is op de ruimte die een patiënt van zijn huisarts krijgt. Daarbij zal vooral een rol spelen of de huisarts vermoedt dat er psychosociale problemen in het spel zijn.

Dit vormen de elementen van een observatiesysteem waarmee 273 willekeurige op video opgenomen consulten van zes verschillende huisartsen zijn bekeken. In 67 % van de consulten is de huisarts van oordeel dat ook psychosociale factoren een rol spelen in het betreffende consult. Dat leidt niet altijd tot concrete actie, want in meer dan de helft van deze consulten is alleen over de lichamelijke kant van het gezondheidsprobleem gepraat. Vooral in korte consulten is nauwelijks over psychosociale problemen gepraat. Psychosociale gespreksfragmenten verlopen in een aantal opzichten anders dan somatische gespreksfragmenten: de arts is geïnteresseerder en rustiger; stimuleert de patiënt vaker om te vertellen wat hem dwars zit, maar remt hem ook iets vaker wanneer dat inderdaad gebeurt; er is wat meer variatie in het aandeel dat arts en patiënt in het consult hebben (het praten over de lichamelijke kant van gezondheidsproblemen lijkt wat routinematiger te verlopen).

Wanneer we al deze concrete, maar fragmentarische benaderingen van het vage begrip 'ruimte voor de patiënt' door een statistische techniek als factor-analyse proberen terug te brengen tot enkele herkenbare groepen van gedragingen, zien we dat er vier van dergelijke groepen ontstaan:

- a bewust sturend gedrag (stimulerend gedrag; aantal klachten; oordeel over aard en ernst; lengte consult)
- b affectief gedrag (aandacht, rust en interesse)
- c spraakzaamheid van de patiënt

d relatieve spreektijd van arts en patiënt.

Met name de eerste twee factoren blijken bij verdere analyses interessant te zijn. Wanneer de consulten waarin de arts van mening is dat psychosociale factoren een rol spelen verdeeld worden in een groep waarin ook over deze problemen **gesproken** wordt, en een groep waarin dat helemaal **niet** gebeurt, blijken deze consulten alleen van elkaar te verschillen in de mate waarin de huisarts bewust sturend gedrag vertoont, dat wil zeggen dat hij op grond van zijn oordeel over de aard en ernst van de klacht de patiënten gericht stimuleert om over hun psychosociale problemen te praten. Artsen zijn in beide gevallen even affectief. Wel blijkt dat sommige huisartsen affectiever zijn dan anderen, ongeacht het onderwerp van gesprek. Het lijkt er bovendien op dat affectief gedrag (kernbegrip in psychotherapeutische theorieën) wel een noodzakelijke, maar geen voldoende voorwaarde is voor een gesprek over psychosociale onderwerpen.

### Leren luisteren, maar wat dan?

Gesprekstrainingen voor huisartsen waren aanvankelijk voornamelijk gebaseerd op psychotherapeutische theorieën, en met name op de non-directieve hulpverleningstheorie van Carl Rogers. Eén van deze gesprekstrainingen is wetenschappelijk geëvalueerd, door twee maanden voorafgaand aan de eerste, en drie maanden na afloop van de laatste trainingsbijeenkomst video-opnamen te maken in de spreekkamer van de zes huisartsen, die aan de gehele training hebben meegedaan, en deze te analyseren op veranderingen in hun gedrag. Hierbij is vooral gelet op gedrag dat in de training is aangeleerd.

Dit zijn de doelstellingen van de training:

- 1 het is een gesprekstraining, en geen persoonlijkheidstraining.
- 2 de training is gericht op het diagnostisch proces, dat wil zeggen: op het vergroten van de vaardigheden van de huisarts in het opsporen en herkennen van psychische problematiek; er worden geen therapeutische vaardigheden aangeleerd.
- 3 de aangeleerde vaardigheden worden verondersteld in de dagelijkse praktijk van de huisarts toegepast te (kunnen) worden.

Het evaluatie-onderzoek is uitgevoerd door psychologen die niet bij de gesprekstherapie zelf betrokken waren. Een drietraps onderzoeksvraag werd geformuleerd:

- a gedragen de huisartsen zich na afloop van de training anders dan daarvoor?
- b krijgen de patiënten in de nameting meer ruimte om over hun problemen te praten?
- c praten de patiënten na afloop van de training ook meer over de psychosociale kanten van hun gezondheidsproblemen?

Voor het beantwoorden van deze vragen is gebruik gemaakt van hetzelfde observatiesysteem dat in het vorige hoofdstuk is beschreven. Daarnaast is gebruik gemaakt van een observatiesysteem dat ontwikkeld is door de Engelse onderzoekers Byrne en Long. In dit observatiesysteem kan iedere gedragsuiting worden ondergebracht in een gedetailleerd categorieënsysteem. Het observatiesysteem is geschikt voor dit evaluatie-onderzoek omdat (onder andere) het gedrag dat in de training wordt aangeleerd in het systeem is opgenomen. Naast deze 'empathische factor' kent het systeem nog een

'informatieve factor' en een 'directieve factor' (N.B. Het observatiesysteem van Byrne en Long meet daarmee zowel affectief als instrumenteel gedrag).

Wanneer we het gedrag van de artsen in voor- en nameting met elkaar vergelijken valt op dat zij zich inderdaad op een aantal punten anders zijn gaan gedragen. Alle veranderingen zijn bovendien in de verwachte richting. Het is dus mogelijk om huisartsen gedrag te leren, dat zij enkele maanden later in hun dagelijkse werk nog vertonen. De training was gericht op het afleren van actief, directief gedrag, en het aanleren van passief, empathisch gedrag. Alle huisartsen gedroegen zich na de training empathischer, enkele van hen waren ook minder directief. Informatief gedrag nam bij sommige huisartsen toe, bij anderen af (waarbij aangetekend moet worden, dat de training niet gericht was op informatief gedrag). De veranderingen blijken ook wanneer we kijken naar de ruimte die de patiënten in het consult hebben om te praten over wat hen dwars zit: na afloop van de gesprekstraining duren de consulten gemiddeld langer, en de patiënten zijn, zowel absoluut als relatief, langer aan het woord. De huisartsen zijn na afloop van de training rustiger, kijken de patiënt vaker aan en maken een geïnteresseerdere indruk. met andere woorden: na de training gedragen de huisartsen zich anders dan daarvoor. Ze zijn niet allemaal evenveel veranderd, maar wel allemaal in dezelfde richting, en wel in de richting die in de training is aangeleerd. Wat echter opvalt (en enigszins teleurstellend is), is dat er *niet* vaker over psychosociale problemen gepraat wordt: zowel voor als na de training vinden de artsen in veel meer consulten dat er psychosociale problemen aan de orde zijn, dan er daadwerkelijk ter sprake komen. Dit betekent dat het blijkbaar niet voldoende is om alleen maar ruimte te scheppen voor de patiënt om over zijn problemen te praten. Er is méér voor nodig om hem ook echt aan het praten te krijgen. Met andere woorden: de psychotherapeutische concepten blijken goed aan huisartsen geleerd te kunnen worden, maar in de huisartspraktijk niet automatisch de beoogde uitwerking te hebben. Het kan zijn dat dit komt omdat niet alleen de huisartsen, maar ook de patiënten moeten leren zich anders te gaan gedragen. Ze zijn gewend om vooral met hun lichamelijke problemen bij de huisarts te komen, en het kan zijn, dat dit niet van de ene dag op de andere verandert. Het zou interessant geweest zijn om na te gaan of de veranderingen in het gedrag van de huisarts tot een grotere tevredenheid bij de patiënt leiden, maar helaas beschikken we niet over deze gegevens. Daarom moet op dit moment een belangrijke conclusie van het onderzoek zijn, dat het niet voldoende lijkt om huisartsen empathisch gedrag aan te leren in een training die beperkt blijft tot de diagnostische fase: wanneer de huisarts niet tegelijkertijd therapeutische vaardigheden aanleert om de problematiek die op tafel komt goed te kunnen hanteren, is het belangrijkste resultaat van de training, dat consulten twee keer zo lang gaan duren, zonder dat er verder veel verandert. En dat kan nooit de bedoeling zijn!

### **Arts-patiënt communicatie en de kwaliteit van de hulpverlening**

In de eerste twee onderzoeksbijdragen aan deze bundel is nagegaan welke gedrag van de huisarts aan de patiënt ruimte geeft om te praten over wat hem dwars zit. Dit

is gedaan door alleen naar die consulten te kijken, waarvan de arts van mening is dat psychosociale problemen een rol spelen, en vervolgens na te gaan of de huisarts zich anders gedraagt in consulten waarin over deze problemen gesproken wordt, dan in consulten waarin alleen over de lichamelijke kant van de problemen wordt gepraat. Bovendien is in de tweede bijdrage nagegaan of huisartsen zich in hun werk empathischer gaan gedragen, wanneer ze een gesprekstaining in die richting hebben gevolgd. In beide gevallen beschikken we alleen over gegevens over de consulten zelf. We weten niet wat de patiënt ervan vindt. Ook weten we niet wat collega-huisartsen beschouwen als een 'goed' consult. De concepten die gebruikt worden zijn, afkomstig uit een ander vakgebied: de psychologie. Maar uiteindelijk zullen huisartsen zelf moeten beoordelen in hoeverre deze concepten relevant en bruikbaar zijn voor de uitoefening van hun vak.

Vanuit deze gedachte is een nieuw onderzoeksproject opgezet, dat voor een deel gebruik maakt van materiaal dat verzameld is voor het proefschrift van NIVEL-collega Peter Verhaak. Van de consulten die hij op video verzameld heeft is het gedrag van de huisarts in drie hoofdgroepen vastgelegd:

- 1 affectief gedrag (verbaal en non-verbaal)
- 2 patiëntgericht gedrag
- 3 methodisch werken.

Bovendien is van deze consulten bekend wat de tevredenheid van de betrokken patiënten is. Een selectie van deze consulten is vervolgens voorgelegd aan een panel van 12 ervaren huisartsen, die (onafhankelijk van elkaar) een oordeel hebben gegeven over de kwaliteit van de psychosociale hulpverlening van de betrokken huisartsen.

Vaak wordt kritiek gegeven op onderzoek naar arts-patiënt communicatie, omdat in de meeste projecten alle consulten door elkaar heen worden geanalyseerd, ongeacht welk gezondheidsprobleem aan de orde is. Om tegemoet te komen aan deze kritiek zijn voor dit project consulten gekozen met een zelfde gezondheidsprobleem. Gekozen is voor 'hypertensie', omdat dit een gezondheidsprobleem is dat veel voorkomt onder de bevolking, serieuze aandacht verdient, en een probleem is, dat -naast lichamelijke- ook duidelijke psychosociale componenten heeft. In totaal kwamen 103 consulten in aanmerking voor dit onderzoek.

De eerste onderzoeksvraag luidt: is het mogelijk om een betrouwbaar kwaliteitsoordeel te verkrijgen over de psychosociale hulpverlening van de huisarts. Met 'betrouwbaar' bedoelen we dat de panel-leden onderling consistent zijn in hun beoordeling van de consulten. Om dat te bereiken hebben de panel-leden een korte training gekregen en een schriftelijke instructie. In de instructie zijn enkele punten opgesomd waar de panel-leden op moesten letten bij hun beoordeling van de kwaliteit van het psychosociaal handelen van de huisarts. Het kwaliteitsoordeel is gegeven in de vorm van een rapportcijfer (tussen 0 en 10). Met deze procedures blijkt het mogelijk een betrouwbaar kwaliteitsoordeel te bereiken. In de rest van het onderzoek is per consult het gemiddelde panel-oordeel gebruikt als maat voor de kwaliteit van het psychosociaal handelen van de betrokken huisarts.

De tweede onderzoeksvraag heeft betrekking op de samenhang tussen de door ons vastgelegde arts-patiënt communicatie, de door collega's beoordeelde kwaliteit, en de tevredenheid van de patiënt. Bij een onderlinge vergelijking van consulten die van het panel een onvoldoende ( $< 5.9$ ) kregen met de consulten die minstens als 'goed' ( $> 7.0$ ) werden beoordeeld, blijkt dat de huisarts in de goede consulten veel meer affectief gedrag vertoont: hij kijkt de patiënt vaker aan, maakt een geïnteresseerdere indruk, en laat via allerlei passieve uitingen merken dat hij luistert naar wat de patiënt vertelt, hem begrijpt, en met hem meeleeft. Ook betreft hij in de 'goed' beoordeelde consulten de patiënt meer bij het hulpverleningsproces. Tussen 'goede' en 'onvoldoende' consulten bestaan geen verschillen in de mate waarin de huisarts methodisch werkt, dat wil zeggen: de hulpvraag verheldert en het consult structureert. In een discriminant-analyse (een statistische techniek waarmee men op basis van alle bestudeerde gedragingen van de huisarts een voorspelling kan doen over de kans dat een consult door de panel-leden als 'goed' of als 'onvoldoende' beoordeeld zal worden), blijkt dat van maar liefst 95 % van de consulten correct voorspeld kan worden in welk van deze twee groepen ze terechtkomen. Met andere woorden: de kwaliteitsoordelen van het panel worden in hoge mate voorspeld door het affectieve en patiëntgerichte gedrag van de arts. Vooral oogcontact en interesse blijken belangrijk.

Men zou verwachten dat consulten die een hoog kwaliteitsoordeel krijgen van een panel van ervaren huisartsen ook tevreden patiënten zouden moeten opleveren. Dat is maar ten dele waar. Weliswaar bestaat er een samenhang tussen het kwaliteitsoordeel van het panel en de tevredenheid van de patiënt, die niet aan toeval is toe te schrijven ( $r = .19$ ;  $p < .05$ ), maar de gevonden samenhang is niet erg sterk. Dat geldt ook voor de samenhang tussen de tevredenheid van de patiënt en de verschillende soorten gedrag van de huisarts die met behulp van het NIVEL-observatiesysteem zijn vastgelegd. Huisartsen die geïnteresseerd zijn, door hun woorden laten merken dat ze met de patiënt meeleven, en actief zoeken naar allerlei (ook niet lichamelijke) factoren die een rol kunnen spelen bij de gezondheidsproblemen van de patiënt, blijken vaker tevreden patiënten te hebben. Maar ook hier zijn de samenhangen niet hoog. Wat hierbij een rol kan spelen is, dat de meeste patiënten erg tevreden zijn met hun huisarts. Meestal ligt de beoordeling tussen 'tevreden' en 'zeer tevreden'. Het is denkbaar dat sommige patiënten zich gemakkelijker in superlatieven uiten dan anderen, waardoor het tevredenheidsoordeel van de patiënt meer zegt over de betrokken patiënt dan over de betrokken huisarts. Ook kan het zijn dat de tevredenheid van de patiënt bepaald wordt door hoe de huisarts zich meestal gedraagt, en niet zozeer door hoe hij zich in dit ene specifieke consult laat zien. Verder onderzoek zou dit moeten uitwijzen. Voor dit moment moeten we volstaan met de constatering dat het oordeel van een groep ervaren huisartsen over de kwaliteit van de psychosociale hulpverlening beter weerspiegelt wordt in het observatiesysteem van het NIVEL, dan in de tevredenheid van de patiënt.

## Wie zegt dat dit een goed consult is?

De huisarts moet uiteraard niet alleen goede *psychosociale* zorg leveren. In feite is zijn belangrijkste taak het leveren van *medisch-technische* zorg van hoge kwaliteit. Daarnaast moet hij ook in staat zijn de *arts-patiënt relatie* goed te hanteren. Het panel is daarom gevraagd de hypertensieconsulten (beschreven in hoofdstuk 5) ook op deze twee gebieden een rapportcijfer te geven. Voor de beoordeling van de medisch-technische kwaliteit is in de schriftelijke instructie een samenvatting opgenomen van de op dat moment algemeen aanvaarde voorschriften inzake de opsporing en behandeling van hypertensie. Daarnaast is de panel-leden gevraagd te letten op het vermijden van overbodige medisch-technische handelingen, en op het ten onrechte ziek of gezond verklaren van patiënten. Bij de beoordeling van de wijze waarop de huisarts de arts-patiënt relatie hanteert, is de panel-leden gevraagd erop te letten, in hoeverre de arts erin slaagt een goede atmosfeer te scheppen in het consult. De beoordeling van de psychosociale kwaliteit (zie ook hoofdstuk 5) dient vooral gericht te zijn op de gevoeligheid van de huisarts voor verbale en nonverbale signalen van de patiënt dat hem iets dwars zit, op de mate waarin en wijze waarop de huisarts actief hiernaar zoekt, en op de vraag of hij begrip toont voor de psychische en sociale consequenties van de klacht of de behandeling voor leven en welzijn van de patiënt. Los van deze drie kwaliteitsoordelen werd de panel-leden ook gevraagd een aantal vragen te beantwoorden over de algemene hulpverleningsoriëntatie die de huisarts in het consult toont. Tezamen meten deze vragen de mate waarin de huisarts een huisartsgeneeskundige of generalistische oriëntatie heeft (afgezet tegen een louter biomedische oriëntatie). Alle kwaliteitsoordelen, en ook het oordeel over de algemene hulpverleningsoriëntatie blijken betrouwbaar gescoord te kunnen worden. Ze blijken onderling hoog samen te hangen. Dit betekent dat een arts die goed werk doet op psychosociaal gebied, door zijn collega's ook als een goede medisch-technische arts wordt beschouwd. Het is dus niet zo (wat wel eens gevreesd wordt) dat huisartsen die veel praten met hun patiënten een slechtere zorg leveren op medisch-technisch gebied.

Zoals we in het vorige hoofdstuk gezien hebben, blijkt de tevredenheid van de patiënt met zijn huisarts maar ten dele samen te hangen met het paneloordeel over de psychosociale kwaliteit. Nu blijkt bovendien dat de tevredenheid helemaal niet samenhangt met de beoordeling van de medisch-technische kwaliteit. De tevredenheid van de patiënt heeft vooral te maken met de wijze waarop de huisarts de arts-patiënt relatie hanteert, dat wil zeggen: erin slaagt een goede atmosfeer in het consult te scheppen. Zoals in het vorige hoofdstuk is beschreven gebeurt dit blijkbaar vooral wanneer de huisarts zich geïnteresseerd toont, merkbaar meeleeft en actief zoekt naar allerlei (ook niet-medische) elementen die een rol spelen bij de gezondheidsproblemen van de patiënt. Althans, patiënten zijn tevredener, wanneer de arts dit type gedragingen vertoont. Een nadere analyse laat overigens zien dat het wel uitmaakt wat voor soort consult het is: komt de patiënt voor de eerste keer, dan is hij vooral tevreden wanneer de huisarts zijn hulpvraag verheldert (methodisch werken!), geïnteresseerd is en

gericht vraagt naar wat er allemaal meespeelt bij de patiënt; bij vervolggconsulten telt alleen het laatste mee.

Bovendien lijkt het erop dat het in vervolggconsulten belangrijk is dat de huisarts de patiënt intensief betreft bij het verloop van het consult en de geplande behandeling. In die gevallen vindt de patiënt namelijk dat de arts een brede rol heeft op het gebied van de psychische hulpverlening. Over het geheel genomen kennen patiënten hun arts een bredere rol toe op het gebied van de psychische hulpverlening wanneer de arts affectief is (verbaal en non-verbaal), en wanneer hij de patiënt sterk betreft bij de hulpverlening. Daarmee vertoont dit patiëntenoordeel, zij het iets milder, ongeveer hetzelfde patroon als het panel-oordeel over de psychosociale kwaliteit.

In hoofdstuk 5 is reeds beschreven hoe het panel-oordeel over de psychosociale kwaliteit samenhangt met de gedragselementen van het NIVEL-observatiesysteem: artsen worden kwalitatief beter beoordeeld wanneer ze affectief zijn (verbaal en non-verbaal), wanneer ze de patiënt veel invloed geven, en wanneer ze gericht zoeken naar factoren buiten de klacht-in-engere-zin. We zien dezelfde soort samenhangen bij de andere kwaliteitsoordelen, met twee uitzonderingen:

- bij de beoordeling van de medisch-technische kwaliteit wordt het panel-oordeel niet beïnvloed door de vraag of de huisarts de patiënt veel of weinig invloed geeft.
- bij de beoordeling van de kwaliteit van de arts-patiënt relatie speelt het bij het panel geen rol of de arts gericht zoekt naar factoren buiten de klacht-in-engere-zin.

Ook zijn bij het medisch-technisch kwaliteitsoordeel de gevonden verbanden wat zwakker dan bij de andere twee kwaliteitsoordelen, hetgeen verklaard kan worden door de oorsprong van het NIVEL-observatie-instrument, dat immers primair ontwikkeld is om de psychosociale hulpverlening van de huisarts vast te leggen. Opvallend is echter de overheersende invloed van het non-verbale affectieve gedrag bij alle drie kwaliteitsoordelen. Samengevat wordt 34 % van de variantie in het medisch-technisch kwaliteitsoordeel verklaard door de gedragselementen van het NIVEL-observatiesysteem, tegen 58 % van de variantie in het psychosociale kwaliteitsoordeel en 40 % van de variantie in het oordeel over de kwaliteit van de arts-patiënt relatie. Ook deze cijfers bevestigen de primaire geschiktheid van het NIVEL-observatie-instrument voor het vastleggen van de psychosociale hulpverlening.

Een laatste feit dat het vermelden waard is, is dat (net als bij de patiënten-tevredenheid) ook hier het type consult van belang blijkt te zijn bij de kwaliteitsoordelen van het panel. Ruwweg komt het er op neer dat ook hier het door het panel wordt gewaardeerd, wanneer in eerste consulten aan vraagverheldering wordt gedaan, en wanneer in vervolggconsulten de patiënt veel invloed krijgt op het verloop van het consult en de behandeling. Dit pleit ervoor in onderzoek naar arts-patiënt communicatie niet alleen consulten te selecteren met vergelijkbare gezondheidsproblematiek, maar ook te letten op de vraag of het betreffende consult een eerste consult is of een vervolggconsult.



## Instrumentele en affectieve aspecten van arts-patiënt communicatie

Aangezien het NIVEL-observatiesysteem zijn basis vooral vindt in psychologische hulpverleningstheorieën en oorspronkelijk ook ontwikkeld is om de psychosociale hulpverlening van de huisarts te bestuderen, is het niet verwonderlijk dat dit systeem vooral de door een extern panel beoordeelde *psychosociale* kwaliteit van een consult goed weet te verklaren. De verklaringskracht ten opzichte van de medisch-technische kwaliteit is duidelijk veel minder groot. Daarom is gezocht naar observatiesystemen uit de instrumentele onderzoekstraditie, die beter dan het NIVEL-systeem in staat zijn de communicatie over medisch-technische zaken goed vast te leggen. Door een dergelijk observatiesysteem toe te passen op dezelfde consulten die eerder met het NIVEL-systeem zijn gescoord, hopen we bovendien meer inzicht te krijgen in het intrigerende raadsel dat in onderzoek uit de affectieve onderzoekstraditie altijd gevonden wordt dat de tevredenheid van de patiënt vooral bepaald wordt door het affectief gedrag van de arts, terwijl in onderzoek uit de instrumentele traditie vooral taakgericht gedrag bepalend lijkt te zijn voor de tevredenheid van de patiënt (zie ook hoofdstuk 2).

Voor dit onderzoek is een psycholoog ingeschakeld die niet bij de eerdere projecten betrokken was, en niet bekend was met de wijze waarop de 103 hypertensieconsulten in de eerdere projecten beoordeeld waren.

Gekozen is voor het door Debra Roter ontwikkelde observatie-systeem RIAS (Roter's Interaction Analysis System), omdat dit systeem goed gedocumenteerd is, veel wordt gebruikt, en in een vergelijkende studie gunstig uit de bus kwam. Alle afzonderlijke uitingen van de arts worden in dit observatiesysteem gescoord. Wel zijn er in vergelijking met Roter's eigen onderzoek enkele aanpassingen gemaakt, zowel in het observatie-systeem zelf, als in de gebruikte methode.

Om met dat laatste te beginnen: in Roter's onderzoek zijn *audiobanden* geanalyseerd van een aantal (amerikaanse) *simulatie*patiënten met een chronische longaandoening, terwijl in het huidige onderzoek gebruik is gemaakt van *videobanden* van *echte* patiënten die met hypertensie bij hun (nederlandse) huisarts komen (zie ook de hoofdstukken 5 en 6).

Ook is het observatie-instrument zelf op een aantal punten aangepast: Roter gebruikt in haar onderzoek vier taakgerichte of instrumentele gedragscategorieën en één socio-emotionele of affectieve categorie. Wij maken bij de instrumentele categorieën die daarvoor in aanmerking komen (het geven van informatie; het vragen van informatie; het therapeutisch counselen) een onderscheid tussen medisch-technische, en psychosociale onderwerpen. Bovendien worden (op basis van een factor-analyse) *drie* affectieve categorieën gebruikt:

- 1 *Verbale aandacht*. Deze categorie lijkt het meest op het empathie-begrip in psychologische hulpverleningstheorieën. De categorie omvat gedragingen als: instemming tonen, hummen, meeleven tonen, met woorden laten merken dat je naar de patiënt luistert en hem begrijpt.

- 2 *Bezorgdheid tonen*. Deze categorie verwijst naar de mate waarin de arts zich betrokken toont met de emotionele kant van de gezondheidsproblemen van de patiënt door te laten zien dat hij zich zorgen maakt, of juist door de patiënt gerust te stellen.
- 3 *Sociaal gedrag*. Deze categorie lijkt het meeste op de enige socio-emotionele categorie uit Roter's eigen onderzoek en verwijst vooral naar sociale conversatie: persoonlijke opmerkingen, grapjes, lachen, en het complimenteren van de patiënt. Daarnaast wordt een vierde affectieve categorie gebruikt: "tonen het ergens niet mee eens te zijn"; dit is de enige negatieve categorie in het RIAS-systeem. De betrouwbaarheid van het RIAS-systeem blijkt zeer hoog te zijn.

Naast het RIAS-systeem van elkaar wederzijds uitsluitende gedragscategorieën zijn ook enkele globale affectmaten gebruikt, die weliswaar ook van Roter afkomstig zijn, maar niet in deze vorm door haar gebruikt zijn in haar studie over het belang van instrumenteel ten opzichte van affectief gedrag. Beoordeeld werden:

- \* boosheid/irritatie
- \* angst/nervositeit
- \* dominantie/assertiviteit
- \* interesse/bezorgdheid
- \* warmte/vriendelijkheid

Behalve 'dominantie' zijn alle globale affectmaten betrouwbaar gescoord; het oordeel over de dominantie van de huisarts is daarom uit het onderzoek verwijderd.

Van alle instrumentele gedragingen van de huisarts hangt het geven van medische informatie het hoogste samen met de panel-oordelen over het optreden van de huisarts. Dat geldt zowel voor het oordeel over de medisch-technische kwaliteit, als voor het oordeel over de psychosociale kwaliteit en de kwaliteit van de arts-patiënt relatie. Blijkbaar wordt het geven van medische informatie altijd belangrijk geacht door collega-huisartsen. Dat geldt niet voor de andere gedragscategorieën. Sommige categorieën hebben geen enkele relatie met de panel-oordelen; andere hangen slechts met enkele van de panel-oordelen samen.

Van het verbale affectieve gedrag blijkt de empathie-factor het sterkst samen te hangen met alle panel-oordelen. Het tonen van bezorgdheid hangt alleen samen met de panel-oordelen over de medisch-technische kwaliteit en over de arts-patiënt relatie. Maar het meest opvallend is dat 'sociaal gedrag' (de categorie die het meeste lijkt op de enige affectieve gedragscategorie uit Roters eigen onderzoek) alleen maar samenhangt met de beoordeelde kwaliteit van de arts-patiënt relatie: wanneer een huisarts veel persoonlijke opmerkingen, grapjes en andere spanning-reducerende opmerkingen maakt, vindt het panel ervaren huisartsen dat hij zorgt voor een goede atmosfeer in het consult; zijn primaire taken (het verlenen van goede medisch-technische en psychosociale zorg) worden echter niet significant beter beoordeeld. Hiermee is althans een deel van het raadsel van de tegenstrijdige onderzoeksresultaten in de affectieve en instrumentele school opgelost: sociaal gedrag leidt misschien tot een betere sfeer in

het consult, maar het leidt niet zonder meer tot betere consulten. Daarvoor is de psychotherapeutische invulling van het begrip 'affectief gedrag' noodzakelijk. Overigens zijn de allersterkste samenhangen met de verschillende panel-oordelen niet te vinden in het verbale deel van het observatiesysteem (RIAS), maar in de globale affectmaten, die voor een belangrijk deel afhankelijk zijn van nonverbaal gedrag.

Dat blijkt ook wanneer al het gemeten gedrag tegelijkertijd in beschouwing wordt genomen. Het observatiesysteem van Roter blijkt een zeer sterke verklaringskracht te hebben, maar deze is grotendeels gebaseerd op de globale affectmaten. Concreet:

- 60 % van de medisch-technische kwaliteit wordt verklaard door de interesse die de arts toont, de hoeveelheid medische informatie die hij geeft, zijn instructies, en het ontbreken van psychosociale vragen.
- 70 % van de variantie in het psychosociaal handelen wordt verklaard door de interesse die de arts toont, zijn verbale aandacht, de psychosociale informatie die hij geeft en het ontbreken van medische vragen.
- 59 % van de kwaliteit van de arts-patiënt relatie wordt verklaard, door louter de warmte die hij uitstraalt en de interesse die hij toont.
- 63 % van de generalistische oriëntatie wordt verklaard door de interesse van de arts, zijn verbale aandacht, het ontbreken van instructies. het geven van psychosociale informatie, en de warmte die hij uitstraalt.

Met deze resultaten verschaft het observatiesysteem van Roter ons een boeiend en genuanceerd beeld van het functioneren van de huisarts, zoals dat door collega's wordt beoordeeld. In vergelijking met het NIVEL-observatiesysteem wordt ook een breder deel van het handelen van de huisarts door dit observatie-onderzoek gedekt; dit komt met name door Roter's aanvullingen op het terrein van het instrumenteel handelen. Omgekeerd zou men natuurlijk ook kunnen zeggen dat dit instrumentele systeem in zijn gewijzigde vorm nu een breder deel van het handelen van de huisarts dekt, door aanvullingen op het terrein van het affectief handelen. In feite is deze aangepaste versie van RIAS een voorbeeld van een (blijkbaar geslaagde) mengvorm van een instrumenteel en een affectief systeem.

Resteert de vraag naar wat de patiënt ervan vindt. Net als in de vorige hoofdstukken treffen we ook hier wat teleurstellende resultaten aan. Tevredenheid hangt vooral in negatieve zin samen met een aantal gedragsuitingen of -beoordelingen. Patiënten zijn minder vaak tevreden wanneer een huisarts het in een consult niet met ze eens is, wanneer hij een geïrriteerde indruk maakt, of (en dat is zo op het eerste gezicht niet te verklaren) wanneer hij veel psychosociale informatie geeft. Het lijkt erop dat we eerder ontevredenheid gemeten hebben dan tevredenheid. In ieder geval wijst dit onderzoeksresultaat erop dat consulten niet altijd even harmonieus verlopen, en dat er in sommige gevallen wellicht sprake is van een verstoorde arts-patiënt relatie. Inderdaad blijken de negatieve correlaties vooral te vinden in consulten waarin onenigheid bestaat tussen huisarts en patiënt. Bovendien blijkt dat in de harmonieuze consulten de tevredenheid van de patiënt wel degelijk hoog samenhangt met de door

het panel gegeven beoordelingen. Alleen de relatie tussen de tevredenheid van de patiënt en het panel-oordeel over de medisch-technische kwaliteit blijft matig ( $r = .10$ ).

We moeten concluderen dat -naast overeenkomsten- het huidige onderzoek ook duidelijke verschillen vertoont met het eigen onderzoek van Debra Roter. De belangrijkste daarvan is dat in het huidige onderzoek affectief gedrag duidelijk belangrijker blijkt bij de (externe) beoordeling van de kwaliteit van het consult dan het instrumentele gedrag dat gemeten is. Voor een deel zullen de verschillen verklaard kunnen worden uit het feit dat in het huidige onderzoek met video-materiaal is gewerkt, hetgeen een betere manier is om affectief gedrag vast te leggen. Ook is een verfijning aangebracht in de verbale gedragscategorieën van het affectief gedrag. Of de verschillen verder veroorzaakt worden door het feit dat Roter met simulatie-patiënten werkte, terwijl in dit onderzoek echte patiënten zijn gebruikt, is de vraag. Ook kan het zijn dat er in het huidige onderzoek bij sommige van de (chronische) patiënten geleidelijk aan een verstoorde arts-patiënt relatie is ontstaan, hetgeen in een laboratoriumsituatie niet gemakkelijk zal gebeuren. Tenslotte is het denkbaar dat Amerikaanse dokters zich anders gedragen dan hun nederlandse collega's. De proefbandjes die we van Debra Roter ontvingen om het observatiesysteem te trainen wijzen wel in die richting. Deze veronderstellingen kunnen alleen getoetst worden in een vergelijkend onderzoek in Amerika en Nederland, waarin van dezelfde onderzoeksmethodologie gebruik wordt gemaakt.

## Conclusie

De vorige hoofdstukken hebben alles bij elkaar heel wat informatie opgeleverd over de hoofdvraagstelling van dit proefschrift:

*Welke elementen uit het gedrag van de huisarts zorgen voor een goede hulpverlening?*

Nu wordt het tijd om de balans op te maken: Wat heeft al deze informatie (deels afkomstig uit de literatuur, deels van mijn eigen onderzoek) ons nu geleerd. Sommige onderwerpen verdienen een nadere bespreking; veel ervan ook nader onderzoek. De resultaten worden vanuit drie verschillende gezichtspunten bekeken, te weten op hun theoretische consequenties, hun onderzoekstechnische consequenties en hun consequenties voor het onderwijs aan (aanstaande) huisartsen. Tot slot zullen nog enkele bespiegelingen worden gewijd aan de rol van patiëntentevredenheidsonderzoek bij de beoordeling van de kwaliteit van de verleende zorg.

## *Theoretische consequenties*

De in Hoofdstuk 2 geuite veronderstelling dat de theoretische achtergrond van onderzoekers op het terrein van de arts-patiënt communicatie, en de keuze van hun observatiesysteem vergaande consequenties heeft voor de resultaten van hun onderzoek blijkt in dit proefschrift inderdaad waar te zijn: als je enige gereedschap

een hamer is, zie je ieder probleem vanzelf als een spijker. Affectieve observatiesystemen schieten tekort wanneer de probleemoplossende kant van de huisartsgeneeskunde beschreven moet worden; instrumentele observatiesystemen blijken niet goed in staat de emotionele kant van de hulpverlening te beschrijven. Een intelligente mengvorm van beide systemen is noodzakelijk om het gedrag van de huisarts in zijn volle breedte en rijkdom te beschrijven. De door mij aangepaste versie van Roter's observatiesysteem blijkt zo'n gemengd systeem te zijn; het is in staat om een groot deel van de variatie in de kwaliteitsoordelen te verklaren, ongeacht of het gaat om de medisch-technische kwaliteit, de psychosociale kwaliteit, of de kwaliteit van de arts-patiënt relatie. Roter's observatiesysteem is in aanleg een instrumenteel systeem. Echter, in feite is er door een aantal aanpassingen een nieuw observatiesysteem ontstaan dat zowel de probleemoplossende als de (psycho)therapeutische kant van het werk van de huisarts belicht. Een belangrijk element in die aanpassingen is een onderscheid binnen het begrip 'affectief gedrag' tussen de 'sociale' component en de 'empathische' component. De sociale component verwijst uitsluitend naar het scheppen van een goede arts-patiënt relatie; de empathische component heeft daarnaast een belangrijke diagnostische en therapeutische functie in het consult. Ook de aanvulling van het verbale systeem met enkele globale (non-verbale) affectmaten, is belangrijk gebleken. Deze non-verbale globale affectmaten bleken krachtige voorspellers voor alle kwaliteitsoordelen van het onafhankelijke panel.

De positieve resultaten die het onderzoek met deze aangepaste versie van Roter's observatiesysteem hebben opgeleverd, mogen niet tot de conclusie leiden, dat dit observatiesysteem nu het 'Enige Echte Observatiesysteem' is. Met dit proefschrift is immers ook een bewijs geleverd voor de stelling dat iedere onderzoeksvraagstelling vraagt om een daarop toegesneden observatie-instrument. Een heel ander voorbeeld: wanneer men geïnteresseerd is in machtsproblemen in het medisch consult, of in de wijze waarop onderhandeld wordt tussen huisarts en patiënt, heeft men andere observatiesystemen nodig, dan wanneer men vooral geïnteresseerd is in de psychosociale hulpverlening van de arts.

### *Methodologische consequenties*

Een eerste belangrijke conclusie met betrekking tot de onderzoekstechnische kant van observatieonderzoek is, dat het sterk de voorkeur verdient om met video-materiaal te werken, en niet te volstaan met audio-opnamen. Video-materiaal maakt het mogelijk naast verbaal ook non-verbaal gedrag te bestuderen: het oogcontact tussen arts en patiënt, de aandacht die uit zijn houding spreekt, en alle subtiele signalen waarmee hij het gesprek een andere wending kan geven. Ook kan alleen zó bij een moment van stilte worden vastgesteld of de arts in zijn papieren zit te kijken, of dat de arts op die manier ruimte schept voor de patiënt om te vertellen wat hem dwars zit. De belangrijke rol die nonverbaal gedrag blijkt te vervullen bij alle kwaliteitsoordelen (óók de medisch-technische kwaliteit) rechtvaardigt een algemene aanbeveling voor het gebruik van videomateriaal bij observatie-onderzoek.

In het proefschrift worden ook enkele aanbevelingen gedaan voor het oplossen van problemen met betrekking tot de technische kant van de observatiesystemen en de wijze waarop ze geanalyseerd kunnen worden. Overigens zijn deze aanbevelingen vooral ook bedoeld als onderwerp van verder onderzoek.

### *Consequenties voor opleiding en nascholing*

Een goed gesprek is een belangrijke voorwaarde voor een goede hulpverlening. De huisarts moet in de eerste plaats in staat zijn een werkbare relatie met zijn patiënt op te bouwen. De kwaliteit van de arts-patiënt relatie blijkt in hoge mate van invloed op de tevredenheid van de patiënt. De kwaliteit van de arts-patiënt relatie wordt vooral bepaald door de interesse die de arts in zijn patiënt toont en de warmte die hij uitstraalt. Maar voordat we nu concluderen dat een 'goede' arts dus een 'warme' arts is zijn twee waarschuwingen op zijn plaats.

De eerste is, dat een goede arts-patiënt relatie niet automatisch betekent dat er ook goede zorg verleend wordt. Daar is meer voor nodig, zowel voor het leveren van goede medisch-technische zorg, als voor een goede psychosociale hulpverlening. Het eerder gemaakte onderscheid binnen het begrip 'affectief gedrag' is hier van belang: sociaal gedrag is alleen van belang voor het scheppen van een goede sfeer in het consult, en daarmee alleen voor de kwaliteit van de arts-patiënt relatie; empathie heeft daarnaast ook een belangrijke diagnostische en therapeutische functie in het consult. Met betrekking tot de kwaliteit van de psychosociale hulpverlening is bovendien aangetoond dat het weliswaar heel belangrijk is om aandachtig en empathisch te zijn, maar zeker niet voldoende. Voor een goede psychosociale hulpverlening zijn daarnaast allerlei instrumentele gedragingen van belang: stellen van psychosociale vragen, uitleg geven over de invloed van stress en emoties op ziekte en gezondheid, maar ook allerlei medisch-technische instrumentele gedragingen, zoals het geven van veel medische informatie. Dat laatste kan verklaard worden uit het feit dat patiënten, wanneer ze naar de dokter gaan, in feite twee soorten emoties hebben: *onzekerheid* (wat is er met me aan de hand? wat moet ik doen om weer beter te worden?) en *angst* (heb ik iets ergs? ik ga toch niet dood?). Een goede reactie op de eerste emotie is: medische informatie geven; vertellen wat er aan de hand is, en wat de beste behandeling daarvoor is. Om de angst van de patiënt goed te hanteren is daarentegen vooral affectief gedrag nodig. Bij somatiserende patiënten (dat zijn patiënten die vaak bij de huisarts op het spreekuur komen met allerlei vage lichamelijke klachten waarvoor geen oorzaak gevonden kan worden) is bovendien sprake van een extra complicatie. Het probleem van deze patiënten is, dat ze tegelijkertijd twee tegenstrijdige angsten hebben: de angst iets te mankeren, iets dat bovendien zo ingewikkeld is, dat geen enkele dokter het kan vinden; en daarnaast de angst dat ze *niets* mankeren, en dat de dokter hen als aansteller beschouwt. De huisarts wordt hierdoor in een paradoxale situatie gebracht, aangezien het ledigen van het ene type angst juist een versterking betekent van het andere type angst. Het is daarom niet voldoende de patiënt

simpelweg gerust te stellen. Een intelligente combinatie van affectieve en instrumentele gedragingen is hier waarschijnlijk het juiste antwoord. Naast empathie speelt het geven van medische informatie hierin in ieder geval een cruciale rol.

Hoe deze instrumentele en actieve gedragingen in de dagelijkse praktijk van de huisarts precies gecombineerd moeten worden kan niet alleen uit de psychologie worden geleerd. In de psychotherapie weten immers hulpverlener en hulpvrager beide op voorhand dat er gewerkt moet worden aan psychische problemen. In de huisartspraktijk is er altijd ook een lichamelijk probleem, en is het vaststellen van de relatieve invloed van beide juist een belangrijke opgave voor de huisarts. Een belangrijke aanbeveling van dit proefschrift is dan ook serieus te investeren in trainings- onderzoeks- en onderwijsprogramma's voor de ontwikkeling van specifieke psychosociale technieken die geschikt zijn voor de huisartspraktijk. De grote groep patiënten met psychosociale problemen in de huisartspraktijk en de nog grotere groep van somatiserende patiënten, die een aanzienlijk deel van de tijd van de huisarts in beslag nemen rechtvaardigt een dergelijke inspanning ten zeerste.

### *Consequenties voor het gezondheidszorgbeleid*

In de vorige paragraaf is aanbevolen extra te investeren in onderwijs- en onderzoeksprogramma's met betrekking tot de ontwikkeling van communicatievaardigheden die specifiek geschikt zijn voor de psychosociale hulpverlening en de hulpverlening aan somatiserende patiënten in de huisartspraktijk. Deze aanbeveling is uiteraard ook van belang voor het gezondheidszorgbeleid, met name bij het stellen van prioriteiten voor de besteding van onderzoeksgelden, en wellicht ook bij het bepalen van duur en inhoud van de beroepsopleiding tot huisarts. Daarnaast is het echter ook van belang aandacht te hebben voor de structurele en financiële randvoorwaarden waarbinnen de huisarts zijn werk moet verrichten. En hoewel het gebruikelijk is om bij beleidsaanbevelingen vooral voor veranderingen te pleiten, kan het soms geen kwaad om acht te slaan op het goede vaderlandse spreekwoord: "onderzoek alles, maar behoud het goede". In Amerika wordt met enige jaloezie gekeken naar (onder andere) het Nederlandse gezondheidszorgsysteem met zijn gelaagde structuur en zijn relatief sterke eerste lijnsgezondheidszorg. Ook waarschuwt men daar voor de invloed van de honoreringsstructuur op de wijze van hulpverlening. Wanneer artsen apart gehonoreerd worden voor het verrichten van allerlei technische ingrepen (zoals kleine chirurgie, zwachtelen en tapen, injecties, en dergelijke), krijgt het medisch consult daarmee automatisch een instrumenteler karakter, zoals goed te zien is in onder andere Duitsland, België en ook Amerika. Op dit moment is het Nederlandse honoreringssysteem voor de huisarts wat dit betreft gunstig te noemen: het abonnementssysteem voor ziekenfondspatiënten, en de huidige regeling voor particuliere patiënten waarbij (nagenoeg) alleen consulten en visites worden gedeclareerd zet geen premie op het verrichten van instrumentele handelingen. Uit de resultaten van dit proefschrift kan als aanbeveling worden geformuleerd, dat het bij onderhandelingen over een andere honoreringsstructuur voor huisartsen van belang is zich rekenschap te geven van de diagnostische en therapeutische waarde van 'het gesprek'. Wetende,

dat de hulpverlening aan patiënten met gezondheidsproblemen die naast lichamelijke ook psychosociale elementen bevatten veel voorkomen in de huisartspraktijk, maar bovendien de huisarts ook relatief veel tijd kosten (per consult en wat betreft het benodigde aantal consulten) zou het aanbeveling verdienen om deze verhoging van de werklast tot uiting te laten komen in de honoreringsstructuur van de huisarts.

### *Tevredenheid en kwaliteit van zorg*

In onderzoek naar arts-patiënt communicatie wordt de tevredenheid van de patiënt meestal als maatstaf genomen. In de literatuur over de medische opleiding is de beoordeling door collega's meestal het belangrijkste criterium, waaraan de kwaliteit van de verleende zorg wordt afgemeten. Dit proefschrift heeft, overigens in navolging van ander onderzoek, laten zien dat deze twee bronnen andere resultaten produceren. Er is nauwelijks een relatie tussen de tevredenheid van de patiënt en de beoordeelde kwaliteit op medisch-technisch gebied, en slechts een bescheiden relatie tussen de kwaliteit van de psychosociale hulpverlening en de tevredenheid van de patiënt. In feite hangt de tevredenheid van de patiënt vooral samen met het panel-oordeel over de kwaliteit van de arts-patiënt relatie.

Nu kan dit natuurlijk liggen aan de beperkte reikwijdte van de tevredenheidsschaal die in dit onderzoek is gebruikt, en dit moet zeker verder worden onderzocht. Het lijkt er echter op, dat ook naar aanvullende verklaringen gezocht moet worden, met name omdat ook in de literatuur dergelijke lage samenhangen worden aangetroffen. In het proefschrift worden verschillende mogelijke verklaringen gegeven voor het ontbreken van sterke samenhangen tussen de tevredenheid van de patiënt en de door het panel beoordeelde kwaliteit van de zorg. Elk van deze verklaringen leent zich voor verder onderzoek. Zo blijkt (hier, en eigenlijk in al het tevredenheidsonderzoek) dat patiënten in zijn algemeenheid uiterst tevreden zijn over hun huisarts. Meestal schommelt de score tussen 'tevreden' en 'zeer tevreden'. Dit zou kunnen betekenen dat de kleine verschillen in tevredenheid die gevonden worden, in feite meer zeggen over de antwoordtendenties van patiënten (met name de mate waarin men geneigd is in superlatieven te praten) dan over verschillen in het gedrag van de arts. Als dit het geval is, is het waarschijnlijk beter niet naar tevredenheid te kijken, maar juist naar *ontevredenheid*: naar de mate waarin van de norm wordt afgeweken.

Een tweede mogelijke verklaring is, dat patiënten hun huisarts niet zozeer beoordelen op hun concrete gedrag in dat ene consult, maar dat hun oordeel gebaseerd is op hoe hun huisarts zich meestal gedraagt. Wanneer hij het toevallig een keer wat druk heeft, en daardoor haastiger is dan anders, wordt dit hem niet meteen kwalijk genomen. De hoge samenhang tussen de tevredenheid van de patiënt en de beoordeelde arts-patiënt relatie geeft ook aan dat tevredenheid wellicht eerder een kenmerk is van de relatie tussen huisarts en patiënt dan van zijn specifieke gedrag in een enkel consult. De consequentie van een dergelijke gedachtengang is, dat er alleen een goed oordeel van de kwaliteit van een huisarts verkregen kan worden door naar veel consulten van dezelfde arts te kijken.



Een laatste verklaring vormt een combinatie van de beide vorige. Bij deze verklaring gaan we ervan uit dat de tevredenheid van de patiënt inderdaad een relatiekenmerk is, maar dan vooral een negatieve. De tevredenheid van de patiënt hangt vooral samen met maten die wijzen op een verstoorde communicatie: patiënten zijn ontevreden wanneer hun huisarts het vaak niet met hen eens is, wanneer hij geïrriteerd is, of zenuwachtig. Blijkbaar is er in die consulten iets mis. Waar twee vechten hebben twee schuld, en het is moeilijk op voorhand te bepalen wie het bij het rechte eind heeft, wanneer arts en patiënt van mening verschillen. De collega's zijn het blijkbaar meestal met de huisarts eens, want hun kwaliteitsoordeel over het medisch-technisch handelen vertoont juist een *positieve* samenhang met het aantal keren dat de huisarts het niet eens is met de patiënt. En dat is natuurlijk ook wel voorstelbaar: soms moet een huisarts wel een onaangename boodschap verkondigen, en patiënten zijn ook niet altijd zo maar bereid om hun leefwijze te veranderen ten bate van hun gezondheid. Soms ook dringen ze aan op een verwijzing naar een medisch specialist, terwijl dit uit het oogpunt van medische zorg niet strikt noodzakelijk is. Echter, er is natuurlijk ook sprake van een natuurlijk bondgenootschap tussen de huisarts en zijn collega's, en ook van een gemeenschappelijke cultuur. De geneeskunde moet nog wennen aan de toenemende mondigheid van de patiënt, en soms liggen de belangen ook werkelijk uiteen, waarbij het niet op voorhand duidelijk is welk belang het zwaarst moet/mag wegen. Twee dingen kunnen we hieruit leren. In de eerste plaats dat het voor huisartsen belangrijk is beter (dat wil zeggen professioneler) te leren omgaan met situaties waarin zij met hun patiënt van mening verschillen over de juiste aanpak van zijn gezondheidsprobleem. Bovendien lijkt het van belang een einde te maken aan de twee gescheiden circuits die er momenteel bestaan voor het onderzoek naar arts-patiënt communicatie en het medisch onderwijs. Met andere woorden: het is van belang bij onderzoek naar de kwaliteit van de hulpverlening niet alleen het oordeel van collega's als maatstaf te nemen, maar in ieder geval ook te kijken naar de tevredenheid van de patiënt. In onderzoek naar de communicatie tussen huisarts en patiënt is naast het oordeel van de patiënt ook het oordeel van deskundigen van belang. Alleen dan kan er sprake zijn van een integratie van de onderzoeksresultaten van beide werelden. Alleen dan kan er meer zicht ontstaan op de waarde en de grenzen van kwaliteitsoordelen uit verschillende bronnen die beschouwd kunnen worden als verschillende partijen in de gezondheidszorg.



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## Appendix 1

Profiles of the instrumental and affective consultation (see "Introduction")

	instrumental consultation	affective consultation
<b>Quality Measures (0-10)</b>		
- technical-medical	7.5	6.9
- psychosocial	6.8	8.0
- doctor-patient relationship	7.1	7.8
<b>Time Measures</b>		
- length consultation	13'22"	13'51"
- length physical examination	5'12"	0'39"
- GPs eye contact	6'38"	11'35"
- GPs speaking-time	3'06"	2'57"
- patient's speaking time	3'11"	7'42"
<b>Verbal Utterances (RIAS)</b>		
- affective	87	156
- instrumental	119	71
% medical	70%	28%
% psychosocial	-%	31%
% directions/instructions	25%	28%
% other	5%	13%
<b>Global Affect Measures (0-6)</b>		
- interest	5	5
- warmth	5	5
<b>Patient Satisfaction (0-5)</b>	3.67	3.50





## Appendix 2

### Observation and Registration forms

- |   |  |              |
|---|--|--------------|
| 3 | Room for the patient   |              |
|   | - observation form NIVEL   | page 209-211 |
|   | - registration form GP   | page 213     |
| 4 | Evaluation of an interview training course for general practitioners |              |
|   | - observation form NIVEL   | page 215-216 |
|   | - observation form Byrne & Long                                      | page 217-218 |
|   | - registration form GP   | page 219     |
| 5 | Doctor-patient communication and the quality of care                 |              |
|   | - observation form NIVEL   | page 221-224 |
|   | - instruction and observation form Assessment of Quality             | page 225-229 |
|   | - registration form GP   | page 231     |
|   | - registration form patient  | page 233-234 |
| 6 | Who is to say that it was a good consultation?                       |              |
|   | - observation form NIVEL   | page 221-224 |
|   | - instruction and observation form Assessment of Quality             | page 225-229 |
|   | - registration form GP   | page 231     |
|   | - registration form patient  | page 233-234 |
| 7 | Instrumental and affective aspects of doctor-patient communication   |              |
|   | - observation form NIVEL   | page 221-224 |
|   | - instruction and observation form Assessment of Quality             | page 225-229 |
|   | - registration form GP   | page 231     |
|   | - registration form patient  | page 233-234 |
|   | - observation form RIAS  | page 235-237 |



GP: ..... Tape: ..... Patient: ..... Time: ..... Counter: .....

Examination.....  
Conversation.....

**Consultation:** - number of patients .....  
- age .....  
- sex .....  
- symptoms presented as reason for consultation:  
somatic psychosocial mixed administrative social chat  
..... .....

- Number of complaints and/or signals (+ description) presented at the consultation:

	somatic	psychosocial	mixed	administrative	social chat
1. ....	.....	.....	.....	.....	.....
2. ....	.....	.....	.....	.....	.....
3. ....	.....	.....	.....	.....	.....
4. ....	.....	.....	.....	.....	.....
5. ....	.....	.....	.....	.....	.....
6. ....	.....	.....	.....	.....	.....
7. ....	.....	.....	.....	.....	.....
8. ....	.....	.....	.....	.....	.....

- Nature of the consultation: somatic / psychosocial / mixed / administrative / social chat

If psychosocial: at whose initiative is the psychosocial aspect dealt with

1. GP / patient
2. GP / patient
3. GP / patient
4. GP / patient

- Physical examination                   yes / no
- Referral                                    yes / no
- Repeat consultation                    yes / no

- Diagnosis GP:                            relative contribution:    1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_ 5

- Diagnosis observers:                    relative contribution:    1 \_\_\_ 2 \_\_\_ 3 \_\_\_ 4 \_\_\_ 5

Where 2 through 5, on what grounds?

- Verbal: .....
- Non-verbal: .....
- Own ideas: .....

- Style of behavior according to Byrne & Long

	somatic		psychosocial		mixed	
	diagnosis	therapy	diagnosis	therapy	diagnosis	therapy
1						
2						
3						
4						
5						
total						

		somatic	psycho-social	mixed	admini-strative	soc ch
<b>GP</b>						
I Passive utterances:	paraphrases	.....	.....	.....	.....	.....
	reflections	.....	.....	.....	.....	.....
	supporting remarks	.....	.....	.....	.....	.....
II Stimulating process variables:	getting started	.....	.....	.....	.....	.....
	persist in asking questions	.....	.....	.....	.....	.....
III Inhibiting process variables	attempt to interrupt	.....	.....	.....	.....	.....
	restrain	.....	.....	.....	.....	.....
	cut off	.....	.....	.....	.....	.....
IV Attentive behavior	Time administration:					
	direction of head/gaze	.....	.....	.....	.....	.....
	attitude	.....	.....	.....	.....	.....
	encouraging	.....	.....	.....	.....	.....
Obs:	direction of head/gaze	.....	.....	.....	.....	.....
	attitude	.....	.....	.....	.....	.....
	encouraging	.....	.....	.....	.....	.....
V Interest/concern						
-	1__ 2__ 3__ 4__ 5__ +	.....	.....	.....	.....	.....
VI Rushed						
-	1__ 2__ 3__ 4__ 5__ +	.....	.....	.....	.....	.....
<b>Patient</b>	Volubility:					
	number of starts	.....	.....	.....	.....	.....
	number of questions	(st.....)	(st.....)	(st.....)	(st.....)	(st.....)
	degree of continuous talk	.....	.....	.....	.....	.....
<b>Time:</b>	electronic device	Patient				
		GP	.....	.....	.....	.....
		total	.....	.....	.....	.....

Where the complaint or total complaints are (also) psychosocial assessed by the GP and/or observers

What is the treatment?

- I. The GP does not discuss the number of psychosocial aspects of the complaint
  - a. the GP is exclusively concerned with somatic aspects 
    - Impression of the observers:
    - 1. medical preference error
    - 2. avoidance behavior
  - b. the GP does not pick up the verbal cues, i.e.:  
(see also list of complaints) .....
  - c. the GP does not respond to the non-verbal cues, i.e.: .....
  - d. ....
  
- II. The GP responds to a number of psychosocial aspects of the complaint
  - a. somatic approach by means of medication (or referral to non-psychosocial careworker)
  - b. by means of conversation: 
    - as a confidant
    - calms patient
    - exploring
    - encourages insight
    - changes behavior
  - c. by means of advice
  - d. by means of referral to psychosocial careworker or institutions, i.e.:  
.....
  - e. by means of returning the problem to the patient



Registration form to be filled in by the GP

Additional information to the GP video tapes

Tape: ..... code number:..... age:.....

**Question 1**

Can you indicate on a 5-point scale whether psychosocial aspects also play a role in this (these) complaint(s) - in view of the background to the consultation as a whole, and if they do, to what extent in relationship to the somatic components?

- 1. In my opinion these complaint(s) are purely organic
- 2. In my opinion organic aspects contribute more to the totality of these complaints than the psychosocial aspects
- 3. In my opinion psychosocial aspects make an equal contribution with organic aspects to the totality of these complaints
- 4. In my opinion the psychosocial aspects contribute more to the totality of these complaint(s) than the organic aspects
- 5. In my opinion the totality of these complaints are psychosocial.

**Question 2**

Can you indicate your assessment on the seriousness of each of these complaints or signals presented by the patient?

Description of the complaint or cluster of complaints

	Seriousness of the complaint	
	Certainly not serious	Certainly very serious
1. ....	..... ..... ..... .....	..... ..... ..... .....
2. ....	..... ..... ..... .....	..... ..... ..... .....
3. ....	..... ..... ..... .....	..... ..... ..... .....
4. ....	..... ..... ..... .....	..... ..... ..... .....
5. ....	..... ..... ..... .....	..... ..... ..... .....

**Question 3**

(Assessment of own behavior)

How would you assess your own behavior during this consultation, taking account of your limits as GP

Minimal Optimal

|.....|.....|.....|.....|





GP: ...../ Round: ...../ Tape: ...../ Patient: ...../Counter: .....

**Consultation:** - number of patients .....  
 - age .....  
 - sex .....  
 - symptoms presented as reason for consultation:  
 somatic psychosocial mixed administrative social chat  
 ..... .....

- number of complaints and/or signals (+ description) presented at the consultation:

	somatic	psychosocial	mixed	administrative	social chat
1. ....	.....	.....	.....	.....	.....
2. ....	.....	.....	.....	.....	.....
3. ....	.....	.....	.....	.....	.....
4. ....	.....	.....	.....	.....	.....
5. ....	.....	.....	.....	.....	.....
6. ....	.....	.....	.....	.....	.....
7. ....	.....	.....	.....	.....	.....
8. ....	.....	.....	.....	.....	.....

- nature of the consultation: somatic / psychosocial / mixed / administrative / social chat

- physical examination yes/no      Seriousness of the complaint:  
 1 2 3 4 5 .....  
 - referral yes/no                      1 2 3 4 5 .....  
 1 2 3 4 5 .....  
 - repeat consultation yes/no        1 2 3 4 5 .....

interest/involvement  
 - 1 2 3 4 5 +

rushed relaxed  
 - 1 2 3 4 5 +

the assessment of GP behavior  
 - 1 2 3 4 5 +

attitude of GP  
 - 1 2 3 4 5 +

Relative contribution of diagnosis

GP: 1 2 3 4 5  
 observers: 1 2 3 4 5

**Patient:** volubility : number of starts .....  
 (st....) (st....) (st....) (st....) (st....) (st....)  
 number of questions .....  
 degree of continuous talk: .....

Time	electronic device	patient GP total						
			.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....	.....	.....	
.....	.....	.....	.....	.....	.....	.....	.....	
.....	.....	.....	.....	.....	.....	.....	.....	
.....	.....	.....	.....	.....	.....	.....	.....	
.....	.....	.....	.....	.....	.....	.....	.....	
.....	.....	.....	.....	.....	.....	.....	.....	

Where the complaint or total complaints are (also) assessed as psychosocial by GPs and/or observers

What is the treatment?

I. GP does not discuss the number of psychosocial aspects of the complaint

a. GP is exclusively concerned with somatic aspects

Impression of the observers:

1. medical preference error

2. avoidance behavior

b. GP does not respond to verbal cues, i.e.:  
(see also list of complaints) .....

c. GP does not respond to non-verbal cues, i.e.:  
.....

d. GP refers the patient for further physical examination

e. ....

II. The GP responds to a number of psychosocial aspects of the complaint

a. somatic approach:

1. medication

2. referral

(to non-psychosocial careworker)

b. by means of conversation:

- as a confidant

- calms patient

- supportive

- exploring

- encourages insight

- changes behavior

c. by means of advice

d. by means of referral to psychosocial careworker or institutions, i.e.:  
.....

c. by means of passing the problem back to the patient.

OBSERVATIONFORM BYRNE AND LONG

1 DIAGNOSTIC PHASE  
 2 PRESCRIBING PHASE

OBSERVER: GP:  
 TAPE: COUNTER:  
 PATIENT:

Doctor-centred behaviour	somatic		psycho social		mixed		admini- strative		social chat		value	
· Offering self												
· Relating to some previous experience												
· Direct question												
· Closed question												
· Self answering question (rhetorical)												
· Placing events in place/time/sequence												
· Correlational question												
· Clarifying												
· Doubting												
· Chastizing												
· Justifying other agencies												
· Criticizing other agencies												
· Challenging												
· Summarizing to close off												
· Repeating patient for affirmation												
· Suggesting												
· Apologizing												
· Miscellaneous professional noises												
· Directing												
· Giving information or opinion												
· Advizing												
· Direct terminating												
· Suggesting or accepting collaboration												

Patient-centred behaviour	somatic	psycho social	mixed	admini- strative	social chat	value
· Giving or seeking recognition						
· Offering observation						
· Broad question						
· Concealed question						
· Encouraging						
· Reflecting						
· Exploring						
· Answering patient questions						
· Accepting patient ideas						
· Using patient ideas						
· Offering of feeling						
· Accepting feeling						
· Using silence						
· Summarizing to open up						
· Seeking patient ideas						
· Reassuring						
· Indicating understanding						
· Indirect terminating						
· Pre-directional probing						
Negative behaviour						
· Rejecting patient offers						
· Reinforcing self position						
· Denying patient						
· Refusing patient ideas						
· Evading patient questions						
· Refusing to respond to feeling						
· Not listening						
· Confused noise						
TOTAL						

Registration form to be filled in by the GP

Additional information to the GP video tapes

Tape: ..... code number: ..... age: .....

**Question 1**

Can you indicate on a 5-point scale whether psychosocial aspects also play a role in this (these) complaint(s) - in view of the background to the consultation as a whole, and if they do, to what extent in relationship to the somatic components?

- 1. In my opinion these complaint(s) are purely organic
- 2. In my opinion organic aspects contribute more to the totality of these complaints than the psychosocial aspects
- 3. In my opinion psychosocial aspects make an equal contribution with organic aspects to the totality of these complaints
- 4. In my opinion the psychosocial aspects contribute more to the totality of these complaint(s) than the organic aspects
- 5. In my opinion the totality of these complaints are psychosocial.

**Question 2**

Can you indicate your assessment on the seriousness of each of these complaints or signals presented by the patient?

Description of the complaint or cluster of complaints

Seriousness of the complaint  
Certainly not serious      Certainly very serious

1. ....	..... ..... ..... .....
2. ....	..... ..... ..... .....
3. ....	..... ..... ..... .....
4. ....	..... ..... ..... .....
5. ....	..... ..... ..... .....

**Question 3**

(Assessment of own behavior)

How would you assess your own behavior during this consultation, taking account of your limits as GP

Minimal                                      Optimal

|.....|.....|.....|.....|



Observer: ..... Tape: ..... Number of patients: .....  
 GP: ..... Counter: ..... Age: ...../...../.....  
 Consultation number: ..... Sex: ...../...../.....

	cnr	complaints	RFE	gp/p	p/s		cnr	complaints	RFE	gp/p	p/s
1						7					
2						8					
3						9					
4						10					
5						11					
6						12					

Relation somatic-psychosocial during the entire consultation

Purely somatic    1                    2                    3                    4                    5                    Purely psychosocial

Assessment of the cluster of complaints according to the observers

Assessment of the systematic approach

	Assessment of the cluster of complaints according to the observers						Elucidation of the problem			Defining the problem			Plan		
	1	2	3	4	5	6	yes	no	n/a	yes	no	n/a	yes	no	n/a
1:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are several complaints approached in sequence    yes    no    n/a    in part  
           

Assessment of patient centeredness:

	Problem elucidation/Definition						Treatment					
	1	2	3	4	5	n/a	1	2	3	4	5	n/a
1:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Total time	<input type="text"/>			
Time off screen	<input type="text"/>			
Time on screen	<input type="text"/>			
	Duration	Speaking time GP	Speaking time patient	Looking time
- Somatic fragments	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
- Psychosocial fragments	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
- Mixed fragments	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
- Administrative fragments	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
- Social chat	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
- Elucidation of the problem	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Somatic	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Psychosocial	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Where the complaint or total complaints are (also) assessed as psychosocial by GP and/or observers.

What is the treatment?

I. GP does not respond to a number of the psychosocial aspects of the complaint

- a. GP responds exclusively to the somatic aspects
- b. GP does not respond to verbal cues, i.e.:  
(see also list of complaints)
- c. GP does not respond to non-verbal cues, i.e.:  
.....
- d. GP refers patient for further physical examination
- e. ....

II. GP responds to a number of psychosocial aspects of the complaint

- a. somatic approach:

  - 1. by means of medication
  - 2. by means of referral   
(to non psychosocial careworker)

- b. by means of conversation:

  - as a confidant
  - calms the patient
  - supportive
  - exploring
  - encourages insight
  - changes behavior

- c. by means of advice
- d. by means of referral to psychosocial careworker or institutions, i.e.:  
.....
- e. by means of passing the problem back to the patient.



	somatic	psychosocial	mixed
interest/involvement 1 2 3 4 5			
Looking + 0 -			
Following utterances (reflections, using silence, communicating empathy, communicating understanding, supportive remarks) as far as they have a process like character.			
Utterances* which encourage patients to talk: encouraging, persisting with questions, guiding			
Utterances** that introduce topics			
Utterances which request information from the patient in which the GP determines the broad outlines: history, closed questions			
Utterances that inhibit the patient: interruptions, negations, cutting off			

\* develops an existing topic

\*\* aims at new topic

The topics/signals presented in the consultation per fragment

somatic

psychosocial

mixed

administrative

social chat

--	--	--	--	--

## **Observational research on assessment of quality**

The investigation in which you are participating concerns the assessment of the quality of the work of GPs in 100 video consultations.

This research is part of a larger project. The aim of the larger project is expressly not explained to you beforehand; because, in this assessment, we are concerned with your personal opinion and this should in no way be influenced by the researchers or manipulated by them.

The 100 video consultations which you are going to see come from 30 GPs who have made the material available for research purposes. You will understand that both in respect of GPs and the patients, confidentiality is essential. You must therefore, as a requirement of participation in this research project, state in writing that you undertake to maintain this confidentiality.

The consultations share the fact that blood pressure is always taken or that they involve the problem of hypertension. In some cases this is the only problem, but it is often related to many other problems.

Please give an assessment of the total consultation.

In the explanatory information we explain precisely how this is to be done.

You will not be given the background and history of the patients in the video consultations. Although, especially in the beginning, you will find this frustrating it is not important in the context of this particular investigation. You will see that, after watching the consultation, you retain a general impression and it is this general impression that concerns us here.

The general impression does not indicate what was good or bad in the consultation; that is not necessary because these aspects have already been 'measured' in a larger project in a much more concrete way. Our current requirement, as a supplement to the data is to form a general intuitive impression of the total consultation.

You should watch the consultation once and immediately afterwards give your assessment on the observation forms.

Do not weaken your spontaneous impression or add nuances, but rely on your assessment and your own feelings.

We wish you success.

## **Explanatory information on the assessment of quality**

There are no fixed criteria for good and bad treatment in terms of general practice behavior in the Netherlands and perhaps there never will be. Patients differ too much from one another and there is too little consensus on the need for and effect of various treatments.

To an increasing degree however views and assumptions about good care in general practice have been formulated on the basis of research results or from test projects or protocol development.

A number of these views are given below.

They relate to 3 aspects of care of which we would like your assessments:

- the technical-medical behavior;
- psychosocial behavior;
- the doctor-patient relationship.

These three aspects are explained afterwards.

You should read this explanatory information once or twice carefully and then put it aside when you start your observation. The explanatory material is not intended for use as a checklist when you are making your assessment, because we do not want you to focus on one or two presented issues. We are concerned with your own personal total impression of the consultation.

The procedure is as follows:

View a consultation once and then immediately fill in three assessments on the observation form (on technical-medical behavior, psychosocial behavior, doctor-patient relationship)

Your assessment will be expressed in ordinary numerical school grades from 0 through 10.

Remember we are relying on your judgment. Please do not weaken it.

### **Technical-medical behavior**

Technical-medical behavior refers to the activities and decisions that the doctor takes in his professional role. The concern here is whether his behavior vis à vis the health problem is responsible from a medical and technical-medical point of view.

The GP should carry out all the activities that are required for this health problem and avoid unnecessary activities.

The risk of damage to the patient must be kept as small as possible and the doctor should be as alert to incorrectly stating a patient is healthy as to incorrectly stating that a patient is sick.

As regards blood pressure, the following activities are considered necessary in every consultation (source: NUHI protocol.)

- History: Always ask after the patient's health and allow for questions. In the case of use of medication, talk about taking the medicine and any complaints.
- Physical research: Always take blood pressure. Weigh patient in the case of obesity and in the case of B-blokker medication take the patient's pulse.
- Therapy: The lowest effective dose should be used. Diastolic pressure should be < 100 and preferably <90 mmHg (with patients above 65 diast. <110 and syst. <180 mmHg).
- Referrals: In the case of inadequate response to an adequate therapy, when suspecting organic damage and in case of manifest complaints relating to vision.
- Return visits: Concrete follow-up appointments should be made. Where there is a responsive attitude after  $\pm$  3 months, in other cases within 6 weeks.

### **Psychosocial behavior**

This refers to being responsive and paying attention to the non-somatic aspects relating to the complaint. It involves not only psychosocial problems, but the background to the complaint and the problems which can be caused by it.

The GP should approach the non-somatic side in an adequate manner and respond to direct and indirect signals given by the patient. He can also attempt to raise psychosocial problems on his own initiative if he suspects that these cause the complaint, sustain it or impede recovery.

Standards for non-somatic consultations have (not) yet been developed. Sometimes support, consolation and putting the patient at ease are appropriate, on other occasions the consultation should be directed at exploring or changing behavior or giving the patient insight into the relationship between somatic complaints and psychological problems.

Finally the doctor should be aware of the incorrect or unnecessary psychologization of the complaints.

### **Doctor-patient relationship**

This aspect is concerned exclusively with the way in which the GP deals with the patient. There must be mutual confidence and understanding between the doctor and the patient and the GP must be seen as receptive to the patient's fears and anxieties.

The patient must feel that he is being taken seriously and that, with due respect to the difference in expertise, he has adequate opportunity to ventilate his own experience of the problem and for his own contribution to the consultation.

In short, the GP has to create an open and safe working relationship with the patient.

### **Explanation of general orientation of the doctor**

As you are undoubtedly aware, there are great differences between GPs in their interpretation and treatment of complaints.

In part, this comes from differences in views about health and sickness, on the sources and consequences of sickness, on treatment, etc. In brief, one can speak of different GP orientations. The second part of the observation form concerns these orientations.

The following 7 dimensions on which GPs (among others) may differ are mentioned on the observation form:

- 1 Is the GP concerned with 'care' or 'cure'?
- 2 Does he have a natural science or a behavioral science orientation in respect of somatic complaints?
- 3 Does he express preference for a businesslike or a personal relationship with the patient?
- 4 Is this a doctor who is not afraid to take risks or does he always play safe?
- 5 Is the GP patient-oriented or complaint-oriented?
- 6 Is his orientation in respect of the psychological problems biological (medication) or more psychotherapeutic (talk)?
- 7 Is the GP oriented more towards maintenance or intervention?

We know what the video doctors think about these dimensions from questionnaire that they filled in.

What we now want to know is whether these views are reflected in the GP's methods.

Please assess the GP on these 7 dimensions and indicate what is the most applicable.

We are concerned with fairly abstract concepts on which everyone has his own ideas and that is precisely why we use this scale.

Our interest is in the general first impression which you retain from the consultation. Do not think too long about it and complete the list quickly after you have seen the consultation.

Observation form Assessment of Quality

No. panel-judge

Tape :  
 Counter :  
 Consultation :

1. Please, express your general opinion of the quality of care:

- technical-medical	0	1	2	3	4	5	6	7	8	9	10
- psychological	0	1	2	3	4	5	6	7	8	9	10
- GP-patient relationship	0	1	2	3	4	5	6	7	8	9	10

2. Please, express your opinion of the general orientation of the GP

- Is the GP care-oriented or cure-oriented?      care      \_\_\_\_\_      cure
- Is the GP oriented to the natural sciences or to the behavioral sciences?      natural sciences      \_\_\_\_\_      behavioral sciences
- Is the GP's approach businesslike or personal?      business-like      \_\_\_\_\_      personal
- Is the GP's playing safe, or prepared to run risks?      playing safe      \_\_\_\_\_      running risks
- Is the GP patient-centered or disease-centered?      patient-centered      \_\_\_\_\_      disease-centered
- Is the GP-s approach biological or psychotherapeutic?      biological      \_\_\_\_\_      psychotherapeutic
- Is the GP maintenance-oriented or intervention-oriented?      main-tenance      \_\_\_\_\_      intervention

Remarks:





Registration form GP

Type of consultation		AGE / SEX									
<input type="checkbox"/> FIRST	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="padding: 2px;">patient 1</td><td style="padding: 2px;">/</td></tr> <tr><td style="padding: 2px;">patient 2</td><td style="padding: 2px;">/</td></tr> <tr><td style="padding: 2px;">patient 3</td><td style="padding: 2px;">/</td></tr> <tr><td style="padding: 2px;">patient 4</td><td style="padding: 2px;">/</td></tr> </table>			patient 1	/	patient 2	/	patient 3	/	patient 4	/
patient 1				/							
patient 2	/										
patient 3	/										
patient 4	/										
<input type="checkbox"/> REPEAT											

(PROBABLE) DIAGNOSIS	VISIT		COMPLAINT						
	NECESSARY	UNNECESSARY	PURELY SOMATIC	SOMATIC WITH PSYCHO-SOCIAL CO-PROBLEMS	SOMATIC WITH PSYCHO-SOCIAL AETIOLOGY	PSYCHOSOCIAL WITH SOMATIC AETIOLOGY	PSYCHOSOCIAL WITH SOMATIC CO-PROBLEMS	PURE PSYCHOSOCIAL	PATIENT*
1.									
2.									
3.									
4.									

\* Patientnumber (if more than one)

General evaluation of the patient's complaints in the context of the consultation.

purely somatic	1	2	3	4	5	purely psychosocial
----------------	---	---	---	---	---	---------------------

	never	seldom	some-times	often	always		
general evaluation of the patient	straight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	straight
	independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	independent
	cooperative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cooperative
	realistic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	realistic
	nagging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nagging
	somatizing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	somatizing



Patient registration form

Dear Sir, Madam,

The Netherlands Institute of General Practitioners in Utrecht conducts a study on patients' opinions about illness, health and the position of the general practitioner.

We ask you to complete the questions mentioned below by ticking the answers you most agree with.

Your GP gave his/her consent for this study but he will not know the answers. Your reaction will be processed anonymously as will be the videotapes.

We thank you in advance for your co-operation.

Did you find the doctor interested in your problems and symptoms?  
 very interested  
 interested  
 neutral  
 not interested  
 very interested

How much time had the doctor for your problems and symptoms?  
 very much time  
 much time  
 sufficient time  
 little time  
 very little time

	never	seldom	sometimes	often	always
1. My doctor knows exactly what is wrong	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. My doctor keeps his patients at a distance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. My doctor is interested in me as a person	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. My doctor is good at handling problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. My doctor talks about non-medical problems as well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. My doctor allows enough time for me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The following cases indicate situations in which one person would consult his doctor, whereas another would prefer to consult someone else (e.g. social worker, priest or teacher) and yet another would not seek help.

Where do you think that it is a job for the GP?



















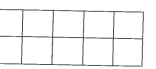






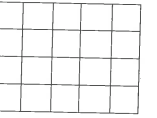
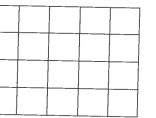
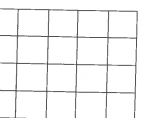
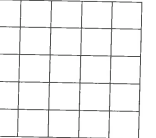
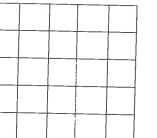
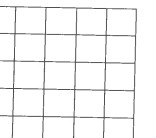
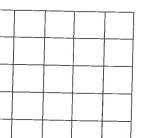
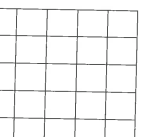
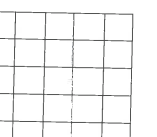
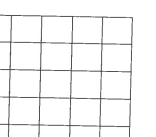
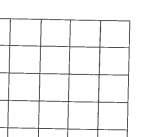
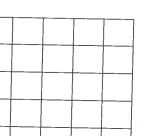
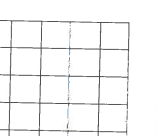
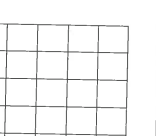
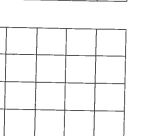

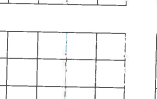
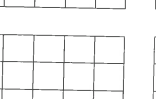
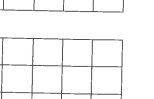


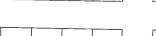
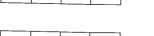


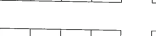
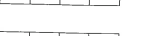
*Answer the question by putting a cross in the circles provided*

	GP	no GP
A person has problems with bringing up a nine year old boy. Who can give good advice on this?	<input type="radio"/>	<input type="radio"/>
Serious problems have arisen in a three-year-old marriage. Who is the best source of help?	<input type="radio"/>	<input type="radio"/>
A retired couple would actually be better off in an old people's home. Who can help?	<input type="radio"/>	<input type="radio"/>
Someone feels very lonely. Whom can he turn to?	<input type="radio"/>	<input type="radio"/>
A woman with five young children has a breakdown and needs help with the housework. Whom can she turn to?	<input type="radio"/>	<input type="radio"/>
Who can best help a patient in the last few weeks of his life?	<input type="radio"/>	<input type="radio"/>
Who is the best person to give children sex education when the parents feel themselves unable to do so?	<input type="radio"/>	<input type="radio"/>

Observation form  
Roter's Interaction Analysis System (RIAS)

Date : \_\_\_\_\_  
No. GP : \_\_\_\_\_  
No. patient : \_\_\_\_\_  
No. tape : \_\_\_\_\_  
Counter : \_\_\_\_\_  
Observer : \_\_\_\_\_  
No. of pages: \_\_\_\_\_

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Personal Joke/Laughs Approve/Compl.				
Agree				
Para Empathy				
Concern/worry Reass./Optim. Legitim Partnership				
Disagree ?Reassure				
Transition				
Orient/Instruct Bids ?Understand ?Opinion				
(?)Med (?)Thera (?)Life (?)Feelings (?)Other				
?Med ?Thera ?Life ?Feelings ?Other				
Gives-Med Gives-Thera Gives-Life Gives-Feelings Gives-Other				
C-Med/Thera C-Life C-Feelings				
?Medication				
Unintelligible				

Time Category	total	
	GP	patient
Personal		
Joke/Laughs		
Approve/Compl.		
Agree		
Para		
Empathy		
Concern/worry		
Reass./Optim.		
Legitim		
Partnership		
Disagree		
?Reassure		
Transition		
Orient/Instruct		
Bids		
?Understand		
?Opinion		
(?)Med		
(?)Thera		
(?)Life		
(?)Feelings		
(?)Other		
?Med		
?Thera		
?Life		
?Feelings		
?Other		
Gives-Med		
Gives-Thera		
Gives-Life		
Gives-Feelings		
Gives-Other		
C-Med/Thera		
C-Life		
C-Feelings		
?Medication		
Unintelligible		

Global Affect Rates

General Practitioner

Anger/irritation	1	2	3	4	5	6
Anxiety/nervousness	1	2	3	4	5	6
Dominance/assertivity	1	2	3	4	5	6
Interest/concern	1	2	3	4	5	6
Warmth/friendliness	1	2	3	4	5	6

Patient

Anger/irritation	1	2	3	4	5	6
Anxiety/nervousness	1	2	3	4	5	6
Dominance/assertivity	1	2	3	4	5	6
Interest/concern	1	2	3	4	5	6
Warmth/friendliness	1	2	3	4	5	6

Remarks:





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## Dankwoord

De verraderlijke wijze waarop het menselijk geheugen werkt doet gemakkelijk onrecht aan diegenen die in de beginperiode van een onderzoek een waardevolle rol hebben gespeeld; de herinnering wordt bijna automatisch gekleurd door hen die in de laatste, hectische periode hun bijdrage hebben geleverd aan de totstandkoming van het eindprodukt. Ik zal niet kunnen ontsnappen aan deze algemene wetmatigheid. Gelukkig verkeer ik in de bijzondere en aangename situatie dat veel van de werkers-van-het-eerste-uur ook nu nog in mijn directe omgeving verkeren.

Wie daar, helaas, niet meer bij is, is Chris Bruins, directeur van het Nederlands Huisartsen Instituut op het moment dat ik daar in dienst trad. Zijn enthousiasme voor de eerste lijn heeft zijn sporen onuitwisbaar in mij nagelaten. Zijn geloof in mijn kunnen heeft voor een belangrijk deel bepaald wat ik kon. Zijn invloed op mij is groot geweest.

Uit diezelfde periode dateren de eerste contacten met mijn beide promotoren Prof. Dr. F. Verhage en Prof. Dr. H.J. Dokter. Toen reeds stimuleerden zij mij om het onderzoek dat ik deed te verzilveren in een proefschrift; een gedachte die ik lange tijd heb weggewimpeld. Ik waardeer het zeer dat zij zo vasthoudend zijn geweest, en dat zij - toen ik jaren later alsnog met promotieplannen bij hen kwam - met een nog even positieve houding bereid waren als promotor te fungeren. Ik ben speciaal blij met Frans Verhage en Heert Dokter als promotoren omdat zij niet gevoelig bleken voor grillige modes, maar door de jaren heen in woord en geschrift trouw zijn gebleven aan wat ik beschouw als de kern van de huisartsgeneeskunde: het interpersoonlijk contact tussen huisarts en patiënt.

De referenten, prof. Dr. E. van der Does en Prof Dr. R.W. Trijsburg, wil ik bedanken voor de zorgvuldige wijze waarop zij het manuscript hebben doorgenomen, en voor de geanimeerde discussies die hier het resultaat van waren.

Een groep die een speciale plaats in dit Dankwoord verdient is de groep huisartsen die aan het onderzoek heeft meegewerkt. Door zich open te stellen voor een zo indringende wijze van onderzoek als video-observaties van hun spreekuurconsulten hebben zij zich kwetsbaar opgesteld. Ik heb dat zeer gewaardeerd. Ik denk ook dat de huisartsgeneeskunde in Nederland op zo'n hoog peil staat, juist omdat de beroepsgroep huisartsen bereid is zich steeds opnieuw toetsbaar op te stellen. Dat is een compliment meer dan waard. Veel andere beroepsgroepen zouden hier een

voorbeeld aan mogen nemen. Dat daarnaast de ontvangst in veel huisartspraktijken zo warm en gastvrij was, was een bijkomend genoegen, dat ik mij altijd goed (soms letterlijk!) heb laten smaken.

Ook wil ik het panel huisartsen bedanken dat de kwaliteitsbeoordeling gedaan heeft van een aantal op video opgenomen consulten. Zij hebben een belangrijke huisartsgeneeskundige inbreng in mijn onderzoek gegeven.

Onderzoek te mogen verrichten binnen een wetenschappelijke organisatie als het NIVEL beschouw ik als een voorrecht. Ik heb in de loop der jaren alle posities binnen het NIVEL bekleed, alle collegiale en hiërarchische relaties gekend. Ze hebben alle een speciale en positief gekleurde betekenis voor mij.

Het Bestuur van het NIVEL wil ik bedanken voor de ruimte die mij gegeven is voor de afronding van mijn proefschrift, maar ook voor de wijze, waarop het door de jaren heen invulling heeft gegeven aan de besturing van het NIVEL als professionele organisatie; een invulling die ik zou willen karakteriseren als 'gedistantieerde betrokkenheid'. U was er wanneer het nodig was, en dat is een goede zaak.

Het Managementteam heeft gedurende een lange periode geruisloos mijn taken behartigd. Dat is te meer bijzonder daar voor de meeste van hen wetenschappelijk werk prioriteit geniet boven regel- en organisatiewerk. Jouke van der Zee, als waarnemend directeur, Peter Groenewegen, Titus de Jong, en - in de laatste fase - Peter Verhaak wil ik danken voor het feit dat ik zonder schuldgevoelens aan mijn proefschrift heb kunnen werken. Het behoeft geen uitleg dat zonder Jouke mijn proefschrift niet mogelijk was geweest.

De onderzoekersvergadering was - zoals voor iedereen van het NIVEL - het collegiale forum waar al mijn onderzoeksplannen en conceptpublicaties op een kritisch-constructieve reactie konden rekenen. Het multi-disciplinaire karakter daarvan heeft mij bewust gemaakt van eigen blinde vlekken, die ontstaan wanneer men lange tijd met één onderwerp bezig is. Het heeft, hoop ik, ook gezorgd voor een evenwicht tussen de wetenschappelijkheid en de toepasbaarheid van mijn onderzoek.

Enkele mensen wil ik speciaal danken voor hun bijdrage aan mijn onderzoek: in de allereerste plaats Peter Verhaak en Emmy Sluijs, beiden als leerling bij mij begonnen, beiden inmiddels uitgegroeid tot zelfstandige, en begaafde onderzoekers. Peter waardeer ik om de scherpzinnige wijze waarop hij de zwakke plekken in een redenering kon blootleggen; Emmy vanwege de consciëntieuze, en altijd opbouwende kritiek, en voor haar merkbare aanwezigheid op momenten waarin dat nodig was. Ook Jouke van der Zee is altijd een van mijn vaste critici geweest. Startend met de opmerking dat hij geen verstand had van het onderwerp maakte hij altijd de meest verstandige opmerkingen. Onze relatie is ook in wetenschappelijk opzicht vruchtbaar gebleken.

Met genoegen zal ik ook terugdenken aan de samenwerking met Johan Dronkers, freelancende duizendpoot, die het meest saaie deel van het observatiewerk heeft

gedaan en dat met grote zorgvuldigheid en humor deed; met hem heb ik ook het meeste ongecompliceerde plezier gehad. Marleen Duister dank ik voor het enige deel van het werk dat ik echt niet zelf had kunnen doen: het zorgen dat uit de database de juiste en correcte databestanden gereed kwamen voor analyse. Sietske de Boer heeft in de korte tijd dat zij assistent-onderzoeker van de videotheek is veel nuttig werk verricht.

Ik heb veel gehad aan de medewerkers van de bibliotheek, die altijd bereid waren om met spoed (want zo gaat dat) publikaties uit alle delen van de wereld voor mij op te vragen. Alma de Leeuw heeft de literatuurreferenties gecontroleerd, opdat ook de lezers van mijn proefschrift deze publikaties gemakkelijk kunnen vinden. Dank daarvoor.

De omslag en vormgeving van het boek zijn ontworpen door Andries Harshagen, die zijn ervaring als grafisch ontwerper en echtgenoot van mijn huisarts heeft weten te combineren tot een mooi produkt. Hij kan prachtig vertellen hoe de omslag de communicatie tussen huisarts en patiënt weerspiegelt. Bernadette Kamphuys heeft het typewerk voor haar rekening genomen en met gevoel voor detail alle afzonderlijke manuscripten tot een geheel gemaakt; Peter Verhaak heeft de ondankbare taak op zich genomen de laatste tekstcorrecties te verzorgen, waarbij hij het zelfs klaarspeelde de indruk te wekken dat hij het heel leuk vond om dat te doen. Dat het boek uiteindelijk op tijd en in deze vorm gereed is gekomen is aan deze drie mensen te danken.

Als mijn Engels ook voor buitenlanders begrijpelijk is, is dat te danken aan Stafford Wadsworth die alle teksten nauwgezet heeft gecorrigeerd of - voor zover deze oorspronkelijk in het Nederlands zijn gepubliceerd - vertaald.

Tenslotte: ik zou de inhoud van mijn proefschrift geweld aandoen wanneer ik in mijn dankwoord alleen aandacht zou hebben voor de instrumentele ondersteuning bij de produktie van mijn proefschrift. De affectieve kant is minstens zo belangrijk. Dat heb ik ondervonden bij alle medewerkers die ik tot nu toe heb genoemd: het was en is een goed team om in te werken. Dat heb ik ook ondervonden bij Lenie Jurrius, hoofd huishouding van het NIVEL, die mij regelmatig verwende met zelfgemaakte soep en andere lekkere hapjes. Vaak was het zowel op het NIVEL als thuis te druk om geconcentreerd te kunnen werken. Ik heb dan met genoeg gebruik gemaakt van mijn onderduikadres in Zaltbommel, waar de studeerkamer van Mieke Stumpel altijd voor mij klaar stond. Ook de stationsrestaurant van Geldermalsen, en mijn oude studeerkamer in mijn oude ouderlijk huis hebben regelmatig eenzelfde functie voor mij vervuld. Tot slot wil ik ook met nadruk Sjaan van der Meijden noemen die al vanaf de geboorte voor onze kinderen Egbert en Sophie zorgt met een gouden combinatie van nuchterheid en warmte. Zij heeft er met name voor gezorgd dat ik niet in de valkuil ben gevallen van veel werkende moeders: je op beide fronten schuldig voelen; ik ben de afgelopen jaren op beide fronten gelukkig geweest. En uit veel dankwoorden bij proefschriften blijkt dat ik daarin bevoorrecht ben.



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## *Curriculum vitae*

Jozien Bensing werd op 12 maart 1950 in Tilburg geboren. In 1967 behaalde zij het einddiploma gymnasium bèta aan het Theresialyceum in Tilburg. Daarna ging zij psychologie studeren aan de Rijks Universiteit van Utrecht, waar zij in 1975 het doctoraalexamen klinische psychologie behaalde. De studie werd gedurende een jaar onderbroken voor het bestuurslidmaatschap van de studentenvereniging C.S. Veritas. Tijdens haar studie verrichtte zij een aantal studentassistentschappen, op het gebied van zowel onderwijs als onderzoek.

Sinds 1974 is zij werkzaam bij het Nederlands Huisartsen Instituut (NHI), en zijn rechtsopvolger: het Nederlands Instituut voor Onderzoek van de Eerstelijnsgezondheidszorg (NIVEL). Aanvankelijk werd zij aangesteld als onderzoeker naar de psychosociale hulpverlening van de huisarts. In 1979 werd zij benoemd tot hoofd van de afdeling Wetenschappelijk Onderzoek; in 1984 volgde een aanstelling als waarnemend directeur. Sinds 1985 is zij algemeen directeur van het NIVEL. In 1989 en 1990 is zij door het Bestuur van het NIVEL vrijgesteld van managementtaken, onder andere om dit proefschrift te kunnen voltooien.

Het onderzoek waarop dit proefschrift is gebaseerd maakt deel uit van een langlopend onderzoekprogramma naar arts-patiënt communicatie en de psychosociale hulpverlening van de huisarts. Het fundament hiervoor is gelegd in de beginperiode van de auteur bij het NHI, toen zij begon met de aanleg van een collectie videobanden van huisarts-patiënt gesprekken, die door de jaren heen steeds verder is uitgebouwd en tot op heden bewaard is gebleven. Deze collectie video-banden is onderwerp (geweest) van veel publikaties van de auteur en haar collega's. Dit proefschrift is daar een voorbeeld van.

