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Journal website	http://www.jfponline.com/Pages.asp?AID=5148
Pubmed link	http://www.ncbi.nlm.nih.gov/sites/entrez?Db=pubmed&Cmd=ShowDetailView&TermToSearch=17605949&ordinalpos=1&itool=EntrezSystem2.PEntrez.Pubmed.ResultsPanel.Pubmed_RVDocSum
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Do our talks with patients meet their expectations? Yes, for the most part they do. Results of this study, however, reveal specific areas that require greater attention.

ATIE VAN DEN BRINK-MUINEN, PHD¹

ALEXANDRA M. VAN DULMEN, PHD¹

HANS P. JUNG, MD, PHD²

JOZIEN M. BENSING, MD, PHD³

¹NIVEL (Netherlands Institute for Health Services Research), Utrecht, The Netherlands

²Centre for Quality of Care Research, Nijmegen University and Maastricht University, The Netherlands

³NIVEL; and the Department of Health Psychology, Utrecht University, The Netherlands

Address for correspondence
A. van den Brink-Muinen, Ph.D.
NIVEL
P.O. Box 1568
3500 BN Utrecht
The Netherlands
Tel. +31 (0)30 2729639
E-mail a.vandenbrink@nivel.nl

PRACTICE RECOMMENDATIONS

- Patients want an attentive, friendly, frank and empathic doctor who listens well
- To enhance quality of health care, consider asking patients at the end of a visit whether their communication preferences were met

One physician essayist said that good patient-doctor communication, like jazz, calls for improvisation.¹ We agree. And improvise we must when patients' expectations for how physicians will communicate with them vary with the reason for their visit and with individual characteristics. For example, those who are ill may prefer that their doctor communicate with them in a way that is less important to those who are healthy. Patients with biomedical problems may have different preferences than persons with psychosocial problems. And older persons may have communication desires that differ from those who are younger.²⁻⁴

DO PATIENTS WANT CURE OR CARE, OR BOTH?

Depending on the reason for a visit—eg, biomedical or psychosocial—preferences may fit either the cure or the care dimension.

Cure dimension. On one hand, patients expect their doctor to be task oriented and to find a cure for what ails them. They want an explanation of what is wrong and advice about possible treatments, and they want the doctor to do whatever is needed to get answers.⁵

Care dimension. On the other hand, patients may feel anxious and want help or reassurance. They expect the doctor to listen to their story and allow them to disclose all health problems, concerns, and worries. They also expect friendliness and empathy. They want to be taken seriously. The extent to which the doctor shows this *affect-oriented* (and patient-centered) behavior will determine how fulfilled patients feel in their preference for care.^{6,7}

Why does it matter? Good communication serves a patient's need to understand and to be understood.^{6,8,9} And communication aimed at matching patient preferences enhances satisfaction with care, compliance with medical instructions, and health status.¹⁰⁻¹³

How well do we assess patients' communication preferences?

Patient-centered behavior is a necessary tool for discovering and fulfilling patients' task-oriented (cure dimension) and affect-oriented (care dimension) communication preferences.¹⁴⁻¹⁷ It's important to know how well primary-care physicians interpret patients' preferences for clinical encounters and if they respond in a manner that satisfies those expectations.

Reassuringly, patients indicate on surveys that their physicians do a fairly good job of interpreting their communication preferences and acting accordingly.¹⁸⁻²⁰ They also report that their desires and expectations from consultations are increasingly met.

There is always the worry, though, that physicians in certain practice positions—eg, non-gatekeeper roles or positions involving only part-time clinical responsibilities—would be challenged to assess patient preferences as accurately as others.²¹

The aim of our study

While it's encouraging that GPs by and large understand their patients and communicate with them meaningfully, we wondered whether communication could improve further. Our purpose in this study was to gain detailed insight into patients' specific preferences in physician communication and, through patients' subjective perspectives and observed real practice consultations, learn how well physicians communicate according to those preferences.

METHODS

Design

We derived physician data from the Second Dutch National Survey of General Practice (2001). This study was carried out in practices representative of Dutch general practice.²² We asked patients for permission to videotape consultations with the GP, and asked them to sign a consent form. Collected data were kept private as per regulations.

We videotaped consultations of 142 GPs (76.1% male) and 2784 patients (41.2% male). The number of patients cared for by each GP ranged between 17 and 21 (mean 19.6). Each patient was videotaped just once. We rated roughly 15 patient-consultations per GP (13-15, mean 14.8), excluding the first 3 to correct for possible bias because of the video camera. Before and immediately after the consultation, patients 18 years of age and older answered a questionnaire. We used data from 1787 patient consultations.

Patients rate their communication preferences

The patient questionnaire covered demographic characteristics (gender, age, education); health problems (psychosocial or not [ICPC-coded])²³; overall health during the past 2 weeks (1=excellent, 2=very good, 3=good, 4=fair, 5=poor); and depressive feelings during the past 2 weeks (1=not at all, 2=slightly, 3=moderately, 4=quite a bit, 5=extremely) (COOP-WONCA charts²⁴).

We defined communication preferences as "the extent of importance patients attach to communication aspects."²⁵ Patients' preferences and the actual performance by the GP were measured using the conceptual framework of the QUOTE scale (**q**uality **o**f **c**are **t**hrough the patient's **e**yes).^{5,25}

Before consultation, patients recorded how important they considered different aspects of communication for the forthcoming visit (1=not important, 2=rather important, 3=important, 4=utmost important). Following consultation, they rated the GP's performance in meeting their expectations for these aspects (1=not, 2=really not, 3=really yes, 4=yes).

Factor analysis of both the pre-visit and post-visit lists of questions on preference and performance revealed 2 relevant sub-scales: an affect-oriented scale of 7 communication aspects and a task-oriented scale of 6 communication aspects (Cronbach's alpha between 0.74 and 0.89).

We also used communication aspects from the original 4-points scale to present 4 new categories that compared and contrasted preferences and relevance. These categories included: important and performed; important and not performed; not important and performed; not important and not performed. In the multilevel analysis, we included the two subscales using the original 4-points scale.

Socio-demographic and practice variables were derived from the GP questionnaires in the Second Dutch National Survey of General Practice (2001).

Video observations

Nine observers measured verbal behavior that was measured by means of the videotapes of the visits using the Roter Method of Interaction Process Analysis (RIAS²⁶), a well-documented, widely-used system in the US and Netherlands. This observation system distinguishes both affect-oriented (socio-emotional) and task-oriented (instrumental) verbal behavior of doctors and patients, reflecting the care and cure dimensions, respectively. The RIAS categories are mutually exclusive and exhaustive.

Affect-oriented communication consists of personal remarks, agreements, concerns, reassurances, paraphrases, and disagreements.

Task-oriented talk includes asking questions, giving information, and (only GPs) counseling about medical/therapeutic and psychosocial, social context and lifestyle issues, and process-oriented talk (instructions, asking for understanding).

After the RIAS-coding had been finished, we calculated the total numbers of affect-oriented and task-oriented verbal behaviors separately for GPs and patients.

The relevance and performance items and the RIAS-categories all measured the affect-oriented and task-oriented aspects.

We used the Noldus Observer-Video-Pro computer program for the observation study,²⁷ including measurement of consultation length. The inter-observer reliabilities were good to excellent: between $r=0.80$ to $r=0.95$ per category, except for personal remarks (0.72).

Patient centeredness measured in 3 ways

The observers, using a 5-point scale, also rated the extent to which GPs communicated in a patient-centered way in 3 areas: patient's involvement in the problem-defining process; patient's involvement in the decision-making process; doctor's overall responsiveness to the patient.

Based on ratings in these 3 areas, we determined an overall magnitude of patient centeredness (Cronbach's alpha 0.75). Observers and the responsible researcher met weekly to validate the quality of rating. The same was done for the RIAS coding

Controlling variables

For GPs, controlling variables were gender, age, and number of fulltime equivalents (FTEs) working. For patients, GP and patient gender were included in the variable 'gender-dyad'—male GPs/male patients, male GPs/female patients, female GPs/male patients, female GPs/female patients. Other patient variables were age; education (low=no/primary school, average=secondary school, high=higher vocational training/university); health problems: somatic or psychosocial (ICPC-chapters); overall physical health and mental health during the past 2 weeks; and consultation length.

Data analysis

We used descriptive and multilevel analyses. The intra-class correlations of the affect-oriented and task-oriented communication and patient-centeredness were significant (between .05 and 0.23), which made it clear that consultations of one and the same GP did indeed exhibit a greater degree of similarity than consultations of different GPs. So, multi-level analyses were necessary to account for the clustering of patients with the same GP.²⁸ We applied a significance level of ≤ 0.05 (two-sided).

RESULTS

Response rate

The overall patient response rate was 88%. Non-response analysis of gender, age, and type of insurance showed no bias resulting from patients' refusal.

GP response rate was 72.8%. Respondents were representative of all Dutch GPs with respect to gender, age, working hours, practice experience (mean 15.6 years, s.d. 8.3, range 1-32), and location (58% in an urban area). More GPs worked in a partnership or group practice than in a solo practice (39%). We analyzed the influence of the practice type on doctor-patient communication and deemed it insignificant.

Study population

GP and patient characteristics appear in **Table 1**. Among patients, 22% had little education, 62% had an average education, and 16% had higher education. Nearly 10% had a psychosocial problem. GP-patient gender dyads were as follows: 32.1% male GP/male patient; 45.3% male GP/female patient; 6.9% female GP/male patient; 15.8% female GP/female patient.

Preference and performance of communication aspects

GPs good with affect-oriented communication aspects

Patients considered 6 of 7 affect-oriented communication aspects as very important (87%-96%, **Table 2**). The item, "Dr. was empathic to me," was less important (61%) than items like "Dr. listened well to me" (96%) and "Dr. took enough time for me" (93%). We noted only a few discrepancies between preference and performance of the GPs' affect-oriented behavior. If patients said beforehand that a communication aspect was important, the doctors nearly always performed that aspect. For instance, 87% wanted enough attention from the doctor and received it, while 99% of all patients received GP's attention, whether it was important to them or not.

GPs less successful with task-oriented communication aspects

Many patients wanted information, explanations, advice, and help with their problems (85%-94%, **Table 2**). They said being examined (which is more a preferred behaviour) and knowing the diagnosis were less important (63% and 77%, respectively) than, say, receiving advice on what to do and having details of treatment explained.

GPs also performed most of the task-oriented aspects, if patients considered these aspects important.

Subjectively, preferences for the GPs' task-oriented behavior and perceived performance often went together, although more discrepancies were visible than with affect-oriented behavior. One fifth of patients said they were not helped with their problems, though they had said beforehand that this was important. Likewise, GPs did not give a diagnosis to nearly 20% of patients who considered it important.

GP communication varies with doctor gender and patient characteristics

GPs engaged less in affect-oriented than in task-oriented communication (48.6 and 70.0 utterances on average, respectively, $P \leq .001$).

The more patients considered affect-oriented talk by their GPs important, the more the GPs actually showed affective as well as patient-centered behavior (**Table 3**). Patients' preferences for task-oriented behavior (question-asking, information-giving, and counseling) were mirrored in their doctors' talk.

When taking into account other GP and patient characteristics, female doctors were more often affect-oriented as well as task-oriented when communicating with patients than were male doctors, especially with female patients. In consultations with older patients and those in poor health, the doctors were more affective than in consultations with younger and healthy patients.

DISCUSSION

The main findings of our study suggest that most patients receive from their GPs the kind of communication they prefer in a consultation. In general, patients consider both affect- and task-oriented communication aspects important, and believe these aspects are often performed. Our findings agree with most of the literature.^{5,14,20} Furthermore, patients' preferences are for the greater part reflected in the GPs' observed communication during the visit, which agrees with one earlier study¹⁸ but not with others.^{5,20}

Patient preference for an affective doctor is very often met. GPs are generally considered attentive, friendly, frank, empathic, and good listeners. Patients seem satisfied in this respect. However, the task-oriented communication of the GPs is sometimes less satisfying. Contrary to patient preference, for example, GPs are not always able to make a diagnosis.

Moreover, patients often do not know when an examination is necessary. This agrees with the finding that some patients were examined contrary to their expectation. Another explanation might be that, though patients were asked to report the importance of communication aspects, they reported normative expectations—ie, how they hoped the doctor would behave.² Besides, GPs have their own interests with respect to workload, time management, and practice management. This may explain why GPs feel reluctant to put much emphasis on communication aspects.¹⁸

Observed physician behavior: patients usually get what they want.

Looking at the relationship between preferences and actual GP communication, it appears that the more patients prefer an affective or caring doctor, the more they are likely to get an empathic, concerned, interested, and patient-centered doctor, especially when psychosocial problems are expressed. An affective GP was patient centered, involving patients in problem definition and decision making. This relationship between affective behavior and patient-centeredness was also found in earlier studies.^{22,29} However, Swenson found that not all patients wanted the doctor to exhibit a patient-centered approach.³⁰

Likewise, the more patients prefer a task-oriented doctor, the better the chance they will have a doctor who explains things well, and who gives information and advice to their satisfaction. However, task-oriented doctors are usually less affective and less patient-centered when talking with patients. In view of the postulate that a doctor has to be curing as well as caring,⁶ doctors would be wise to give attention to both aspects.

GPs do improvise while communicating with patients. The study shows another important result: GPs and patients working together are able to create the type of encounter both want. GPs are able to change their behavior in response to real-time cues they believe patients are giving in an encounter. The conclusion was based on the finding that an aspect which was important, still was not performed (or vice versa). So, it was meant on a higher level than real-life communication during the visit.

Physician gender often makes a difference. Our findings furthermore suggest that female doctors are more affective and task-oriented when talking with their patients than are male doctors, especially with female patients. In view of the steady increase of female doctors in general practice, this combined communication style may become more common in the future.

Psychosocial complaints prompt affective communication. Patients presenting a psychosocial problem are also more likely to encounter an affective doctor than those presenting a biomedical problem. The growing number of psychosocial problems in the population may additionally lead to a more affective communication style of the future GPs.

Eventually the demand and the supply of affective communication may coincide. However, it is a challenge for every doctor to keep his mind open to both biomedical (task-oriented) and psychosocial (affective-oriented) information.³¹

Study caveats. Because we used scale scores for affect- and task-oriented preferences instead of the separate item scores for patient preferences, the reflection of preferences for GP communicative behavior might be somewhat overestimated. Likewise, we used total observation scores for affect- and task-oriented talk instead of the separate RIAS-categories. More detailed measures of such communication aspects as empathy—which GPs addressed less than patients preferred—might give better insight into patient preferences.

Final thoughts on personal application. Primary care physicians would do well to take notice of patients' preferences for communication. GPs in our study were often able to grasp what patients considered important to talk about, and there seemed to be only modest mismatches between patient expectations and physician behavior. To increase the quality of health care, consider asking patients at the end of a visit whether their preferences were met.

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ACKNOWLEDGEMENTS

We acknowledge the participating general practitioners and patients, the observers of the videotaped consultations, and the Ministry of Health, Welfare and Sports for funding (for the greater part) the research project.

DISCLOSURE

No potential conflict of interest relevant to this article was reported.

TABLES

TABLE 1 GP AND PATIENT CHARACTERISTICS (N GPs=142, N PATIENTS=1787)

	mean	s.d.	range
GP			
CHARACTERISTICS:			
- age (yrs)	46.9	6.2	32-62
- FTE (0.2-1.0)	0.8	0.2	0.2-1.0
PATIENT			
CHARACTERISTICS:			
Age (yrs)	49.5	17.4	18-95
psychosocial problem (1=yes)	9.8		
overall health (1=excellent, 5=poor)	3.2	1.1	1-5
depressive feelings (1=not at all, 5=extremely)	2.2	1.2	1-5
consultation length (min.)	10.1	4.8	1.3-33.0
PATIENTS'			
PREFERENCES:			
- affect-oriented preference (1=not, 4=utmost important)	3.2	0.5	1-4
- task-oriented preference (1=not, 4=utmost important)	3.1	0.6	1-4

TABLE 2 CARE VS CURE-CENTERED COMMUNICATION: PHYSICIANS FARE BETTER ON THE CARE SIDE (N=1787)

Affect-oriented aspects (care dimension)	performed		not performed		Total	
	N	%	N	%	N	%
Dr. gave me enough attention						
Important	1304	87.5	9	0.6	1313	88.1
not important	174	11.7	4	0.3	178	11.9
Dr. listened well to me						
Important	1456	95.3	10	0.7	1466	95.9
not important	61	4.0	1	0.1	62	4.1
Dr. took enough time for me						
Important	1412	92.3	11	0.7	1423	93.1
not important	105	6.9	1	0.1	106	6.9
Dr. was friendly						
Important	1331	87.2	3	0.2	1334	87.4
not important	193	12.6	0	0.0	193	12.6
Dr. was frank to me						
Important	1451	95.5	5	0.3	1456	95.8
not important	63	4.15	0	0.0	63	4.2
Dr. took my problem seriously						
Important	1455	95.8	7	0.5	1462	96.3
not important	55	3.6	1	0.1	56	3.7
Dr. was empathic to me						
Important	846	58.4	36	2.5	882	60.9
not important	492	34.0	74	5.1	566	19.1
Task-oriented aspects (cure dimension)						
Dr. diagnosed what's wrong						
Important	921	62.8	209	14.2	1130	77.0
not important	197	13.4	140	9.5	337	23.0
Dr. explained well what's wrong						
Important	1166	78.3	101	6.8	1267	85.0
not important	175	11.7	48	3.2	223	15.0
Dr. informed well on the treatment						
Important	1304	86.6	109	7.2	1413	93.9

not important	75	5.0	17	1,1	92	6.1
Dr. gave advice on what to do						
Important	1294	85.9	121	8.0	1415	94.0
Not important	75	5.0	16	1.1	91	6.0
Dr. helped me with my problem						
Important	1031	70.0	121	18.9	1152	88.9
not important	94	6.4	16	4.7	110	11.1
Dr. examined me						
Important	902	59.9	132	8.8	1034	62.8
not important	228	15.1	244	16.2	472	27.2

- totals do not always count up to 1787 because of missing data

TABLE 3 ON OBSERVATION, PHYSICIAN COMMUNICATION CORRESPONDED TO PATIENT PREFERENCES (N GPs=142, N PATIENTS=1787)

	Affect-oriented talk GPs	task-oriented talk GPs	Patient centeredness
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GP CHARACTERISTICS:

- age (yrs)	-0.20	-0.37 *	-0.01 *
- fte (0.2-1.0)	-12.13 *	2.45	0.03

PATIENT CHARACTERISTICS:

Gender-dyad: ^a

- male/female	-0.89 ³	0.17 ⁴	0.01
- female/male	9.40 ^{1,2,4}	6.24 ^{1,4}	0.10
- female/female	5.73 ^{1,3}	6.85 ^{1,2,3}	0.02
Age (yrs)	0.09 *	-0.15	-0.00 *
Education (1=low, 2=middle, 3=high)	-0.70	0.15	0.05
psychosocial problem (1=yes)	7.93 *	-4.62 *	0.13 *
Overall health (1=excellent, 5=poor)	1.13 *	0.96	-0.01
Depressive feelings (1=not at all, 5=extremely)	0.78	-0.72	0.01
Consultation length (min.)	4.03 *	4.30 *	0.04 *

PATIENTS' PREFERENCES:

- affect-oriented preference (1=not, 4=utmost important)	2.81 *	-1.94	0.16 *
- task-oriented preference (1=not, 4=utmost important)	-4.23 *	3.62 *	-0.15 *

* P < 0.05

¹ Score differs significantly from score of male GP/male patient dyad (reference group)

² Score differs significantly from score of male GP/female patient dyad

³ Score differs significantly from score of female GP/male patient dyad

⁴ Score differs significantly from score of female GP/female patient dyad