Doctor-patient Communication and the Quality of Care
The Role of Affective Behaviour

Jozien M. Bensing

Several studies have shown that between 30 and 60 percent of the patients in general practice present health problems for which no firm diagnosis can be made. This makes the work of general practitioners fundamentally different from hospital care. Luckily most of these patients get better because of the self-limiting character of their disease. Some of them do not, and they are not the easiest group of patients to deal with.

Patients without a diagnosis

Patients without a diagnosis means in the biomedical model: patients without a disease. Before presenting some of my research data, I would like to make some general observations about this particular group of patients that have a certain impact on the medical consultation.

1. It is dangerous to use the term «patients without a disease». It is dangerous because of two conflicting reasons: first of all it suggests that there is no health problem at all, while the only thing you know is that you cannot explain the illness in the biomedical model. Extending your frame of reference to a biopsychosocial model will often help you to explain the illness and therewith to accept the illness as a suitable case for treatment, instead of denying its existence and feeling annoyed by it. But for quite another reason it is also dangerous to talk about patients without a disease, because often you cannot be sure that there is no biomedical etiology in the health problems presented. Patients without a disease sometimes do have a disease, that is not yet known in the biomedical science, or that is not yet recognized. It is therefore better to speak about «patients without a known disease» or: «patients without a disease that can be explained in the biomedical model». This double danger of the term «patients without a disease» has conflicting consequences for the communication with the patient.

2. «Patients without a disease» visit their GP (General Practitioner) because they are suffering. Whatever the GP may think about the biomedical origin of their health problem, the patient is suffering. There are but few patients who visit their GP for profit, for instance for insurance reasons. Mostly they suffer. They are in pain, they have difficulties in moving, doing their usual things. And they suffer psychologically: they suffer the mixed fear of having something serious, something lifethreatening that the doctor is not able to detect, and at the same time they suffer from the fear to be seen as a malingerer by the doctor to whom they come for help, because the doctor cannot find a diagnosis. When patients visit their doctor – and that is equally true for patients without a known disease – it is to be helped in their suffering.

3. Patients without a disease are often seen as difficult patients. The question arises: difficult for whom? It is argued before that it is not the patient that is difficult, but the doctor-patient relationship. There is even some evidence that in this relationship it is the doctor who has the difficulties and not the patient.

How general pactitioners see their patients

Figure 1 shows some data about the reciprocal relationship of Dutch GPs and their patients without a diagnosis. The data are from 1524 videotaped consultations in which doctor and patient mutually answered some questions about the other, and besides the doctor assessed the patients' health problems on a five-points-scale ranging from 1 (purely somatic) to 5 (purely psychosocial).

When the patients with psychosocially assessed health problems are compared with the patients with pure somatic health problems it shows that GPs have a rather unfavourable picture of the patients whose health problems they see as influenced by psychosocial factors: These patients were seen by their GP as less realistic, less cooperative, less self-supporting and less frank or straightforward than patients with somatically assessed health problems. They were also seen as more somatizing.

How patients see their general practitioners

With these types of labels one would expect the patients not to be very happy

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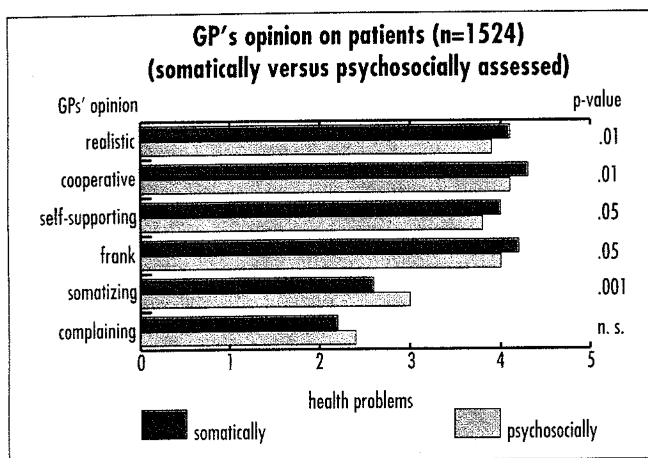
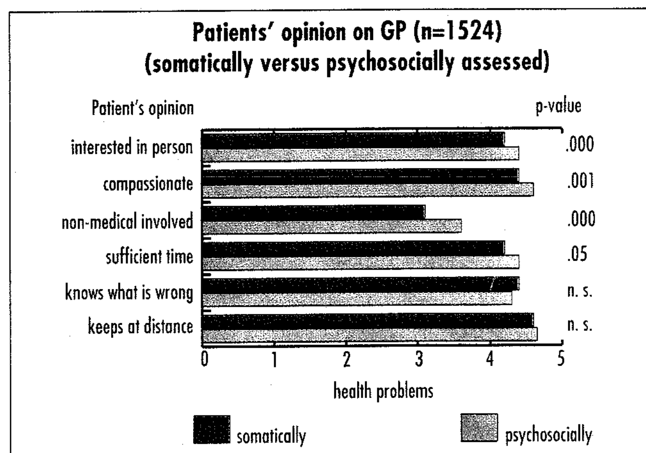


Figure 1



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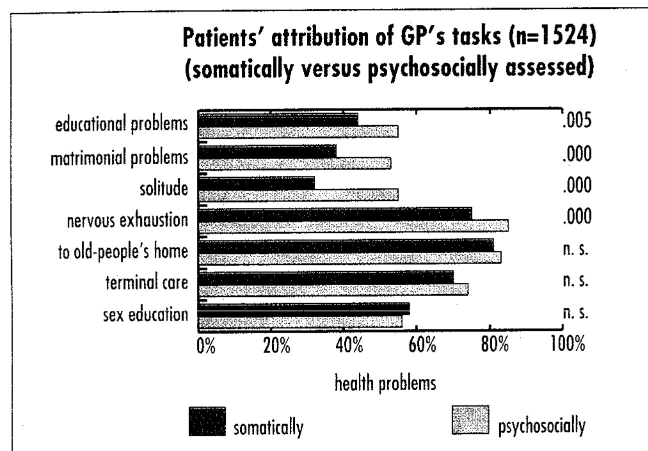

Figure 3

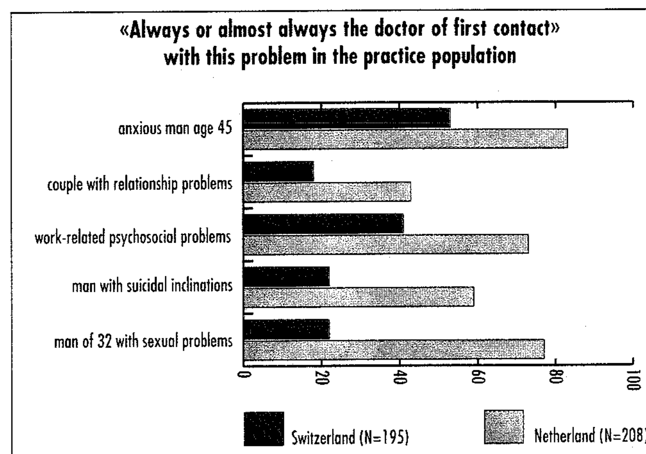

Figure 4

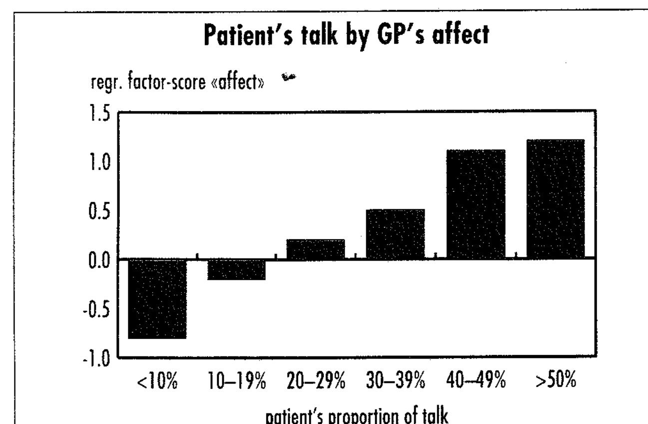

Figure 5

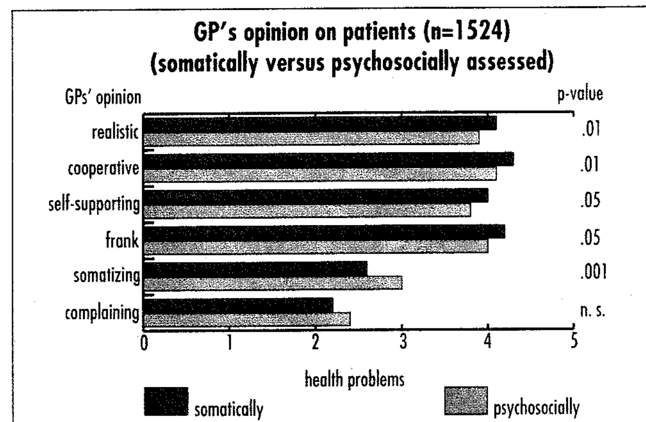

Figure 6

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either. Quite contrary, however, those patients are very satisfied with their GP. *Figure 2* shows that the psychosocially assessed patients find their GP more interested in themselves as a person, more compassionate with their problems, more inclined to involve non-medical issues in the consultation and more inclined to take the necessary time for the patient. Patients with psychosocially assessed health problems seem to like their GP. This lack of reciprocity is an intriguing thing: doctors feeling uneasy with patients who are very satisfied. I was wondering whether that could come because doctors and patients have different expectations about each other. And indeed, this seems to be true.
Part of the explanation is shown on *figure 3* where the patients' opinion about the GP's task is presented. Patients with psychosocially assessed health problems more often attribute a task to the GP in advising parents with problems in raising their children, in counselling people with matrimonial problems, in supporting people who suffer from loneliness, and assisting housewives who suffer from nervous exhaustion. These are all tasks in the psychosocial domain. There are – on the other side – no differences in task attribution with regard to helping elderly people to find a place in a home-for-the-elderly, giving support in the last weeks before dying, or giving children sex education, if the parents have difficulties in doing that themselves.
So it seems that patients with psychosocially assessed health problems attribute a broader task to their GP in the psychosocial domain than patients with somatically assessed health problems. Even when they present physical complaints only, as often they do.
In other words: They come to the GP because they expect the GP to help them with their psychosocial problems, even when they present physical symptoms only. The discrepancy between patients' and GPs' mutual assessments could easily be due to differences in the interpretation of the task at hand.

Are Swiss doctors less aware of the problem?

Of course, these figures are from the Netherlands, but in Switzerland the discrepancies could easily be still larger than in the Netherlands. In an international comparison study that the Netherlands Institute for Primary Care is carrying out at the moment, Swiss doctors proved to be less inclined to think that people with all kind of psychosocial problems will turn to their GP in their first appeal for professional help as compared to GPs in the Netherlands (*figure 4*).
So it can be assumed that Swiss «patients without a diagnosis» often see a GP that is not aware that his patients could turn to him with problems in the psychosocial sphere, especially when these problems are masked by somatic health problems as often is the case in general practice.

Expectations and needs of the patient

These three observations are relevant when we talk about the essential ingredients of good doctor-patient communication:

1. A patient without a diagnosis can either be a patient whose health problems need a psychosocial explanation or a patient with a not yet known biomedical disease.
2. Patients without a disease nevertheless suffer: from physical as well as psychological pain.
3. Patients without a disease come to general practice because they expect the physician to help them in a broad sense.

These observations make clear why people visit a doctor and what they want from him. It is good to remember that people when they get ill, are in pain, or feel miserable in fact seldom visit a doctor. They only visit their doctor when they don't know exactly what is wrong and think that – maybe – it is something serious. And further: when they want to be certain that what they feel is not the start of cancer or one of those other unpleasant illnesses that one keeps hearing about on radio and television. Going to a doctor means for most people: being anxious, or at least a bit nervous. Moreover, going to the doctor produces additional uncertainty and anxiety, because people don't know whether they will be able to describe their symptoms accurately or whether the doctor will understand them and take them seriously.
The result is that when patients visit their doctor they have two sorts of needs:

1. A need to know what is wrong (the diagnosis) and what can be done about it (prescription, advice, referral).
2. A need for understanding, for support, a need to be put at ease, a need for acceptance and respect.

The first is a cognitive need; this relates to the rational in us and can be clearly distinguished from the second need which is an emotional one. The American physician *George Engel* (founder of the biopsychosocial model in medicine) has called this double need of the patient so very poetically:

1. the need to know and understand
2. the need to feel known and understood

A visit to the doctor always involves a combination of both needs. When one of these is absent, people solve their problems themselves, alone or with the help of family, friends or medical encyclopedia.

Instrumental and affective behaviour

If you agree with me that each patient has two basic needs, «a need to know and understand and a need to feel known and understood», the consequence is that each doctor should have two types of behaviour at his disposal:

a. instrumental behaviour, which is primarily meant to solve the health problem,
b. affective behaviour which is primarily meant to create a relationship with the patient in which the patients feels se-

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Table 1: Reliability Scores Affect Variables (Pearson's correlation)

	interjudge	test/retest
eye-contact	.97	
shown interest	.51	.68
non-specific behaviour	.89	.81
verbal empathy	.53	.88

Table 2: Factor Analysis Affect Variables

eye-contact	.66
shown interest	.66
non-specific behaviour	.69
verbal empathy	.62

cure to talk with the doctor about his concerns.

In medicine and in medical research, instrumental behaviour tends to get more attention than affective behaviour. The former Director of the Rockefeller Foundation, Doctor *Kerr White* has declared in an interesting book «The Task of Medicine», that doctors – in this case American doctors – tend to overestimate the value of diagnostic tests while underestimating the value of the patients' own story in comprehending the nature of the patient's disease. In communication research most effort is devoted to the exchange of information meant to solve the medical problem and much less to the affective side of the communication meant to ease the patient to tell his own story. *Kerr White* thinks that 80 percent of the doctor's healing power has to be found in the black box of this part of GP's behaviour, and urges doctors as well as researchers to pay more attention to this part of medicine.

Measurements of affective behaviour

The following data are from a large collection of videotaped real life consultations in general practice, which have been gathered by the Netherlands Institute for Primary Care in the course of several years and have been observed and computerized to keep them ready for all kinds of research projects on doctor-patient communication. From the total databank of 5000 consultations I selected a sample of 1524 consecutive consultations of 30 different General Practitioners, being all recorded in the same period for one and the same research project. It is the same data set from which were presented already the mutual assessments of doctor and patient.

The focus was on affective behaviour. Four measures for the GP's affective behaviour were developed:

1. Eye-contact, in literature thought necessary both for decoding emotions and messages that the patient feels difficult to tell, and for showing the patient that you are listening to the patient's story. Eye-contact was stopwatch-clocked.
2. Shown interest (the observer's rating on a five-points-scale); this is a global assessment, based on verbal and nonverbal behaviour.
3. Non-specific behaviour (like «hmm»), this type of behaviour is thought necessary in literature to keep the patient telling his story and encouraging him to continue.
4. Verbal empathy (reflections and so on); this type of behaviour is thought necessary to give the patient the feeling that his story and his emotions are understood by the GP and genuinely accepted.

The reliability of the measures was satisfactory for «shown interest», which is a scaled variable and fairly good for the other variables which are counted or stopwatch-clocked *(table 1)*. A factor-analysis on these four measures of affective behaviour revealed one clear factor with an eigen value of 1.724 and 43.2 percent explained variance. It was decided to use the factor score in the analyses to have one comprehensive and consistent measure of the GP's affective behaviour (*table 2*).

From psychological theories it can be hypothesized that GP's affective behaviour would result in more talking by the patient, more room for psychosocial aspects of the presented health problem and longer consultations. A higher level of patient satisfaction is also expected.

Effects of affective behaviour

Figure 5 shows that the patients' talking is indeed directly related to the GP's affective behaviour: those consultations in which the patient fills less than 20 percent of the consultation time are characterized by a very low level of GP's affective behaviour; on the other hand: patients who fill more than 40 percent of the consultation time find themselves talking to doctors displaying much affective behaviour.

Figure 6 shows that affective behaviour also coincides with a hightened awareness for the psychosocial aspects of the patient's health problems: score 1 means that the GP thinks that the presented health problems are entirely somatic in nature; score 4 and 5 mean that the GP thinks that the patient's problems are predominantly or exclusively psychosocial in nature.

In line with *figure 6* is *figure 7* which shows that consultations in which psychosocial topics are explicitly discussed between doctor and patient are characterized by high levels of affective behaviour. In purely somatic consultations GPs are clearly less affective than in consultations where psychosocial topics are discussed.

It is no wonder that consultations with a high level of affective behaviour tend to last longer than consultations with low le-

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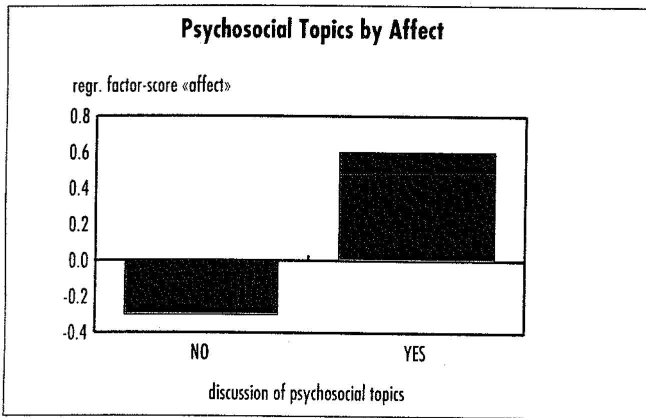

Figure 7

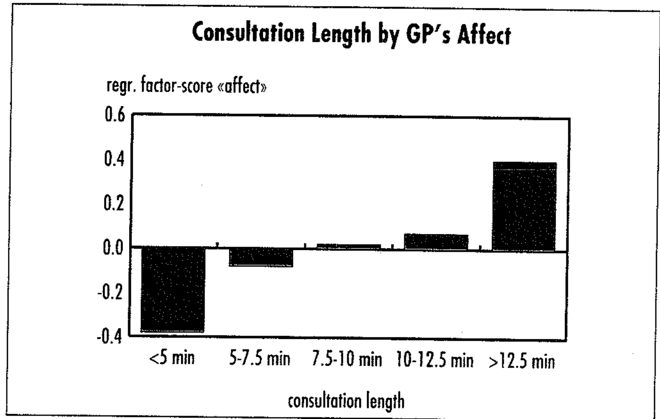

Figure 8

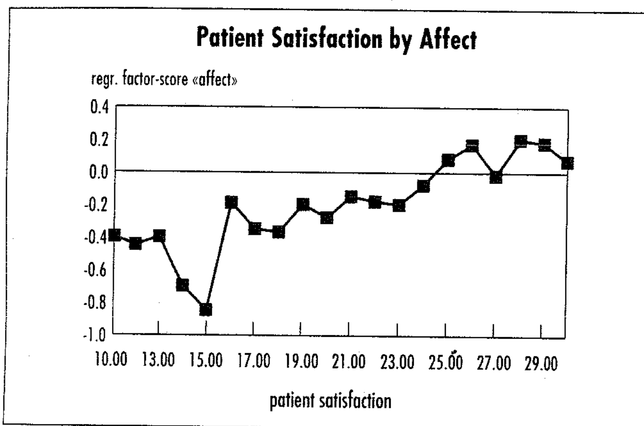

Figure 9

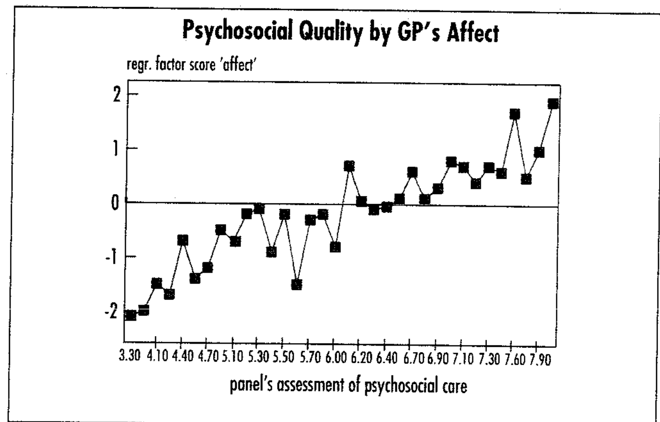

Figure 10

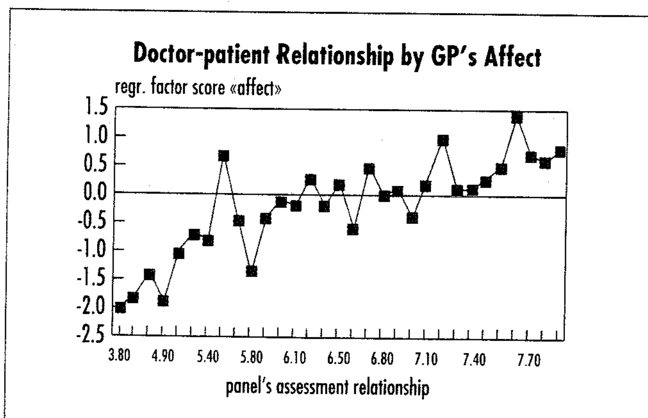

Figure 11

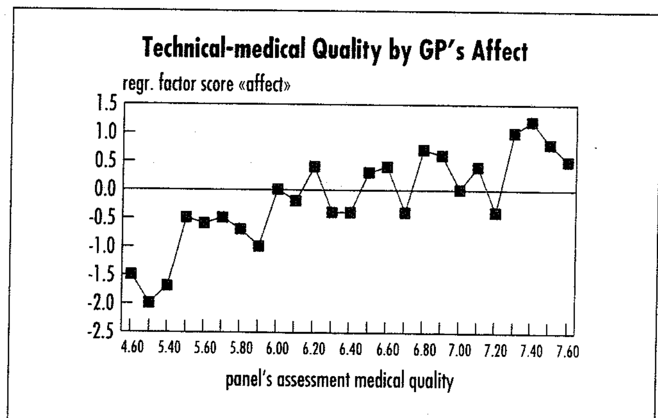

Figure 12

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vels of affective behaviour *(figure 8)*. Although it is important to note that the differences are only found on the extremes of the distribution: in consultations that last shorter than 5 minutes there is very little affective behaviour; in consultations that last longer than 12.5 minutes there is relatively much affective behaviour. In between there is not much difference. Most patients are very satisfied with their General Practitioners. Yet, there are some differences between patients, and as *figure 9* shows there is a nearly linear relationship between patient satisfaction (which ranges from 6 to 30) and the GP's affective behaviour.
So all our hypotheses are confirmed. In consultations with much affective behaviour patients do talk more, the GP is more aware of psychosocial aspects of the patient's health problems, there is more explicit attention to psychosocial care, and the patient is more satisfied with the delivered care. In a multivariate analysis all these variables proved to have an independent relationship with GP's affective behaviour.

A profile of the affective general practitioner

Till now all analyses have been done on the consultation level. But affective behaviour is not only a characteristic of the consultation; it can also be seen as a characteristic of the General Practitioner: some GPs are in general more affective than others.
Table 3 shows that indeed on the GP-level the same results are found as on the consultation-level: the profile of the affective GP. The affective GP is a GP who is highly aware of the psychosocial context of his patients' health problems, talks a lot about psychosocial problems during the consultation, or perhaps it is better to say that he lets his patients talk a lot about their problems; his consultations tend to last a bit longer than the consultations of his less affective colleague and his patients are more satisfied with the delivered care.
Another important finding was that – at least in the Netherlands – the affective GP seems to be rather restricted in his instrumental behaviour. As can be seen in *table 4* there are positive correlations with patient education and advising selfcare, but negative correlations with all other instrumental types of behaviour: most important is that the affective GP writes significantly fewer prescriptions than his less affective colleague and performs fewer technical-medical interventions. The negative relationship with referrals to medical specialist just does not reach significance, nor does the ordering of laboratory tests and other diagnostic procedures.
So it seems that the affective GP is a doctor who generates less costs in the health care system; yet his patients are very satisfied; this combination of findings make him the ideal doctor for insurance companies. But what about the quality of care? For that – of course – is the most important.

Table 3: Profile of the Affective GP

psychosocial assessment	.60***
psychosocial talk	.64***
consultation length	.47**
patient's talk	.77***
patient satisfaction	.38*

* p<.05, **p<.01 ***p<.001

Table 4: Profile of the Affective GP

patient-education	.16
self-care	.27
medications	-.34 *
technical interventions	-.31 *
referrals	-.24
external diagnostics	-.18
administrative talk	-.14

Pearson's Correlations *p<.05

Table 5: Quality Assessment

- panel of 12 experienced GP's
- all consultations with hypertensive patients (n=103)
- quality rating (10-points-scale):
  - technical-medical quality
  - psychosocial quality
  - quality of doctor-patient relationship

Affective behaviour and the quality of care

To test the relationship between the GP's affective behaviour and the quality of care, we decided to show a sample of these 1524 consultations to a panel of experienced general practitioners and to ask them to rate the quality of care *(table 5)*. Therefore it was necessary to draw a sample of homogenuous consultations with a health problem that was both rather frequent in general practice and serious enough to deserve devoted attention. Furthermore it had to be a health problem for which the biomedical model has no equivocal answer.
Hypertension is a condition that fulfills all these conditions. *Stephans* wrote in 1988 about 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.»
We found 103 consultations with hypertensive patients among our total sample of 1524 videotaped consultations. Ten GPs rated independently from each other the quality of care on a ten-points-scale. Three different dimensions of the quality of care were assessed:
- technical-medical care (on the basis of a protocol for the detection and treatment of hypertension, developed by the

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Table 6: Quality of Care – Affective Versus Instrumental Behaviour

	Quality of care		
	psychosocial	technical-medical	relationship
GP's affective behaviour	.70**	.48**	.60**
GP's instrumental behaviour			
* psychosocial	.34**	.02	.21
* technical-medical	.24*	.42*	.20

*p<.01 **p<.001

Table 7: Quality of Care by Specific Time Measures

	Quality of care		
	psychosocial	technical-medical	relationship
eye-contact	.53**	.26*	.39**
psychosocial talk	.50**	.17	.30
somatic talk	.18	.12	.17
physical examination	- .00	.26*	.07

*p<.01 **p<.001

Family Medicine Department of the Nymegen University)

- psychosocial care (the panel was asked to pay attention to the degree in which the GP is receptive to, and himself investigates the non-somatic aspects of the patient's health problem, which should not only concern psychosocial problems as such, but also the background to the complaint and the problems that are caused by it or by its treatment)
- doctor-patient relationship (which has exclusively to do with the manner in which the doctor dealt with the patient, for instance by putting him at ease, making jokes, social chatting, and so on).

The panel-members got an extensive training beforehand and were provided with a written instruction about the quality criteria. The range of the scores proved to be rather wide, between 3 and 9, showing a wide variation in quality of care; the reliability of the three quality measures varied between .79 and .88. This provided us with rather strong and well-discriminating measures for the three types of quality of care.

In *figure 10* it is shown that there is a direct relationship between the panel's assessment of the quality of psychosocial care and the GP's affective behaviour. GPs who were rated under six on a ten-points-scale had all displayed little affective behaviour in the consultations. A same nearly linear relationship exists between the quality of the doctor-patient relationship and GPs affective behaviour (which is not very surprising after all, *figure 11*).

It is more surprising that the same pattern can be shown for the panel-assessed technical-medical quality of care *(figure 12)*. Remind that the criteria for the technical-medical quality of care were derived from a medical protocol which was very instrumental in nature! So it seems that affective behaviour does not only play a role in creating a meaningful relationship with the patient or in the quality of psychosocial care, but it seems also to play a role in the technical-medical quality of care.

Some curiosity is raised by these results about the balance between affective and instrumental behaviour, especially with regard to the technical-medical quality of care.

Instrumental behaviour

Therefore we have observed these 103 hypertension consultations with a widely used American observation system: Roter's Interaction Analysis System. This is a very detailed observation system in which each utterance of GP and patient is classified in one of 37 distinct categories. The reliability of this observation system has proven to be high in several studies. This observation system has its roots in the instrumental research tradition, so we have analyzed the instrumental categories in relationship to panel-assessed quality of care.

A factor analysis on those instrumental categories revealed two distinct factors together explaining nearly 55 percent of the variance. The first factor consists of medical information-giving, medical questioning, medical counselling and giving directions. The second factor consists of psychosocial information-giving, psychosocial questioning and psychosocial counselling *(table 8)*.

In *table 9* the correlations are shown between these two types of instrumental behaviour and the three measures of the quality of care. On top are the correlations between the GP's affective behaviour and the quality of care. Four things can be noted:

- First and most important: affective behaviour is strongly related to all measures of the quality of care, even to the quality of technical-medical care.
- Second: the quality of the doctor-patient relationship is not related to any type of instrumental behaviour, nor the medical nor the psychosocial type.

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Table 8: Factor Analysis of Instrumental Behaviour
(Roter'sInteraction Analysis, RIAS)

	factor 1 (medical)	factor 2 (psychosocial)
medical information	.75	.01
medical questioning	.74	.11
medical counselling	.78	.01
giving direction	.78	-.05
psychosocial information	-.11	.54
psychosocial questioning	.28	.70
psychosocial counseling	-.01	.79
eigen value	2.451	1.378
% explained variance	35%	19.7%

Table 9: Quality of Care by Relative Time Measures

	Quality of care		
	psychosocial	technical-medical	relationship
% eye-contact	.66**	.39**	.55**
% psychosocial talk	.56**	.14	.38*
% somatic talk	-.32**	-.20	-.27*
% physical examination	-.37**	-.00	-.32**

*p<.01 **p<.001

Table 10: Main Conclusions – Affective Behaviour is Important in Both the Process and Outcome in General Practice

process	outcome
1. room for the patient	1. patient satisfaction
2. alertness on psychosocial aspects	2. quality of care
3. room for psychosocial topics	3. cost-effectiveness

- Third: the quality of technical medical care is related to medical instrumental behaviour, but not more than to affective behaviour.
- Fourth: the psychosocial quality of care is related to GP's affective behaviour, but also to both psychosocial and medical instrumental behaviour.

This latter result is intriguing, but can be explained by the double need of the patient who visits his doctor already mentioned before: the need to know and understand (GP giving medical information) and the need to feel known and understood (this emotional need asks for the GP's affective behaviour).

Conclusions

The main conclusions summarized in *table 10* bring us back to the start: the difficult task of communicating with «patients without a diagnosis». Caring for this category of patients cannot mean that firstly you try to exclude biomedical diagnoses and only then you try to find a psychosocial reason for the health problems. Patients will not accept that, because they have this double need. Series of studies show that most people are aware of psychosocial factors influencing health and illness, and are willing to talk about it in the medical office. But they also want to be sure that there is no organic reason for their problem. And they want it both and they want it at the same time.

A common problem in general practice is that doctors feel first and foremost responsible for finding a biomedical diagnosis. This keeps nagging on their mind. Patients also want to know what is wrong and press for further diagnostics. Therefore in the beginning most attention of both is often given to biomedical procedures. When this one-sided strategy is allowed with somatizing patients, however, the GP will find himself in a trap, a «folie à deux» which at the end leads to what in the Netherlands is called «somatic fixation».This study shows that a two-sided strategy, aimed at both biomedical and psychosocial diagnostics will help, but most of all adequate affective behaviour is necessary for good quality of care.

GP's affective behaviour is relevant both in the process and in the outcome of general practice. With regard to the process we have shown that the GP's affective behaviour gives room to the patient to talk about his concerns, which heighten the GP's awareness of the psychosocial context of the patient's health problems and

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facilitates talking about psychosocial topics. With regard to the outcome we have shown that the affective GP has satisfied patients, seems to be rather cost-effective and gets favourable quality assessments, not only on the quality of psychosocial care or the quality of the doctor-patient relationship, but also on the quality of technical-medical care. Affective behaviour will not solve all your problems in the communication with «patients without a diagnosis» but it certainly helps to keep that delicate balance of art, science and communication.

Appendix

Engel G. L.: The Need for a New Medical Model: a Challenge for Biomedicine. Science 1977; 196: 129–136.

Engel G. L.: Towards an Improved Dialogue. In: *White K.*: The Task of Medicine. Menlo Park, California: The Henry J. Kaiser Family Foundation, 1988.

Huygen F.: Preface to: *Grol R.*: To Heal or to Harm. The Prevention of Somatic Fixation in General Practice. Exeter: RCGP, 1983.

Roter D. L.: The Roter Method of Interaction Process Analysis. Baltimore: John Hopkins University, 1989.

Stephans G. G.: Reflections of a Post-Flexnerian Physician. In: *White K.* The Task of Medicine. Menlo Park, California: The Henry J. Kaiser Family Foundation, 1988.

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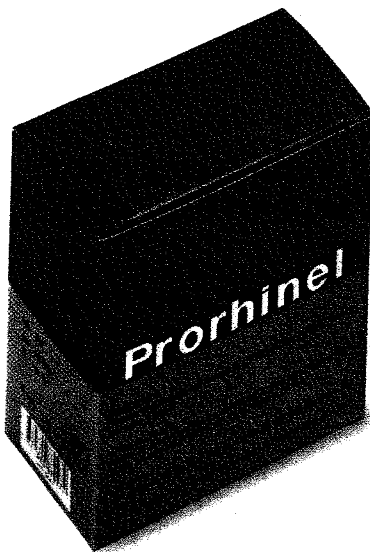

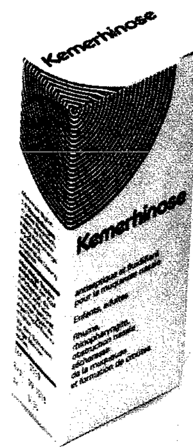

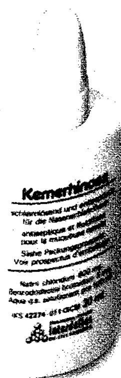

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Prorhinel
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