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Communication Accommodation in Healthcare Provider-Patient Exchange

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Healthcare provider-patient communication is of a paramount importance in healthcare provision as poor communication exchange with patients is associated with lower patient satisfaction, misdiagnosis, mistreatment and negative medical outcome. In patient-centered care the healthcare provider has to be sensitive to each patient's unique needs, preferences, concerns, experiences and values to guide clinical decisions. Even though the provider-patient encounter is interpersonal in nature, in practice it is often an intergroup communication. In the last several decades, an impressive body of interpersonal communication theories have been developed for communication accommodation. Although these theoretical approaches are helpful in healthcare interactions, they still remain overlooked and have been applied only sparingly. In this brief article we explore interaction-centered communication and the associated theory and strategies in healthcare setting.

Keywords: provider-patient encounter; communication accommodation

I. INTRODUCTION

Over the last few decades healthcare communication has changed from an illness-centred to a patient-centred approach. With this change, the complexity of healthcare communication is obvious (Epstein and Street, 2007; McCormack *et al.*, 2011). In most cases, the healthcare provider-patient encounter is still seen as intergroup rather than interpersonal communication. Healthcare providers need effective communication skills to break this barrier in order to achieve better provider-patient exchange. Poor communication exchanges with patients have been associated with lower patient satisfaction, misdiagnosis, mistreatment and negative medical outcome (Zolnierek and DiMatteo, 2009; Hojat *et al.*, 2011; Kaplan *et al.*, 2013) Even though inter-personal communication is considered as social in nature, the healthcare provider-patient interaction differs from the communication exchange between friends and family members. This is evident when considering issues of equality, power balance, expectations of tasks to be accomplished, and specific interests or expected outcomes (Bylund *et al.*, 2012).

Many studies have reported the shortcomings in medical interactions. A study on nonverbal communication between doctors and patients reported that, in more than 50% of the cases, the doctors did not converge to patients' nonverbal behaviours (A.D'Agostino and Bylund, 2011). Baker and Watson (2015) reported unpleasant experience among patients due to the healthcare providers' poor communication strategies. Watson and Gallois (2002) reported that patients rated the healthcare providers positively when patients were given more control in the consultations, even in cases where the healthcare providers were directive and exerted control over the patients. A study among elderly patients found that the perception of quality of life among the patients reduced when healthcare providers used patronizing speech, high levels of interpersonal control and counter-accommodation (Lagacé *et al.*, 2012). Patient-centred care requires flexible

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healthcare providers who are responsive to each patient's unique needs, preferences, concerns, experiences and values to guide clinical decisions.

A. Theory in Healthcare Communication Research

Theories in healthcare communication research are used to understand, explain and predict health beliefs, attitudes, intentions, and behaviours of individuals, dyads, groups, and mass audiences. Although there have been many theoretical approaches used to explain healthcare interactions (Giles, 2008; White, 2008) many interpersonal communication theories remain overlooked and are only used occasionally in healthcare communication.

The healthcare provider-patient communication can be either individually centred, interaction-centred or relationship-centred, and this depends a person's state of mind, the messages exchanged between the interlocutors, or the relationship between them (Bylund *et al.*, 2012). The interaction-centred theories focus on the content, forms, and functions of messages and the behavioural interaction patterns between persons (McCormack *et al.*, 2011). These theories assume that interpersonal communication is transactional and is useful for healthcare communication. It is suggested that when the healthcare provider and patient interact, they are affected by each other simultaneously.

B. Communication Accommodation Theory

Communication Accommodation Theory (CAT), developed by Giles, a social psychologist who attempted to account for the variations in dialect and word choice which depended on one's communication partner (Giles and Powesland, 1975). CAT has since been expanded to encompass a wider range of conversational strategies and a theoretical model of the overall communication process (Coupland *et al.*, 1988). CAT examines interpersonal interactions from an intergroup perspective. CAT seeks to explain the attitudes, motivations, intentions, and identities that interface with social and contextual factors to impact communication choice and outcomes (A.D'Agostino and Bylund, 2014).

The theory of communication accommodation is made up of two constructs: convergence and divergence. Convergence is defined as a strategy whereby individuals adapt their communicative behaviours in order to become more similar to their interlocutor's behaviour. This is done to seek approval, affiliation, and/or interpersonal similarity to reduce social distance (Soliz *and* Giles, 2014). Convergence leads to accommodation and the exchange is productive. Convergence may at times lead to over-accommodation. Even though over-accommodation is seen as a form divergence, at times it can lead to productive exchange. Divergence is said to occur when the interlocutor's express differences in their speech and nonverbal gestures (Bourish *and* Giles, 1976). Divergence leads to counter-accommodation where an individual aim to maximize differences between himself or herself and their communicative partner and the exchange in often counterproductive. Divergence may also lead to over-accommodation where the behaviour of the interlocutor becomes exaggerated and artificial, according to the situational norms, and it may offend the communicative partner.

Even though maintenance is often referred to as a third construct, it is similar to divergence, in which a person persists in his or her original style, regardless of the communicative behaviour of the interlocutor (Bourish *and* Giles, 1976; Giles, 2016). This often leads to non-accommodation. The amount of non-, counter-, and over accommodating one receives can be an important ingredient for continuing or withdrawing from an interaction. Those traditionally perceived as having greater power tend to be accommodated more than those with less power (Giles, 2008).

CAT can be used in the healthcare setting to predict and explain verbal and nonverbal behavioural modifications that healthcare providers and patients make to their behaviour, often to create, maintain, or decrease social distance in their interaction. CAT explains how behavioural strategies, like rate of speech, eye contact, gestures are used to accommodate speech and nonverbal behaviour (Miller, 2002; Giles, 2008). Street (1991) was the first to apply CAT to the medical interaction. Since then many studies have used CAT in studying communication behaviours in healthcare settings (Watson *and* Gallois, 1998, 2002; A.D'Agostino *and* Bylund, 2011). However, due to the unique nature of the provider-patient relationship, accommodation would not be expected in all aspects of the interactions. Therefore, some behaviours should be complementary, as healthcare provider and patient work to maintain communicative differences related to their roles.

C. Strategies in Communication Accommodation Theory

There are five strategies described within CAT: approximation, interpretability, discourse management, emotional expression and interpersonal control (Giles *and* Powesland, 1975; Giles, 2016). These strategies provide detailed analyses of healthcare provider-patient interactions and the identification of aspects of effective communication.

1. Approximation concerns how individuals adjust their speech patterns such as the speech rate, volume, tone, use of dialect or accents to converge towards or diverge from their partner's speech. Appropriate approximation occurs when speakers perceive that their speech patterns complement each other.
2. Interpretability strategies focus on each speaker's conversational competence. The highlight is on conversation content. Interlocutors who modulate their language and word choice to ensure their words are understood demonstrate appropriate interpretability.
3. Discourse management strategies involves conversation processes to promote conversation between interlocutors. Appropriate discourse management strategies include turn-taking, changing topics as needed, responding to non-verbal cues and using conversational repair, such as face maintenance, that allows patients to maintain a positive self-image and prevents interactions from becoming ineffective or negative.
4. Accommodative emotional expression takes place when healthcare providers deliver appropriate levels of reassurance and empathy in response to patients' emotional needs.
5. Interpersonal control focuses on the roles and power relations between interlocutors. Appropriate interpersonal control strategies used by healthcare providers promote equality between themselves and patients.

Studies have shown that, when the speakers adopt these strategies appropriately, the interactants rate the communication as effective (Chevalier *et al.*, 2017)

II. CONCLUSION

Application of CAT strategies in medical interaction help the interpretation of patterns and flow of healthcare provider-patient conversations and help identify occasions of accommodation or non-accommodation. There will always be power imbalance between healthcare providers and patients, as healthcare providers have specialized knowledge and information that is not always accessible to patients. Although health-care professionals may move from intergroup identities (professional and social) to personal identities (individual likes and dislikes), it is often their intergroup identities that are most salient. Healthcare professionals need to improve their communication skills for an effective provider-patients exchange.

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