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Finding Common Ground: Defining and Measuring Provider-Patient Rapport

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The challenge: Reaching common ground

Rapport, an important factor in provider-patient communication and a key component of relational communication, has been inconsistently defined in the literature. Additionally, researchers have found it difficult to measure to its complex and often ambiguous nature. This project provides a conceptual and operational definition of rapport, as well, as identifies some of the measurable components of rapport.

Rapport at-a-glance

Methodology

Rapport components were identified through a review of the literature and focus groups. Findings were used to inform the Rapport Development Model (RDM). A rapport scale was developed that measured verbal, nonverbal, and para-verbal behaviors. The scale was pilot-tested using existing videotaped medical encounters between standardized patients and medical residents. New definitions of rapport, focus group results, measurable behaviors, and the RDM are presented in this poster.

Defining rapport

Conceptual definition: A feeling of connectedness and emotional support between physicians and patients.

Operational definition: Rapport is built through specific behaviors. Positive rapport behaviors are comprised of rapport-initiating and enhancing behaviors, which can lead to positive rapport. Negative rapport behaviors are comprised of rapport terminating behaviors, which can lead to no rapport or negative rapport. Ultimately, positive rapport should lead to increased patient comfort (reduced anxiety), patient self-disclosure, and patient trust, whereas, negative rapport should lead to reduced or decreased patient comfort (anxiety), patient self-disclosure, and patient trust.

Focus groups: What the patients said…

In addition to the literature review, two focus groups were held in order to draw on the experiences of real patients who had recently interacted with their physicians. Focus group 1 included students at large mid-western university and focus group 2 included non-students who were 45 years old or older. Participants in both groups were asked to recall a recent medical visit where they felt they experienced high rapport/low rapport. Specifically, participants were asked to identify and discuss specific behaviors or communication that they felt indicated high/low rapport with their physicians.

Definitions of rapport:

"I've always found when I feel I have rapport…is when I hear them laugh. Or…where all of a sudden they stop being this faceless person in a white coat and all of a sudden they will laugh at things and become human."

"…feeling at ease or a comfortableness with your doctor so you can talk to them no matter what the topic is."

Positive rapport communication and behaviors reported:

Affirmation of patient: Using "facial expressions or acknowledgments appropriate to the situation or information being provided" For example, if something hurts and you say that it hurts, "just a little bit of an expression that says, 'yeah, that does hurt.'"

Negative rapport communication and behaviors reported:

Mechanical communication: Physicians "going through the motions; there was nothing behind the nod."

Dismissing patient concerns: "I had one [physician] who actually told me to be quiet when I was asking questions because he wanted to tell me the whole thing."

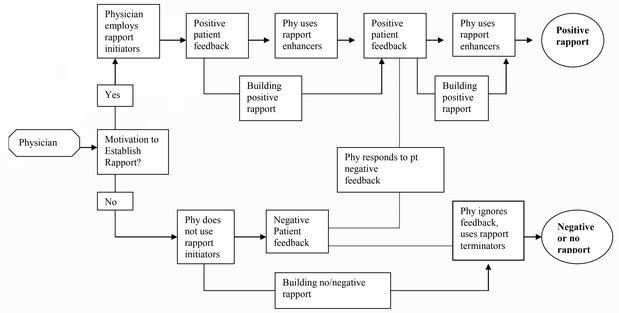
"When they minimize your symptoms…especially if you are a woman."

Initiating, enhancing, and terminating rapport behaviors

Measurable Rapport Behaviors

Initiating	Enhancing	Terminating
Physician introduced themselves to pt	Used facial expressions adapted to pt comments	Used unexpressive facial expressions
Addressed pt by surname	Used tone of voice that was interested & engaged	Maintained closed body posture
Made initial eye contact	Continued eye contact	Interrupted pt
Shook hands during initial introduction	Addressed pt concerns, provided supportive & inclusive statements	Acted bored or disinterested; used a monotone voice
Asked about pt comfort	Put pt at ease	Changed subject
	Acknowledged & answered questions	Dismissed pt comments or concerns
	Used humor appropriately	Acted distracted during medical visit

Rapport Development Model (RDM)



Rapport Development Model (RDM) during the primary care visit

The RDM suggests there are four components to building rapport within the primary care visit: 1) physician motivation to build rapport; 2) the actual rapport behaviors (initiating, enhancing, and terminating; 3) patient feedback; and 4) outcomes (self-disclosure, trust, patient comfort). Part II of the model suggests that positive rapport may lead to increased patient self-disclosure, trust, and comfort while negative rapport may lead to decreased patient self-disclosure, trust, and comfort.

Implications for rural health communication and future steps

With the significant increase of diabetes in rural areas and the challenges identified in communicating complex information, identifying barriers to the treatment and self-management of the disease is critical. We also need to help providers create an environment that lends itself to partnership building, shared-decision making and honest, open, and respectful communication. Patients need to feel comfortable asking questions and providing sensitive information and providers need to attend to verbal and nonverbal cues that are important to understanding the whole patient and not just the disease. Improving rapport (and relational communication in general) will go a long way in helping patients and providers find common ground which has been shown to improve health outcomes. Further research needs to focus on testing the model and exploring the role motivation plays in rapport-building and patient outcomes of trust, comfort, and self-disclosure along with training providers to attend to rapport initiating and enhancing behaviors while minimizing rapport-terminating behaviors.

Acknowledgements

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For further reading:

Norling, G. R. (2005). Developing a theoretical model of rapport-building during the primary care visit. In Haider, M. (Ed.), Global public health communication: Utility, value and challenges. Boston: Jones and Bartlett.