

How my physician could adapt his or her behaviors to my preferences?

Nowadays, the recommended approach in physician - patient interaction is patient - centeredness. As the name suggests, patient - centeredness implies to put the patient in the center of the consultation and to take his or her perspective. Nonetheless, physician guidelines commonly advise to show sharing and caring towards every patient. In other words, physicians are advised to share information with their patients, to discuss the therapeutic possibilities, to negotiate decisions, to explore the inner experience of their patient, and to show warmth and empathy. However, taking the perspective of each patient implies going further than this “one size fits all” approach. Indeed, not every patient wants their physician to explain the disease or explore their feelings. Older patients, for example, are known to prefer less sharing physicians. So we posit that better consultation outcomes can be achieved if the physicians adapt their behavior according to their different patients.

Based on a literature review, we propose a model which displays the process of physician behavioral adaptability. Firstly, in order to adapt his or her behavior to different patients with different preferences, a physician needs to infer these preferences based on the patients’ behaviors. The ability to correctly infer others’ trait and states is called interpersonal accuracy and has been shown to be related to more positive interaction outcomes in the general population as well as in medical setting.

Secondly, if physicians want to show behavioral adaptability, they have to be able to flexibly

change their behaviors from one patient to the other. Former studies showed that on average physicians are indeed able to vary their behaviors according to the different patients they face. It is for example known that physicians behave differently in front of female patients as compared to when with male patients. But in order to be adaptive, these behavioral changes have to correspond to the patients' preferences. A physician showing behavioral adaptability will for example display more sharing of information with a first patient who prefers to know more about his or her disease and treatment, but will then show less sharing in a another consultation with a patient preferring less information giving. It's thus the correspondence between the physician's behavior and the patient's preferences that will determine whether the physician showed in fact behavioral adaptability.

There is evidence showing that a match between physicians' behavior and patients' preferences will lead to better consultation outcomes. We thus posit that more physician behavioral adaptability will be related to more positive consultation outcomes. A hypothesis that has been confirmed by a former study showing that the more sharing behavior the physicians showed to their patient preferring more sharing, the more positive the consultation outcomes were evaluated by the patients.

The proposed model has still to be tested in its entirety, but the literature affords evidence for its validity. The confirmation of the physician behavioral adaptability model will provide guidelines for medical students' training. Future medical curricula might want to include interpersonal accuracy training in order to help physicians infer their patients' preferences. Teaching a variety of communication styles instead of a unique approach might also be beneficial for the physicians who want to offer tailored and individualized care. Such care would be highly advisable, because each one of us is unique and has different preferences concerning the medical interaction.

Publication

[Physician behavioral adaptability: A model to outstrip a "one size fits all" approach.](#)

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