Beyond "One Size Fits All": Physician Nonverbal Adaptability to Patients' Need for Paternalism and its Positive Consultation Outcomes

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Abstract

In this study, we tested whether physicians' ability to adapt their nonverbal behavior to their patients' preferences for a paternalistic interaction style is related to positive consultation outcomes. We hypothesized that the more physicians adapt their nonverbal dominance behavior to match their patients' preferences for physician paternalism, the more positive the patients perceive the medical interaction. We assessed the actual nonverbal dominance behavior of 32 general practitioners when interacting with two of their patients and compared it with each of their patients' preferences for paternalism to obtain a measure of adaptability. Additionally, we measured patient outcomes with a questionnaire assessing patient satisfaction, trust in the physician, and evaluation of physician competence. Results show that the more nonverbal dominance the physician shows towards the patient who prefers a more paternalistic physician, as compared to towards the patient who prefers a less paternalistic physician (i.e., the more the physician shows nonverbal behavioral adaptability), the more positive the consultation outcomes are. This means that physicians' ability to adapt aspects of their nonverbal dominance behavior to their individual patients' preferences is related to better outcomes for patients. As this study shows, it is advantageous for patients when a physician behaves flexibly instead of showing the same behavior towards all patients. Physician training might want to focus more on teaching a diversity of different behavior repertoires instead of a given set of behaviors.

Keywords: physician-patient communication, adaptability, paternalism, nonverbal behavior

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There is widespread agreement that physicians should interact with their patients by using a patient-centered communication style (Epstein, 2000). Patient-centered communication has been documented to be beneficial for both the patient and the physician. Patients who see a patient-centered physician are more satisfied with the consultations (Bensing et al., 2001), trust the physician more (Aruguete & Roberts, 2000), adhere better to the physician's treatment recommendations (Robinson, 2006), and are less likely to sue their physician for malpractice (Ambady et al., 2002).

Patient-centeredness is described as care that "respects the individuality, values, ethnicity, social endowments, and information needs of each patient. […] The aim is customization of care, according to individual needs, desires, and circumstances." (Berwick, 2002, p.84-85). Despite the emphasis on customizing or adapting to each patient, the literature on patient-centered communication often describes a given set of physician behaviors that are linked to positive patient outcomes. Typically these behaviors encompass smiling and nodding, probing for patient emotions, and creating an egalitarian rather than hierarchical relationship (Stewart et al., 1995). If we take the patient's perspective seriously, it becomes clear that there is no "one size fits all". Not all patients benefit from one and the same physician communication style to the same extent. For instance, assertive individuals are more satisfied with a physician who takes more time to explain the rationale of the treatment recommendation (Braman & Gomez, 2004). The anxiety level of mildly anxious individuals decreases when they face a patient-centered physician, whereas the anxiety level of more anxious individuals increases in the same situation (Graugaard & Finset, 2000). In the same vein, more anxious patients have a more pronounced tolerance for physicians whom they perceive as angry (Hall, Roter, & Rand, 1981) or dominating (Street & Wiemann, 1987) than

less anxious patients. The more agreeable the patient, the more he or she benefits from a physician who adopts an affiliative nonverbal communication style (e.g., looking at patient, smiling, or nodding) as compared to a non-affiliative style (Cousin & Schmid Mast, 2013).

Given that not all patients benefit from the same physician interaction style, we suggest that the physician who can flexibly adapt his/her communication behavior to fit each patient's preferences will have patients who experience on average more positive consultation outcomes. This is in line with Epstein and Street Jr.: "One key defining element of effective patient-centered communication is the clinician's ability to monitor and *consciously* adapt communication to meet the patient's needs" (2007, p.7). "Adapt" is the important word here. A physician who tailors his/her verbal and nonverbal communication according to the specific needs and preferences of his/her patients shows what we call *behavioral adaptability*.

Physician Behavioral Adaptability

Communication Accommodation Theory (CAT; Giles, Coupland, & Coupland, 1991) posits that when communicating, people use verbal and nonverbal behavior to accommodate others. Accommodation can occur through two processes: Convergence, which reduces differences among the social interaction partners, and divergence, which amplifies such differences. Research on CAT also demonstrates that communication outcomes are more positive if there is convergence (McCroskey & Richmond, 2000). Convergence and divergence not only happen with respect to a social partner's behavior but also with respect to his/her expectations. When there is convergence to another person's expectations, Expectation Confirmation Theory (Jiang & Klein, 2009) comes into play. This theory claims that a person's satisfaction is increased if his/her expectations are met. Several studies have empirically shown that these predictions hold true (Appleton-Knapp & Krentler, 2006). Taken together, these theories suggest that the more a physician adapts his/her behavior to patient preferences, the more positive the medical interaction outcome for the patient. There is indeed

evidence showing that patients are more satisfied when their preferences are met by the physician's behaviors. Patients are more satisfied when the physician's behavior matches their preferences for information giving (Kiesler & Auerbach, 2006), for participation (Cvengros, Christensen, Cunningham, Hillis, & Kaboli, 2009), and for interaction style (Cousin, Schmid Mast, Roter, & Hall, 2012).

The notion of physician behavioral adaptability encompasses more than just better or worse average convergence of the physician's behavior to the patient's preferences; it contains the idea that a physician flexibly changes his/her behavior and adapts to what different patients prefer. We define physician behavioral adaptability as the physician's ability to change his/her behavior across different patients so that the behavior corresponds to the preferences of each individual patient. A fair test of physician behavioral adaptability is thus the observation of the behavioral change of a physician when confronted with patients harboring different preferences. Most of the existing studies on physician behavioral convergence have not looked at whether the physician changes his/her behavior according to the differences in patients' preferences. The goal of the present study is to investigate whether physician behavioral adaptability is related to better patient outcomes. Showing such a link would open a promising new avenue for research and for physician training. If adaptability is key, then physician training should not focus exclusively on physicians mastering the list of behaviors associated with patient-centered communication. Rather, physicians should additionally be trained in mastering an array of different communication behaviors, including non-patient-centered communication (e.g., paternalistic communication styles).

The Vertical Dimension of Social Interactions

The interpersonal circumplex model is a classification system enabling the description and organization of interpersonal behavior, traits, and motives along two orthogonal dimensions: *control* and *affiliation* (Kiesler & Auerbach, 2003). The control dimension –

sometimes referred to as the vertical dimension – defines where on the power distribution a person stands. The affiliation dimension – also called horizontal dimension – spans from hostility to friendliness and defines how agreeable a person is (Kiesler & Auerbach, 2003).

The vertical dimension is prominent in many respects in the physician-patient interaction. For one thing, being a doctor is a high status position and patients consulting a doctor are typically in a weaker and thus subordinate position because they seek advice, are often in pain, and are vulnerable. The way power plays out in the physician-patient interaction can vary. Patient-centeredness implies egalitarism and partnership between the physician and the patient. The opposite interaction style – paternalism – is characterized by the physician having control and the patient being passive and uninvolved. Paternalism is the "traditional" physician interaction style, based on the biomedical model of care (Engel, 1977). Although this style has largely - and rightly so - been replaced by a biopsychosocial approach characterized by patient-centered care, some patients prefer a paternalistic physician. Male, older, less educated, and more ill patients typically prefer a more paternalistic physician interaction style (Benbassat, Pilpel, & Tidhar, 1998).

In the present study, we are interested in the vertical dimension of social interactions because it has gained relatively little research attention in the study of physician-patient interaction compared to the horizontal dimension (Schmid Mast, 2004). Moreover, research shows that a physician's high affiliative behavior is related to more positive patient outcomes independent of the patient's attitude toward affiliation whereas a physician's low control behavior is related to positive outcomes only for patients valuing this attitude (Cousin et al., 2012). With respect to adaptability, it is therefore possible that a physician's behavioral adaptability is related to positive outcomes particularly on the vertical dimension.

Physician Nonverbal Dominance

Verbal behavior can more easily be controlled than nonverbal behavior (Choi, Gray, & Ambady, 2005). Besides, physician training typically focuses on avoiding physician display of dominance and such training is mostly based on verbal content (Cegala & Lenzmeier Broz, 2002). Thus if the physician expresses dominance, it more likely happens through the nonverbal channel. Indeed, dominance has been shown to be related to nonverbal rather than to verbal cues (Berry, Pennebaker, Mueller, & Hiller, 1997). This is why we focus on physician nonverbal behavior in the present study. We chose seven physician nonverbal behaviors that have been shown to be related to perceived dominance in the general population and in physicians (Hall, Coats, & Smith LeBeau, 2005; Schmid Mast, Hall, Cronauer, & Cousin, 2011): louder voice, more physician speaking time, more gazing at the notes or computer, less gazing at the patient, less nodding, and less smiling, and more visual dominance.

The Present Study

To measure behavioral adaptability as we define it, a physician needs to be observed while interacting with a minimum of two patients who differ in needs and preferences. Only the physician who changes behavior from one patient to the other has behavioral adaptability. As an example, if one patient prefers the physician to communicate in a rather paternalistic way and another patient prefers the physician to communicate in a less paternalistic way, the physician who is able to adapt to these different preferences will show more behavioral adaptability (e.g., speak more loudly to the patient who prefers a paternalistic interaction style and speak more softly to the patient who prefers a less paternalistic interaction style). We assess a physician's level of behavioral adaptability as an individual difference measure (described in more detail in the Method section) and link it to the consultation outcomes reported by several (in our study two) of the physician's patients. We hypothesize that the

more a physician shows behavioral adaptability, the better the patient consultation outcomes are.

Method

Participants

Physicians. Seventy-two general practitioners in the French-speaking part of Switzerland were contacted by mail or phone for voluntary participation. Thirty-three of them agreed to participate in the study. One physician had to be excluded from the analysis, because one of her patients did not fill in the preference questionnaire. The final physician sample was therefore composed of 32 participants (18 men and 14 women) with a mean age of 46.56 (range: 34-63 years old) and with on average 19.53 years of practice experience (range: 9-36 years).

Patients. For each physician, two of his/her patients participated in the study (one female and one male patient per physician with one exception: one physician was videotaped with two male patients instead of one female and one male patient). In total, 64 patients completed the study (33 men, 31 women). The exclusion criteria for patients were: aged less than 18 years, not fluent French speakers, having a psychiatric disorder, or having consulted the physician more than four times in the past. Patients included in the study varied in age from 20 to 84 years old (M = 50.25 years old) and consulted their physician for different reasons (e.g., check-up, back pain, hypertension). On average, they saw a physician between two and three times a year and were seeing this particular physician for the second time.

Procedure

Physicians signed an informed consent form and agreed to be videotaped during two consultations with two of their patients. Patients were approached in the waiting room by the investigator and asked whether they would participate in the study. Patients were then handed an informed consent form to sign. They were informed that the physician would be filmed

during the consultation and that they would not appear in the video but that their voice could be heard on the recording. Additionally, patients were informed that after the medical interaction, they would be asked to fill in a questionnaire measuring how they perceived the consultation and their preferences in terms of how paternalistic the physician should behave towards them. Patients also reported how frequently they saw a doctor and the number of previous visits with this particular physician, their gender, and age. The procedure of this research was reviewed and approved by the regional (Canton of Vaud) research ethics committee. Data from this study unrelated to the present research question have been published elsewhere (Cousin, Schmid Mast, & Jaunin-Stalder, 2013a, 2013b). External raters coded physician nonverbal behavior during medical interactions based on the videotapes.

Measures

Patient preference for paternalism. To assess the degree of each patient's preference for the physician to behave in a paternalistic way, we reversed the sharing subscale of the Patient-Practitioner Orientation Scale (PPOS; Krupat, Yeager, & Putnam, 2000). This subscale measures the patient's preference for the physician sharing power (Krupat et al., 2000). Thus, the reverse of the subscale indicates how much the patient wants a particular physician to show paternalism (i.e., limit the amount of information given to the patient and not involve the patient in the decision-making process). The PPOS inversed sharing subscale contains nine items on a scale of 1 (not at all) to 5 (very much so). Sample items are: "The doctor is the one to decide what is to be discussed during a doctor's appointment" or "Patients should be treated as partners, equal in power and status" (reversed item for our paternalism measure). Items were averaged and larger values indicate that the patient wishes to be addressed in a rather paternalistic way by the physician (Cronbach's Alpha = .66, M = 2.53, SD = 0.64).

Physician nonverbal behavior. Based on the videos of the medical interactions, external raters (all blind to the communication style preferences of the patient and to the hypothesis of this research) coded seven nonverbal behaviors: visual dominance, loudness of voice, speaking time, gazing at the notes or computer, gazing at the patient, nodding, and smiling. The coding of physician nonverbal behavior as well as means and standard deviations are described in Table 1.

For smiling and loudness of voice, global ratings were used. Two raters attended a short one hour training session on the definition of smiling and loudness of voice and on how to use the rating scale. Both raters coded all videos and their ratings were averaged. Cronbach's Alpha was .67 for smiling and .75 for loudness of voice.

Physician visual dominance, speaking time, gazing at the notes, gazing at the patient, and nodding were all coded by two other raters who attended a one day training session on coding. Raters coded the onset and offset of each of the five aforementioned behaviors and we then extracted the total duration (in sec) of each behavior and expressed it as the percentage of the duration of the entire medical encounter. Each videotape was coded by only one rater because prior established inter-rater reliability was good, ranging from $r = .55$ to $r = .99$.

Physician nonverbal behavioral adaptability. We measured physicians' nonverbal behavioral adaptability scores in the following way. Based on the patients' preferences for paternalism, we were able to identify which of the two patients of any one doctor wanted more paternalism than the other. We then looked at whether the physician actually showed relatively more dominance behavior to the patient who wanted more paternalism than to the other patient (the one who preferred less paternalism). For visual dominance, loudness of voice, physician speaking time, and physician gazing at notes (all positively related to physician dominance in the literature), we subtracted the amount of the specific behavior shown toward the patient preferring *less* paternalism from the amount of the same behavior

shown toward the patient preferring *more* paternalism. Higher values indicate that the physician showed increased nonverbal adaptability, because he/she showed a more dominant behavior toward the patient who wanted more paternalism as compared to the patient who wanted less paternalism.

Because smiling, nodding, and gazing at the patient are negatively related to physician dominance, we subtracted the amount of the specific behavior shown toward the patient preferring *more* paternalism from the amount of the same behavior shown toward the patient preferring *less* paternalism. Higher values indicate that the physician showed increased nonverbal adaptability.

Correlational analyses showed that the so computed seven nonverbal behavioral adaptability scores are inter-correlated, except for the smiling adaptability scores. [1] We therefore created a composite measure of overall physician nonverbal behavioral adaptability based on the six inter-related adaptability scores (visual dominance, loudness of voice, physician speaking time, gazing at the notes or computer, not gazing at the patient, and not nodding; Cronbach's Alpha = .66, M = -0.01, SD = 0.15).

Consultation outcomes. We used three measures of consultation outcomes selected from the scales in Blanch, Hall, Roter, and Frankel (2009) and Cousin and Schmid Mast (2013). *Patient satisfaction* was evaluated with the three following items: "I am satisfied with the way my physician treated me.", "I did not like some aspects about my physician's behavior." (reverse scored), "I was completely satisfied with my physician's attitude and general behavior." on a 5-point Likert scale (1 = "completely disagree", 5 = "completely agree", Cronbach's Alpha = .78). *Patient trust in the physician* was assessed with two items: "I totally trust my physician" and "I have the feeling that my physician is reliable" on the

[1] Table of correlations is available from the corresponding author.

same 5-point Likert scales (Cronbach's Alpha = .87). Patients were also asked to evaluate their *physician's competence* with six items. Three items were related to the professional competence of the physician: "I think my physician is competent in his/her profession", "On a few points, I sometimes thought that my physician did not have the necessary knowledge" (reversed item), and "My physician seems to know his/her job perfectly well". The other three items were related to the physician's interpersonal competence: "Sometimes, I thought my physician did not behave in an adequate way", "My physician is a good communicator", and "My physician knows how to present things and behave adequately". The same 5-point Likert scale was used (Cronbach's Alpha = .72). Because these three measures of consultation outcomes are significantly correlated (Cronbach's Alpha = .83), we averaged them to obtain an aggregated measure (M = 4.60, SD = 0.54) with higher values indicating better consultation outcomes.

Analysis

There are two levels in our data. Patient data are clustered within physician. At level 1 (for the 64 patients), there are the overall consultation outcome variable and two control variables: patient gender and age. At level 2 (for the 32 physicians), there are the measure of physician nonverbal behavioral adaptability and three control variables: physician gender, experience, and difference in preference for physician paternalism among the two patients. The latter control variable was introduced because the difference in this preference among the two patients varies among physicians. For some physicians the difference in preference among the two patients is most likely very small and for some physicians, one patient might prefer a very paternalistic physician interaction style while the other might prefer a very non-paternalistic interaction style. Recall that to calculate the physician nonverbal behavioral adaptability we simply identified which patient wanted more physician paternalism than the

other without taking into account the extent of this difference. This is why we controlled for the extent of this difference in the analysis.

Due to the clustered nature of our data, we used multilevel analyses to test whether patients report better consultation outcomes with physicians who adapt their nonverbal behavior according to their patients' preferences about physician paternalism. A log likelihood comparison between the analyses with and without a multilevel approach showed that the multilevel model was a better fit with our data than a model without clustering ($p <$ .01).

Results

In our multilevel analysis displayed in Table 2, we entered consultation outcomes as our dependent variable. This variable is a composite of patient satisfaction, trust in the physician, and the evaluation of the physician's competence. Six control variables were integrated in the model and results show that patient gender and physician gender are the only control variables that are significantly related to consultation outcomes. Female physicians had patients reporting better overall consultation outcomes and female patients reported better consultation outcomes. Physician nonverbal behavioral adaptability was entered in the model as the predictor. Confirming our hypothesis, results show a significant positive relation between physician nonverbal behavioral adaptability and consultation outcomes. In other words, when physicians adapt their nonverbal dominance behavior (i.e., loudness of voice, speaking time, gazing, nodding, and visual dominance) to the level of physician paternalism behavior prefered by each of their patients, they have patients who report better consultation outcomes. Speaking more and more loudly, gazing less at the patient and more at the medical notes, nodding less and showing more visual dominance when with a patient who prefers the physician to be paternalistic than when with a patient who prefers the physician to be less

paternalistic entails that, on average, the patients of this doctor experience their consultations in a more positive way.

Discussion

The goal of this study was to test whether adapting physician nonverbal behavior to patient preferences for physicians’ paternalism is related to more positive consultation outcomes for patients. Results confirm our hypothesis and show that the more the physician adapts his/her personal nonverbal dominance behavior according to what the patient prefers, the better the consultation outcomes (measured as patient satisfaction, patient trust in the physician, and perceived physician competence by the patient). When patients prefer a paternalistic physician interaction style and the physician addresses them in a relatively dominant way by speaking loudly, speaking much, gazing at the computer or the notes and not at the patient, not nodding at the patient, and displaying visual dominance, patients indicate good consultation outcomes. Thus contrary to a patient-centered approach that would suggest avoiding a dominant physician communication style for all patients, our results show that certain patients profit from such a dominant style. More generally, our results suggest that the regulation of some aspects of the physician’s nonverbal dominance behavior according to patient preferencess is an important component of how positive patients experience the medical consultation.

We focused on nonverbal behavior indicative of physician dominance because we expected physician dominance behavior to show up in the nonverbal rather than in the verbal channel given that there is a considerable amount of pressure for physicians to adopt a non-paternalistic, patient-oriented verbal interaction style (Institute of Medicine, 2001). Nevertheless, physicians also express dominance verbally (e. g. less agreement, less emotional talks, or more questions; Schmid Mast et al., 2011). Whether physician behavioral adaptability on the verbal level is also linked to better consultation outcomes still needs to be

investigated. Studying this issue would most likely necessitate holding the medical problem constant, which is not an easy task in studies involving general practitioners in actual consultations with their patients.

We only investigated physician behavior toward two patients. Depending on whether these patients happened to be very different or very similar in their preferences for physician paternalism, the extent to which the physician needs to change his/her nonverbal behavior differs. This is why we included the difference in patient preference for a paternalistic physician interaction style among the two patients as a control variable. Results show that this did not affect our results. To fine-tune the measure of physician behavioral adaptability, future research might want to include a larger number of patients. However, when dealing with real patients, this does not guarantee more variance in patient preferences of physician interaction style. It is possible that there is a self-selection mechanism of patients to a specific physician at work that would reduce variance in patient preferences. In other words, a physician with a certain interaction style might attract patients with a preference for exactly this style and patients with different preferences might have chosen to consult elsewhere.

Another limitation of our study is that we investigated whether the physician adapted to a female and a male patient (one exception). Given that female patients prefer less paternalism in the physician than male patients (Krupat et al., 2000), the physicians might have adapted their behavior according to the gender of the patient more than according to having correctly picked up on the desired interaction style of the patient. It has to be noted, however, that in our sample, the female and male participants did not differ significantly in how much paternalism they prefered from their physicians. Physicians could therefore not simply use the gender of the participant as a proxy for how much paternalism they wanted; they must have inferred the patients' preferences for paternalism somewhat correctly from cues other than gender.

To show behavioral adaptability, the physician has to correctly assess the patient's preferences. These are typically not expressed explicitly by patients. Rather, the physician has to infer them based on the interaction behavior exhibited by the patient. The ability to correctly infer the characteristics of an interaction partner is usually called interpersonal accuracy (Hall & Bernieri, 2001). Research demonstrates that we are quite accurate at assessing what other people feel or think (Hall & Bernieri, 2001) and research shows that the level of a physician's interpersonal accuracy is related to important consultation outcomes. A literature review (Hall, 2011) showed that the better physicians were at accurately decoding nonverbal cues, the more positive the consultation outcomes were in terms of patient satisfaction and appointment keeping, and in terms of how positive the patients evaluated the physician's clinical skills, warmth, and engagement. Future research needs to address how physician interpersonal accuracy is related to behavioral adaptability and whether behavioral adaptability explains why physician interpersonal accuracy is related to better consultation outcomes.

The strength of this study is that it takes the patient's preferences into account and investigates the correspondence between patient preferences and physician behavior. It introduces a novel approach focusing on the ability of the physician to tailor his/her behavior towards the needs and preferences of different patients; a core aspect of the notion of patient-centered care.

Conclusion

Our study shows the benefits of a physician who is able to flexibly adapt his/her behavior according to the needs and preferences of his/her patients. Propagating a specific physician communication style, that is related to positive consultation outcomes, is necessary and useful. However, we should not neglect the fact that patients differ in what they need and want from a doctor in terms of interaction style. To respond to these needs, a physician needs

to possess an array of different communication styles. We provide initial evidence showing that a physician’s flexible use of communication adapted to patient preferences has positive outcomes for the patient. Physician communication training might want to focus more on teaching different communication styles.

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Table 1

Coding of Physician Nonverbal Behavior with Means and Standard Deviations

Visual dominance (*M* = 0.93, *SD* = 0.22): Ratio of percentage of looking while speaking to percentage of looking while listening (Dovidio & Ellyson, 1982). Percentage of seconds the physician was gazing at the patient while speaking divided by the percentage of seconds the physician was gazing at the patient while the patient was speaking.
Loudness of voice (*M* = 2.38, *SD* = 0.24): Amplitude of the voice, coded for each minute of the interaction on a five-point Likert scale (1 = used a soft voice to 5 = used a very loud voice; normal/natural loudness of voice is rated as 3) and then averaged across all minutes
Speaking time (*M* = 0.51, *SD* = 0.20): Duration (in sec) of physician speaking, expressed in percentage of the total medical consultation duration
Gazing at the notes or computer (*M* = 0.38, *SD* = 0.21): Duration (in sec) of gaze focusing on a part of the physician's desk or computer expressed in percentage of the total medical consultation duration
Gazing at the patient (*M* = 0.50, *SD* = 0.26): Duration (in sec) of gaze focusing on the patient's head expressed in percentage of the total medical consultation duration. The patient cannot be seen on the video, therefore the position of the patient's head was estimated by using the patient's voice and the physician's nonverbal cues (e.g. gaze when welcoming the patient).
Nodding (*M* = 0.03, *SD* = 0.03): Duration (in sec) of up/downward motion of the head on a vertical plane expressed in percentage of the total medical consultation duration
Smiling (*M* = 2.72, *SD* = 0.38): Upward extension of the lips displaying warmness and/or agreeableness, coded for each minute of the interaction on a five-point Likert scale (1 = never smiled to 5 = smiled a lot) and then averaged across all minutes

Table 2

Multilevel Analysis (ML) of Physician Behavioral Adaptability Predicting Consultation Outcomes

	Consultation outcomes	
	B (SE)	95% Cl
Control variables		
Patient gender (1 = female, 2 = male)	-0.25** (0.08)	[-0.40, -0.10]
Physician gender (1 = female, 2 = male)	-0.31* (0.14)	[-0.58, -0.03]
Patient age	-0.06 (0.10)	[-0.26, 0.13]
Physician age	-0.04 (0.37)	[-0.80, 0.71]
Physician experience	0.13 (0.37)	[-0.61, 0.88]
Difference in patient preferences	0.16 (0.13)	[-0.11, 0.42]
Predictor		
Physician nonverbal behavioral adaptability	0.62** (0.15)	[0.33, 0.92]

$^{\dagger}p < .10$. $*p < .05$. $**p < .01$.