

ORIGINAL RESEARCH & CONTRIBUTIONS

# When Rapport Building Extends Beyond Affiliation: Communication Overaccommodation Toward Patients with Disabilities

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## Abstract

**Introduction:** Physician rapport with patients is described as a vital component of relationship-centered care, but rapport-building communication behaviors may exceed boundaries and instead indicate patronizing behavior toward patients with disabilities. This paper addresses the types of communication behaviors and contexts for interpreting when rapport building extends beyond boundaries toward patients with disabilities.

**Methods:** Videotaped interactions between third- and fourth-year medical students (N = 142) and standardized patient educators with physical disabilities were qualitatively analyzed.

**Results:** Results suggest six primary themes of exceeding expected rapport boundaries, including baby talk (ie, exaggerated nonverbal gestures and “we” language to indicate “you”), kinesic movement (ie, stiff posture and awkward handshakes), vocalics (ie, volume or pitch that interfered with the flow of conversation), relationship assumptions (ie, communicating assumptions that relationships were grounded in care-receiving), emotional divergence from patient disclosure (ie, minimizing or embellishing disability), and inconsistency with patient emotional cues (ie, responding to negative or neutral disclosure by overly accentuating positive interpretation).

**Discussion:** This study suggests that communication behaviors generally described as positive, rapport-building behaviors can pose negative implications when they exceed the expected quantity or duration, when they are inconsistent with patient verbal disclosure, or when verbal and nonverbal messages are inconsistent. Identified themes serve as examples to understand when rapport building exceeds beyond affiliation and instead appears to indicate patronizing behavior toward patients with disabilities. Suggestions for interpreting communication behaviors within the context of patient disclosure and building capacity to distinguish attitudes and biases limiting communication are addressed.

## Introduction

Physician rapport with patients is described as a vital component of relationship-centered care,<sup>1</sup> where rapport consists of trust and understanding, harmony, and affinity. Overall, rapport-building through open and symmetrical posture, more direct body orientation, closer interpersonal distance, more smiling, head nodding, eye contact, facial expressiveness, and vocal concern are described as beneficial.<sup>2</sup> In the clinical context, physician nonverbal rapport-building behaviors are associated with positive outcomes including increased disclosure about psychosocial components of illness,<sup>3</sup> patient satisfaction,<sup>4</sup> and communication patterns that are reciprocated between physician and patient.<sup>5</sup> Similarly, rapport-building behaviors may indicate nurturing and acknowledging relational/emotional qualities unique to the person rather than the person’s group identity.<sup>6</sup>

However, in interactions with patients with disabilities, physician communication otherwise associated with rapport may instead indicate an overly nurturing inclination to care for the “afflicted” individual.<sup>7</sup> The disability may be the un-named “elephant in the room,” shifting the meaning of communication behaviors in readily apparent to subtle ways.<sup>8</sup> Language implying familiarity and relationship beyond biomedical knowledge may be perceived as biased.<sup>9</sup> As observed in communication toward elderly individuals, high-pitch, exaggerated intonation, simplified vocabulary, and repetition, or nonverbal kinesic/body movement cues—including

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dismissive gestures, dismissive facial expressions, or avoidance—may indicate patronizing communication.<sup>10</sup>

Rapport-building behaviors may indicate familiarity beyond what is appropriate in the particular physician-patient interaction. In addition, physicians are vulnerable to exceeding their judgment and capacity regarding group affiliation and its significance and may rely on cultural bias and stereotyping. In the disability domain, negative stereotypes include dependence and incompetence. Exaggerated intonation, simplified vocabulary, or exaggerated nonverbal cues may indicate negative attitudes by the physician. The elicitation of negative stereotypes is associated with withdrawal, reduced sense of control, and lower self-esteem.<sup>10,11</sup> Similarly, secondary baby-talk as observed in interactions with elderly individuals through high pitch, exaggerated intonation, “we” language to refer to one individual, redundancy, simple vocabulary, pet names, and exaggerated praise<sup>12,13</sup> is also considered patronizing.

This article provides a comprehensive analysis of medical students’ communication toward patients with disabilities. We examined medical students’ verbal and nonverbal behaviors associated with rapport and suggest that quantity or context of these behaviors may restrict patient disclosure and may infantilize patients. Behaviors are interpreted through the theoretical framework of Communication Accommodation Theory (CAT), which describes the ways people adjust their speech styles, or “accommodate” as a means of expressing values, attitudes, and intentions.<sup>14-16</sup> CAT provides a means to interpret communication behaviors in intergroup encounters and proposes that the extent to which individuals shift their communication styles communicates social approval or disapproval.<sup>17</sup> CAT posits that communication behaviors are fueled by social stereotypes of groups, which translate into individual attitudes. For patients with disabilities, stereotypes are abundant and can be exceedingly negative. Attitudes toward people with disabilities are the learned, emotionally toned predispositions representing values and beliefs.<sup>18</sup> Attitudes toward people with physical disabilities include perceptions of sickness, dependency, bitterness, sinfulness, incompetence, asexuality, accident proneness, and nonproductivity.<sup>19</sup> Medical students’ negative attitudes toward patients with disabilities may affect the patients’ self-concept and general health.<sup>20</sup>

Adapting communication to patients with disabilities can be seen as a tension between dominant group discourse to keep disabled “others” in place,<sup>21,22</sup> or in contrast, empowering exchanges by emphasizing “per-

son first” language and discourse about the person as a whole.<sup>23</sup> CAT frames the degree of accommodation (modified communication) in terms of convergence, divergence, and maintenance as the result of perceiving group membership (in this case disability) as salient. Convergence is a change in speech pattern, so as to better fit that of the person to whom one is speaking, and indicates approval, solidarity, personal affiliation, liking or acceptance.<sup>24,25</sup> The desire to meet the expectations of others is described as the driving force in convergence. Physicians who reciprocate language preferences used by patients with disabilities would be converging. Divergence emphasizes differentiation between communication of the physician and patient<sup>25</sup> and is described as demonstrating differences from the “other.” As observed in Duggan et al,<sup>26</sup> medical students who use different language than patients with disabilities, particularly by using “sickness” after the patient uses “disability,” would be diverging. Maintenance occurs when individuals resist change in communication. Physicians who believe that there is “nothing to be done” if a cure is not possible<sup>27</sup> may underaccommodate to patients with disabilities by indicating uneasiness, avoidance, and low rapport. However, physicians may display positive behaviors through “faking good” in attempts to be socially appropriate,<sup>24</sup> which may be observed in overaccommodation through excessive rapport-building behaviors. Expressions of pity or “cute” language<sup>28</sup> would be interpreted as overaccommodation.

To examine the type and context of rapport-building communication toward patients with disabilities and the ways rapport building was identified as exceeding appropriate degree or frequency, or diverging in responding to patient communication behaviors, we asked:

**Research Question 1:** What communication messages and communication contexts suggest that rapport-building behaviors have extended beyond expectations of indicating affiliation towards patients with disabilities?

If communication behaviors exceeding rapport are indeed related to the ways medical students respond to disability, then these behaviors should not be observed in comparable interactions toward patients without a disability. Thus, we compared interactions for the same participating medical students to interactions of comparable complexity but not involving disability.

**Research Question 2:** Will behaviors extending beyond rapport boundaries also be observed toward patients without disabilities?

## Methods

### Participants and Procedures

Interactions between third- and fourth-year medical students (N = 142), and Standardized Patient Educators (SPEs), were videotaped. To compare whether the identified behaviors were targeted only toward patients with disabilities, the same medical students were videotaped in other similar educational interactions not involving disability (a nutrition counseling interaction). All interactions were recorded with digital videorecorder with a wide-angle lens set on a tripod primarily focusing on the student physician, while also recording the SPE. Institutional review board approval was obtained before beginning videotaping, and every step of the protocol guaranteed medical student confidentiality. Participating medical students received a copy of their DVDs and received initial analyzed descriptions of their own behaviors. Interactions occurred as part of the students' family medicine clerkship and included a 12- to 15-minute simulated medical interview followed by nonevaluative, formative feedback from a peer observer, the SPE, and a faculty observer; Duggan et al describe the interaction and methods.<sup>29</sup> To maximize representativeness of participants in the study, interactions were videotaped over the course of one academic year (10 different clerkship rotations); 92% of the medical students participated.

### Interaction Descriptions

During disability interactions, SPEs role-played a shoulder pain complaint, while incorporating their own disability. SPEs were recruited with the criterion of a visually apparent disability and then selected for their backgrounds and perspectives as nonjudgmental educators, articulate communicators, and positive to neutral attitude about physicians. Individuals' disabilities included multiple sclerosis, juvenile rheumatoid arthritis, traumatic spinal cord injury, neurodegenerative disorders, cerebral palsy, muscular dystrophy, blindness, paraplegia, quadriplegia, respiratory failure, and mobility constraints. SPEs initial training included two weekend-long training sessions (12 to 24 hours) and a series of videotaped practice interviews. SPEs received financial compensation for their training and work. Medical students focused on history taking and negotiated a treatment plan (without a physical exam) in a case designed to elicit questions about psychosocial and biomedical components of illness.

Medical students participated in a nutrition counseling interaction used to compare their behavior, where SPEs were prompted to seek counseling by the sudden death of a friend of the same height and body type. The

nutrition counseling case was designed in consultation with the nutrition faculty of the participating medical school. The disability case was designed in detailed consultation with an advisory committee composed of people with disabilities, family members of people with disabilities, state disability agency representatives, and medical educators; the case was pilot-tested and refined prior to the current recording project.<sup>30</sup>

### Qualitative Analysis

The first author (AD), whose expertise includes nonverbal communication, reviewed recordings of all disability interactions to identify examples of medical students responding to an SPE in a manner that appeared inconsistent with other interactions. A research assistant (NS), trained in communication accommodation, then watched this subset of disability interactions and transcribed these portions of the interaction. Blinded to the research question, the same research assistant then watched the nutrition interactions looking for similar behaviors or behaviors that appeared inconsistent with other interactions. The first author and research assistant sorted transcriptions qualitatively and independently into primary and secondary themes, without preconceived categories, using Glaser & Strauss' constant comparative method.<sup>31</sup> In other words, both coders read and categorized all of the interactions separately using an inductive approach to allow categories to emerge from the data. The coders then reviewed identified categorizations together. Where there was disagreement (6% of interactions), coders shifted and reorganized independently and then re-reviewed together until consensus was reached. As an additional guard against arbitrary decision making, coders analyzed the data together after the categories were developed to minimize force fitting the data. Once themes were confirmed by the two independent assessments, transcriptions were quantified within each identified theme. A third communication specialist (YB) reviewed results and videotapes after initial results were presented.

### Results

Medical students' communication behavior was initially flagged based on excessive quantity or duration of the behavior, inconsistency with the verbal message, and nonresponsiveness to patient expressions. In the sample of 142 participating medical student interactions, 57 disability interactions (40%) were identified as crossing the boundaries of rapport through "positive" behaviors that indicate unexpected intensity, duration,

**... identified behaviors were unique to the disability interactions, indicating that medical students used different communication behaviors toward patients with disabilities.<sup>a</sup>**

or out-of-context messages; 29 of the identified 57 of these interactions had more than one example, resulting in a total of 86 occurrences of communication behaviors identified as exceeding expected boundaries of rapport. Within nutrition interactions, only 9 instances of communication inconsistent with the verbal message were identified. Analysis by both initial coders and another communication specialist (AD) revealed that themes identified in the disability interactions were distinct and did not overlap those in the nutrition interactions. Thus, identified behaviors were unique to the disability interactions, indicating that medical students used different communication behaviors toward patients with disabilities.<sup>4</sup>

Primary themes are categorized by types of communication behavior. Secondary themes within each of these six primary themes are related to finer distinctions in language or nonverbal behavior.

### **Primary and Secondary Themes for Crossing Rapport Boundaries**

Within the interactions where the medical students demonstrated aspects of crossing the boundaries of rapport ( $n = 86$ ), six primary themes were identified: 1) baby talk; 2) kinesics and posture overaccommodation; 3) vocalic overaccommodation; 4) relationship assumptions; 5) divergence or underaccommodation; and 6) inconsistency with patient's emotional cues.

#### **Baby Talk**

Nineteen medical students demonstrated secondary baby talk through behaviors common for parents to use in talking to a toddler that communicate paternalistic assumptions when used with adult patients with disabilities. Identified behaviors include exaggerated nonverbal gestures or vocal pitch, "we" language to indicate "you," trivializing language, and using oversimplified language for technical terms.

*Exaggerated nonverbal gestures or vocal pitch.* Four medical students exhibited nonverbal forms of baby talk, including exaggerated pitch range, particularly within the high pitches, or exaggerated gestures to illustrate spoken terms that would seemingly not require visual clarification. Examples include making a large lifting motion with his hands while the medical student asked "How much more stressful workload stuff do you have to do" and nodding "no" while increasing forward lean (as sometimes observed in talking to an infant) while asking "Did anything you were doing bring on the pain?"

*"We" to indicate "you."* Six medical students used "we" to indicate "you." For example, they asked, "How are we doing today?" or "Why are we here today?"

*Trivializing language.* Four medical students used trivializing language or slightly flippant speech or tone of voice, or "cute" language toward the SPE. Examples include asking with a "cute" tone of voice, "Can you point to the pain in just one little spot?" or, holding up one finger and demonstrating pointing, "Are you able to point to the pain with just one finger?"

*Oversimplifying technical terms.* Five medical students exhibited baby talk by oversimplifying technical and medical terms. One example includes explaining that "Some of the muscles in your shoulder, they attach to bones, right? When they get inflamed, they get angry. That's called tendonitis. The -itis means inflammation." Similarly, another student suggested: "To help in your work you should go and get some ergonomics stuff. You know like at Staples, any place that sells computer stuff. You just go to Staples or Best Buy and tell them 'I have problems using the computer and I need a different keyboard.' The padding that can be placed on keyboards will feel like a teddy bear."

#### **Kinesics and Posture**

Eight students exhibited overaccommodation in kinesic behavior or posture in ways that indicated attempts at rapport but translated into awkward communication. Identified behaviors included chair shifting, stiff or closed posture, and awkward handshakes. Although these behaviors may be indicative of general nervousness or inexperience, the same medical students did not use these awkward behaviors in the nutrition counseling interaction.

*Chair shifting.* Three medical students shifted in their chairs in a continuous manner over the course of the interaction, spinning from side to side in a restless manner, while conducting the medical interaction.

*Stiff or closed posture.* Three medical students displayed stiff or closed posture, including sitting with hunched shoulders and a rounded back, minimizing the amount of space of their bodies by sliding their hands between their knees or under their legs.

*Awkward handshake.* Two medical students attempted to shake the hand of an SPE whose range of motion would not allow for reciprocating the gesture. Uncertainty in addressing the handshake was communicated by verbally announcing "I am going to shake your hand" or by reaching to shake hands with a smile that is too big for the context of the initial medical interaction.

#### **Vocalics**

Thirteen medical students showed signs of overaccommodation in the form of modified vocalics, where the volume, pitch, annunciation, or fluency seemed to interfere with the flow of conversation.

*Volume.* Three medical students overaccommodated their speech volume: two students who used quiet, hushed tones, and one student was extremely loud.

*Pitch.* Five medical students indicated overaccommodation through a high-pitched voice, ridden with multiple inflections. Their speech took on a singsong quality where consecutive sentences followed the same, exaggerated pattern of pitch variation.

*Annunciation.* Two medical students overaccommodated by excessively annunciating their words during the interaction, speaking overly slowly and deliberately. Their sentences were noticeably drawn out and slow in tempo.

*Vocal nonfluencies.* Three medical students overaccommodated with vocal nonfluencies: two students used repeated stuttering, and one student giggled when they discussed mobility restrictions.

### **Relationship Assumptions**

Ten medical students overaccommodated by showing surprise to learn that the SPE carried on healthy relationships and communicated negatively framed assumptions about relationships, or about friends or romantic partners, or about general expectations of relationships being defined by receiving care.

*Who takes care of you?* Three medical students indicated that a patient with a disability would require daily assistance and would not likely live alone. These students showed surprise to learn that a person with a disability lived alone, asking: "Who takes care of you?" when the SPE said s/he lived alone.

*Friends.* Two students complimented the SPE for having relationships with friends, responding to disclosure about getting together with friends with comments like, "That's wonderful! Do they remind you to do your exercises?"

*Significant other.* Three students responded in an overly positive manner when they learned the SPE was married or lived with a relational partner, indicating, "Yeah? That's wonderful!" or "It's so good you have a boyfriend."

*Mother.* Two medical students misinterpreted disclosure communication by the SPE's about taking care of his/her ailing mother as assuming they lived with the mother in order to receive ongoing care.

*Divergence or underaccommodation.* Twenty-one medical students demonstrated divergence and/or underaccommodation, in which communication emphasized group differences rather than rapport. Identified behaviors indicating divergence or underaccommodation include erratic question flow, minimizing disability, embellishing SPE disclosure, or overly informal communication.

*Erratic question flow.* Four of the students exhibited erratic question flow, with quick-fired, closed-ended questions. Closed-ended questions about pain level, for example, were followed rapidly by questions about smoking, living alone, then back to shoulder pain, then drug use, then number of hours a day of care.

*Minimizing disability.* Nine students underaccommodated by minimizing disability or by under-responding to pain-related limitations. Examples include telling the SPE to work with a physical therapist to improve posture instead of advising modification of excessive physical demands in the workplace (eg, lifting heavy manuals at work), and asking if the SPE was healthy aside from the "occasional" pain associated with using the wheelchair. Two students minimized disability in their responses to disclosure that the SPE switched physicians because the previous physician was uncomfortable with disability, asking "Was he *that* bad?"

*Embellishing disability.* Three medical students underaccommodated by embellishing disability disclosure, asking about "feeling safe" at home in response to comments on the shoulder pain interfering with sexual intimacy and asking about "street drugs" when the student's query for current medicines resulted in a short list of prescription medications, and when there was no other indication of drug use.

*Overly informal communication.* Five students underaccommodated by using overly informal behaviors, including sitting on the examination table themselves, thus towering over the SPE in a wheelchair, or by conducting the interaction with particularly informal language. ("Mind if I grab a seat?" or "What are your medical things, like what you see a doc for?")

### **Inconsistency with SPE Emotional Cues**

Twenty-one medical students exhibited communication inconsistent with SPE emotional disclosure, responding with positive comments to negative or to neutral disclosure. The same medical students were more likely to match SPE emotional disclosure in the comparison/nutrition counseling interaction.

*Positive response to negative disclosure.* Six students responded with positive comments to negative or painful SPE disclosure, particularly about disability. For example, when the SPE says, "My disability is muscular dystrophy. I was diagnosed when I was 13 and I sat in a wheelchair when I went to college at 17," the medical student responds, "That's great you went to college to study graphic design." Another student, upon hearing the SPE could not lift her hand to shake hands, says, "Oh, great! How are things otherwise?"

*Positive response to neutral disclosure.* Nine medical students responded with positive comments to neutral disclosure, responding to disclosure about everyday life as if getting through work and maintaining a relationship is an accomplishment. For example, students learned that the SPE was a computer programmer and responded, “Wonderful. That’s really wonderful. Do you work every day?” Similar examples include overly positive responses to learning the SPE was married (responding with “That’s really very good.”) or took a daily multivitamin (responding with “Wow. That is great.”) These overly positive responses were absent in the nutrition counseling interactions used for comparison.

## Discussion

This study suggests that communication behaviors generally described as positive, rapport-building behaviors can pose negative implications when they exceed the expected quantity or duration, or when they are inconsistent with patient verbal disclosure or nonverbal expressions. Such overly positive behaviors were observed toward patients with physical disabilities, suggesting overaccommodation to the disability, and highlighting group differences toward people with disabilities rather than interpersonal similarities.<sup>15</sup> This project adds to the literature on intergroup approaches to communication and provides evidence that subtleties in the duration, range, or context of otherwise positive, rapport-building behaviors can have negative implications.

Identified themes serve as examples to understand when rapport building extends beyond affiliation and instead indicates patronizing behavior toward patients with disabilities. The sometimes subtle distinctions between rapport building and crossing into patronizing behavior may be difficult for individuals to address in the moment, especially if the identified behaviors are observed within a generally positive encounter. A specific implication of this work is the need for medical student awareness and training to address intensity, duration, and context of communicating rapport-building behaviors toward patients with disabilities.

Medical students who used *secondary baby talk* modified their communication in ways that would be appropriate to address a child, implying presumption of cognitive impairment or lower intelligence in people with physical disabilities. These behaviors indicate a

need to adapt to cognitive impairments, but the non-verbal gestures clinicians used as “visual aids” were without valid indication of any mental challenges (in fact, *none* of the included disabilities are correlated with cognitive deficits). Similarly, medical students’ use of “we” references to indicate “you” and cute language may indicate assumptions of decreased mental capacity in patients with physical disabilities, a false assumption.

Medical students who exhibited awkward kinesic movements or posture demonstrated recurrent stiff or closed posture and the tendency to spin from side to side in the chair while conducting the medical interactions. This closed-off body language could indicate discomfort or insecurity, as such forms of posture often coincide with feelings of uncertainty and self-doubt. The awkward kinesics or postures of medical students may reflect students’ discomfort with the disability. Interestingly, more than half of the students exhibiting stiff or closed posture simultaneously leaned forward from the waist. Out of context of the disability interaction and the other indicators of awkwardness or avoidance, leaning forward may indicate interest and attentiveness. The awkward kinesics and posture combined with the forward lean provide a mixed message. It may increase the likelihood that the patient with disability might be “forgiving” of the attitudes implied, but decrease the likelihood the patient would feel comfortable labeling the medical student as awkward overall.

Vocalic indications of exceeding boundaries of rapport included more pronounced annunciation. This overarticulation perhaps intended to decrease ambiguity may instead suggest potential misinterpreted signs of physical disability as mental challenges. Overly deliberate speech through high volume was often accompanied by noticeably high vocal “singsong” pitch. The melodic inflections occur out of context with patients’ seeking reassurance. Giggling and stuttering may indicate general discomfort with people with disabilities.

When the discussion shifted from chief complaint to the way in which the pain affected their relationships, behaviors extending beyond rapport included messages indicating assumptions of daily need for care. Half of the students who indicated surprise about relationships appeared surprised to learn someone with a disability might be married. Similarly, these students’ complimentary remarks about a strong network of friends communicated attitudes that implied that this was remarkable and unexpected for people with disabilities.

**Communication behaviors may subtly transmit such cultural biases and negative stereotypes and may inhibit the potential for building patient-relationships through these very behaviors generally considered positive.**

Medical students who exhibited divergence emphasized distinction from patient cues by minimizing disclosure, or in contrast by embellishing disclosure. Furthermore, students who diverged by sitting on the examining table to conduct the interaction or spoke with a lack of formality may have attempted to restore a sense of normalcy to a situation that felt foreign to them. Although perhaps intended to build comfort, these informal cues may blur professional boundaries.

A subset of medical students responded to SPE emotional disclosure with noticeable inconsistency, where positive or encouraging responses were out of context. A positive response in reply to a painful or negative disclosure may indicate uncertainty in addressing patients' emotional cues and treat behaviors expected from able-bodied individuals as "accomplishments" from people with disabilities.

### Limitations and Future Directions

Although the current study extends the literature in both communication and medical education, limitations can be identified. First, interactions were conducted with SPEs, which may limit generalizability compared to the larger patient population. SPEs cannot represent exactly the same style of interaction with each of the medical students, and their own varying degrees of communicative behaviors may have ultimately influenced the ways medical students responded. The current research does not yet account for the ways in which overaccommodation may be gender-specific. For example, females may be more likely to exhibit overaccommodation in the kinesic or vocalic involvement, while males may do so in their questioning patterns. Future research should examine sex differences in identified behaviors.

Notwithstanding these limitations, the current study provides extensive, systematic analysis of communication behaviors in a large, representative data set. Future analysis should examine the mutual influence process between medical students and patients in order to describe the extent to which patients influence changes over time in medical students' behaviors. Future research should also examine a comprehensive analysis of the ways communication behaviors are predictive of process outcomes, such as the ways the interactions are conducted, as well as short- and long-term health outcomes for both physicians and patients. Future research should also examine whether behaviors observed in medical students continue to manifest in interactions with patients with disabilities.

### Conclusions

Identified behaviors that may otherwise be interpreted as rapport building can shift the interaction in ways that pose negative implications for behaviors that on the surface are interpreted positively. This work suggests that subtleties in quantity or duration, or behaviors that are out of context or inconsistent with the verbal content, can imply attitudes and assumptions toward members of stigmatized groups such as persons with disability. Communication behaviors may subtly transmit such cultural biases and negative stereotypes and may inhibit the potential for building patient-relationships through these very behaviors generally considered positive. Interpreting communication behaviors within the context of patient disclosure and comparing medical student communication across multiple patients would be an important step in developing the capacity to distinguish attitudes and biases limiting communication by addressing the communication behaviors that transmit them interpersonally. A significant first step for medical students would be to begin to recognize when their communication behaviors actually build rapport, and when otherwise positive behaviors actually inhibit the interaction. ❖

- <sup>a</sup> Statistical comparisons of objective coding of multiple validated scales provided additional evidence that medical students who used communication behaviors that exceeded expected rapport boundaries did not use the same behaviors in the nutrition counseling interactions. The objective coding and analysis has been written as a separate analysis and will be submitted to a subsequent publication.

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