

Nonverbal Immediacy in the Physician/Patient Relationship

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This study examined the relationships between the nonverbal immediacy of physicians and their patients' satisfaction with them as doctors and overall medical care. Consistent with the results of previous studies in the instructional and organizational communication areas, substantial associations were found in this medical context. Patients who see their physicians as more immediate report more satisfaction with the physician and are generally more satisfied with the medical care they receive. The patients also indicated experiencing less fear of their physician when the physician was more immediate.

In a previous study of communication in the physician/patient relationship the role of communication apprehension was examined to learn whether this common communication problem played an important role within this context. The results presented a mixed picture (Richmond, Smith, Heisel, & McCroskey, 1998). Although trait communication apprehension was significantly correlated with state apprehension in the physician/patient context, no direct relationship between trait apprehension and patient satisfaction with either phy-

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sician or medical care generally was observed. However, state communication apprehension was significantly related to both satisfaction variables.

While an indirect effect for patients' trait communication apprehension cannot be completely discounted, these results point more toward the behaviors of the physician in this communicative relationship as factors in patient satisfaction than the communication-based traits of the patient. One set of communication behaviors, known as "nonverbal immediacy behaviors," have been shown consistently to result in positive interpersonal communication outcomes (Richmond & McCroskey, 2000a).

Many affective orientations of individuals have been found to be associated with nonverbal immediacy. Physicians individually, and Health Maintenance Organizations and other medical delivery systems collectively representing physicians, have become increasingly sensitive to the affective reactions of patients to individual physicians as well as medical care in general. While framed in many different ways and measured in many more, this affective orientation commonly is referred to as patient satisfaction. When framed in terms of the bottom line for most medical professionals, this orientation becomes "satisfied patients are less likely to sue hospitals and doctors than dissatisfied patients." It is important, therefore, to understand the possible role of communication orientations and behaviors of physicians in producing satisfied or unsatisfied patients.

Much of the research on the impact of nonverbal immediacy behaviors has been conducted within the instructional communication context. The results of this research show a very powerful impact attributable to teachers' use of nonverbal immediacy behaviors on student learning both cognitively (McCroskey & Richmond, 1992; McCroskey, Sallinen, Fayer, Richmond, & Barraclough, 1996; Richmond, 1990) and affective (McCroskey, Richmond, Sallinen, Fayer, & Barraclough, 1995). In addition, more immediate teachers have been found to be perceived much more positively by their students (McCroskey et al., 1996). More recently, the generalizability of this "nonverbal immediacy effect" has been examined within the organizational context. In this research it was found that within the supervisor/subordinate relationship nonverbal immediacy of one person in the dyad appeared to not only stimulate reciprocal nonverbal immediacy by the other member but also to be associated with affective impacts (subordinate satisfaction) much like were observed within the instructional context (Richmond & McCroskey, 2000b).

From the consistent observation of a positive relationship between the use of nonverbal immediacy behaviors by people in one-up roles (teachers, supervisors) and positive affective responses by people in one-down roles (students, subordinates) researchers concluded that this pattern should also exist in the physician (one-up) and patient (one-down) relationships. Specifically the following hypotheses were advanced:

H1: There is a positive relationship between the degree of perceived use of nonverbal immediacy behaviors by physicians and self-reported satisfaction with the physician by patients.

H2: There is a positive relationship between the degree of perceived use of nonverbal immediacy behaviors by physicians and self-reported general satisfaction with medical care received by patients.

In previous studies it was found that state fear of the physician was negatively associated with satisfaction with the physician and general satisfaction with the medical care received by the patient. Therefore, this study speculated that this fear may have been produced, at least in part, by "distancing" behaviors by the physicians. These behaviors are

directly opposite to nonverbal immediacy behaviors. If our speculation is correct, patients should experience less fear when dealing with physicians who exhibit nonverbal immediacy behaviors than those who do not. Hence, the third hypothesis was advanced:

H3: There is a negative relationship between the degree of perceived use of nonverbal immediacy behaviors by physicians and self-reported state fear of the physician by patients.

METHOD

Participants

Participants were 214 adult patients from various physicians' offices in medical centers in a mid-Atlantic state. The sample was a convenience sample which included 113 males and 101 females. The mean age of the participants was 34.22. Participants were patients who anonymously volunteered to complete the study questionnaire. All participation took place in physicians' outer-offices following a visit to the physician. Upon leaving the physicians' offices, patients were handed a survey to complete concerning the physician they had just visited. If the patient elected to complete the questionnaire, he or she could place the response in a box near the exit door. If he or she elected not to complete the questionnaire, he or she could place the blank questionnaire in the same box, return it to the person who gave it to her/him, discard it, or keep it. Since the researchers were not present, maintaining control of the instruments was not possible. Therefore, some blank questionnaires were redistributed, and some may have been lost or mishandled. Hence, the proportion of volunteers to contacts could not be computed. Of 300 questionnaires duplicated, 214 were completed and returned.

Participants were not helped by the researchers in the completion of the questionnaire. They were simply asked by the exit staff "if you have the time, would you please complete this questionnaire about physician/patient communication?" Then the questionnaire was handed to the exiting patient. Since the staff was not informed of the nature of the study, if asked for help they were not in a position to answer with anything more than explaining how to complete the instrument or what certain words might mean. The patients were instructed not to identify themselves or their physician in any way. Data were collected over approximately eight weeks (not all medical centers were able to distribute the questionnaires at the same time), but data collection in a given location was limited to a week. The procedure employed was the same as the one in a previous study (Richmond et al., 1998). It was originally modeled on the procedure used for obtaining satisfaction feedback by an HMO in the same area.

Instruments

Nonverbal Immediacy. The Physician Nonverbal Immediacy Measure (PNIM) was developed for this study. The PNIM measure is a 10-item measure adapted from the Teacher Nonverbal Immediacy Measure (TNIM; Richmond, Gorham, & McCroskey, 1986). The 5-step response format of the original instrument was retained (*Never* = 0, *Rarely* = 1, *Occasionally* = 2, *Often* = 3, *Very Often* = 4). Using this response format, the participants were asked to respond to the following ten items: 1) Uses gestures while talking to me; 2) Speaks with a monotone or dull voice when talking to me; 3) Looks at me while talking; 4) Smiles at me while talking; 5) Has a very tense body position while talking to me; 6) Frowns while talking to me; 7) Looks elsewhere while talking to me; 8) Has a very relaxed body position while talking to me; 9) Smiles at me as he or she comes in the room; 10) Uses vocal variety when

talking to me. The alpha reliability estimate for the PNIM in this study was .81. This is very similar to alpha estimates for 10-item versions of the TNIM (McCroskey et al., 1995; 1996). While the instrument employed is referred to as the Physician Nonverbal Immediacy Scale, it should be recognized that it is nothing more than an updated version of the NIM with instructions adapted to the context of the present study.

Fear of Physician. The fear of the physician (FOP) measure employed in a previous study (Richmond et al., 1998) was also employed in this investigation. This five-item instrument was based on a five-item state anxiety measure employed by Spielberger (1966). Each participant is asked to complete the measure about how tense, calm, jittery, nervous, and relaxed he or she feels while talking to his/her physician. The instrument employs a 4-step response option: 1 = *not at all*; 2 = *somewhat*; 3 = *moderately so*; 4 = *very much so*. The alpha reliability estimate for the FOP measure in this study was .88. This is consistent with the estimate in the (Richmond et al., 1998) study and that reported by Spielberger (1966).

Satisfaction with Quality of Medical Care and Physician. The Perceived Quality of Medical Care (PQMC) measure developed for a previous study (Richmond et al., 1998) was also employed in the present study. The alpha reliability estimate for the PQMC in the present study was .94, the same as it was in the Richmond et al., 1998 study. The Satisfaction with Physician (SWP) instrument developed in a previous study (Richmond, et al., 1998) was employed to measure the patients' satisfaction with their physicians. The alpha reliability estimate in this study was .93. This is comparable with the estimate obtained previously (Richmond, et al., 1998).

RESULTS

Hypotheses one and two predicted there would be positive correlations for perceived use of nonverbal immediacy by physicians (PNIM) with patients' satisfaction with their physician (SWP) and their general satisfaction with the medical care they received (PQMC). Both hypotheses were confirmed. The obtained correlation between PNIM and SWP was $r = .49$ (24% shared variance). The obtained correlation between PNIM and PQMC was $r = .55$ (30% shared variance). While these correlations were highly statistically significant ($p < .0001$), the effect size for each relationship should be considered moderate.

Hypothesis three predicted that nonverbal immediacy of the physician (PNIM) would be negatively associated with the patients' fear of their physician (FOP). The obtained correlation between PNIM and FOP was $r = .35$ (12% shared variance). While this correlation was highly statistically significant ($p < .0001$), the effect size for the relationship was lower than for the previous correlations.

DISCUSSION

This study was designed to test hypotheses that predicted that physicians who were seen as more nonverbally immediate with their patients would have patients who were less fearful of those physicians and more satisfied with the physicians and the medical care they received. These hypotheses were confirmed. The correlations obtained between nonverbal immediacy and satisfaction was quite substantial while the correlation with fear of the physician was lower.

In judging the effect sizes obtained here it is important to recognize the limitations on potential effect size imposed by the reduced reliability of the immediacy measure. However, overcoming the attenuating effect of this reduced reliability would not raise the levels of the

obtained correlations to the point where they should be considered "high." This suggests, therefore, that while nonverbal immediacy has been demonstrated in this research to be substantially associated with increased patient satisfaction and reduced patient fear, these two desired outcomes must involve other elements not measured in this investigation. Some of these elements certainly are factors that are not based on the physicians' communication behaviors (for example, how ill the patient is, the medical environment in which the physician/patient interaction takes place, financial matters involved, patient communication behaviors, and so on). It must be recognized that physician communication behaviors clearly are not the only factors impacting patient fears or satisfactions. Indeed, it seems quite possible that with nonverbal immediacy this study may have accounted for all the variance in these outcomes that can be attributed to physician communication behaviors. However, this study cannot accept that supposition prior to additional research work.

While nonverbal immediacy has been demonstrated to have a large and positive effect on and/or association with many desirable outcomes of communication in a variety of contexts and settings in a variety of cultures, it must be noted that nonverbal immediacy has not been advanced as the most critical aspect, much less the only aspect, of communication competence for anyone, including physicians. For example, in the typology of affinity seeking strategies (Bell & Daly, 1984) nonverbal immediacy was advanced as one of 25 strategic behaviors. Similarly, research involving communicator style and socio-communicative orientation have identified many important elements, some of which have no apparent relationship to nonverbal immediacy (Norton, 1983; McCroskey & Richmond, 1995).

It would appear that, although nonverbal immediacy can account for a substantial variance in important outcomes related to physician/patient interactions, it is likely that substantially more variance can be accounted for by adding or substituting other communication variables into the equation. A particularly promising approach would be the socio-communicative style approach (McCroskey & Richmond, 1995). This approach is based on decades of previous research drawing on Jungian psychological theory and proposes two uncorrelated elements of communicator style, assertiveness and responsiveness, as the critical elements of human communication. It seems likely that this approach could build on the foundation of the present investigation.

It also is important that future research in this area broaden the scope of the investigation. Since antiquity it has been argued that the *ethos* or source credibility of a communicator is a critical element in producing positive or negative outcomes from human communication. Does nonverbal immediacy (or do socio-communicative style variables) impact source credibility of a physician? Is source credibility a causal link between nonverbal behaviors and other communication outcomes, or is source credibility simply another outcome? Can a series of causal links among these variables (causal paths) be identified? Are there other important outcome variables that are impacted by variability in physician/patient communication? These and other questions need to be explored in future research in this area.

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