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Respecting patients is associated with more patient-centered communication behaviors in clinical encounters

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Abstract

Objective—Attitudes towards patients may influence how clinicians interact. We investigated whether clinician-reported respect for patients was associated with communication behaviors during **HIV care** encounters.

Methods—We analyzed audio-recordings of visits between 413 adult HIV-infected patients and 45 primary HIV care providers. The independent variable was clinician-reported respect for the patient and outcomes were clinician and patient communication behaviors assessed by the Roter Interaction Analysis System (RIAS). We performed negative binomial regressions for counts outcomes and linear regressions for global outcomes.

Results—Clinicians with higher respect When clinicians had higher respect for a patient, they engaged in more rapport-building, social chitchat, and positive talk. Patients of clinicians with higher respect for them engaged in more rapport-building, social chitchat, positive talk, and gave more psychosocial information. Encounters between patients and clinicians with higher respect for them had more positive clinician emotional tone [regression coefficient 2.97 (1.92-4.59)], more positive patient emotional tone [2.71 (1.75-4.21)], less clinician verbal dominance [0.81 (0.68-0.96)] and more patient-centeredness [1.28 (1.09-1.51)].

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Conclusions—Respect is associated with positive and patient-centered communication behaviors during medical encounters by clinicians and patients.

Practice Implications—Clinicians should be mindful of their respectful attitudes of respect and work to foster positive regard for patients to promote more patient-centered communication and higher quality of care. Educators should consider methods to enhance **trainees'** respect in communication skills training.

Keywords

HIV/AIDS; patient-clinician communication; respect

1. Introduction

Communication training of health professionals emphasizes the acquisition of specific skills, yet attitudes towards patients may also influence how healthcare practitioners interact. Maintaining an attitude of respect for patients is a fundamental value in the medical professionalism, biomedical ethics, and cultural competency literatures, though such attitudes can be challenging to measure. Theoretical framings of respect include the protection of patient autonomy (show respect for the patient's personhood) and unconditional positive regard for the patient as a person. In healthcare settings, An attitude of respect towards patients is placed at the center of bioethics and medical professionalism, and can be understood as having both a cognitive or emotional component (a belief intrinsic within a clinician that the patient has value) and a behavioral component (acting on this belief with observable behaviors). [1] Despite the acknowledged conceptual importance of respect in caring for patients, little empirical data exists on how respect is manifested by healthcare practitioners or how it affects patients. Prior studies in primary care contexts suggest have found that respectful clinician communication behaviors as reported by patients are associated with improved patient adherence to therapeutic regimens [2, 3] and improved health outcomes in chronic disease management. [4-8] In HIV care, the quality of the patient-clinician relationship is important for adherence and clinical outcomes. When patients feel “known as a person” by their HIV care clinician, they are more likely to receive antiretroviral therapy (ART), adhere to ART, and have undetectable HIV viral loads. [9] These outcomes are critical to reducing the morbidity and mortality of persons living with HIV/AIDS (PLWH). Although being known as a person is not a measure that specifically uses the word, ‘respect’, it evokes the essence of respect as acknowledgment of the patient *as a person*. From the patient perspective, PLWH who report that their clinician always treats them with dignity and respect are also more likely to keep their clinic appointments. [10]

The extent to which better patient experiences represent more respectful attitudes on the part of clinicians is unclear, in part because such attitudes can be challenging to measure and far fewer studies have attempted to do so. In the primary care context, one study found that respect for particular patients varied and was associated with more positive clinician communication behaviors. [11] These findings have not been replicated until now. Furthermore, clinician respect for patients may be particularly relevant in HIV care due to several factors such as racial/ethnic differences between patients and clinicians, [12-19] HIV-related stigma, [20-22] and stigma towards substance use disorders. [23-25] Patients

with active substance abuse perceive less respect from clinicians and demonstrate less engagement in HIV care. [10]

No prior studies have assessed clinicians' respect for patients with HIV or the observable clinician behaviors that convey respect to patients. Further elucidation of the role of respect in HIV care is needed to inform efforts to optimize patient-clinician relationships and the health of PLWH. To address this gap, we aimed to investigate whether clinician-reported respect for patients varied with patient or clinician characteristics and whether respect was associated with communication behaviors during clinical encounters. This understanding is needed to inform efforts of optimize patient-clinician relationships, in HIV care and beyond.

2. Methods

Study design, subjects, and setting

We conducted a cross-sectional analysis of data from the Enhancing Communication and HIV Outcomes (ECHO) Study, which was designed to assess possible racial/ethnic disparities in communication in HIV care and to determine which interactions are associated with more positive outcomes among patients with HIV. [12-13, 26-29] Study subjects were HIV care practitioners and patients at four HIV outpatient sites in the United States (Baltimore, Detroit, New York, and Portland). The study received IRB approval from each of the four sites. Eligible clinicians were physicians, nurse practitioners, or physician assistants who provided primary HIV care to patients at one of the study sites. Eligible patients were HIV-infected; age greater than 18; English-speaking; and had had at least one prior visit with their clinician.

Data Collection

Clinicians who agreed to participate gave informed consent and completed a baseline questionnaire. Research assistants then approached patients of participating clinicians in the waiting rooms, with the goal of enrolling 10 patients per clinician. Eligible patients gave informed consent, and then research assistants placed a digital audio-recording device in the examination room to record the patient-clinician encounter. Following the encounter, patients completed a one-hour interview with research assistants and reported demographic, social, and behavioral characteristics. Clinicians also completed post-encounter questionnaires, including assessment of clinician-reported respect for the patient in the encounter.

Measures

Clinician respect—The independent variable was clinician-reported respect for that particular patient assessed immediately following the encounter with the item, “Compared to other patients, I have a great deal of respect for this patient” (5-point Likert scale from strongly agree to strongly disagree). Responses were dichotomized to compare those who strongly agreed/agreed (higher respect) with those who were neutral or disagreed (lower respect). This measure has been used in prior studies in primary care to assess healthcare practitioners' respect for patients. [11, 30]

Communication behaviors—The outcomes were clinician and patient communication behaviors assessed by the Roter Interaction Analysis System (RIAS), a widely used coding system to assess patient and clinician communication behaviors with well-documented reliability and predictive validity. [4-5, 31-32] RIAS analysts assign one of 37 mutually exclusive and exhaustive categories to each complete thought expressed by either the patient or clinician (referred to as an utterance). Four broad types of exchange can be assessed by combining these categories to reflect *socio-emotional communication* (including explicitly emotional talk such as empathy and concern, positive talk including agreements, approvals and compliments, negative talk such as criticisms and disagreements, and social chit-chat), *information-giving* (including biomedical and psychosocial/lifestyle information), *question-asking* (including open-ended and closed-ended questions), and *patient activation* (such as asking for the others' opinions, confirming the others' understanding, or clarifying one's own understanding and cues of interest). The combined category of *rappor-building* is calculated from summation of all utterances by the clinician (and separately, by the patient) in the sub-types of empathy, legitimation, partnership, reassurance, and humor.

In addition, the RIAS provides global ratings of the patient and clinician emotional tone. Emotional tone scores are calculated by summing coders' subjective ratings for patients and clinicians (separately) on several dimensions. The *patient emotional tone* is the sum of coders' ratings of patient dominance/assertiveness, friendliness/warmth, responsiveness/engagement, and sympathy/empathy exhibited by the patient during the encounter. The *clinician emotional tone* is the sum of coders' ratings of clinician interest/attentiveness, friendliness/warmth, responsiveness/engagement, and sympathy/empathy, reverse-coded for the degree to which the clinician was hurried/rushed. Inter-coder reliability, calculated on a random sample of 41 audio files, was greater than 90% agreement in each of the domains.

Summary measures for the encounters included *verbal dominance*, calculated as the ratio of clinician utterances to patient utterances, and *patient-centeredness*, calculated as the ratio of psychosocial/emotional utterances to biomedical utterances. Total visit length for the encounters was also recorded from the audio files.

Covariates—Covariates included patient and clinician demographics and length of patient-clinician relationship. Patient interviews provided socio-demographic information (age, sex, employment, and IV or illicit drug use). Medical records provided data on patient CD4 counts and HIV viral loads. Clinician baseline questionnaires provided self-reported clinician demographic information such as age, sex, and race/ethnicity.

Statistical analysis

We used chi-squared and t-test analyses to investigate associations between clinicians' respect for patients and patient or clinician characteristics. Two types of communication outcomes were analyzed: 1) counts of patient or clinician behaviors (e.g. utterances of rapport-building, utterances of information-giving) and 2) global measures (e.g. patient or clinician emotional tone, clinician verbal dominance in the entire encounter). To examine associations between clinician respect and counts outcomes, we performed negative binomial regressions. To examine associations between clinician respect and global

outcomes, we performed linear regressions with identity link. For both types of analysis, we also used generalized estimating equations with robust variance to account for clustering of patients within clinicians and adjusted for practice site. All multivariable analyses were adjusted for the potential confounders of patient race and drug use, clinician race and age, and length of patient-clinician relationship, because these variables were associated with clinician-reported respect for patients and may influence patient-clinician communication behaviors.

3. Results

Participant characteristics

Table 1 shows patient and clinician characteristics in the study sample. Patients were predominantly male (66%) and African-American (57%), while clinicians were predominantly female (58%) and white (71%). In total, there were 435 patients and 45 clinicians in the study sample. After excluding those with missing data for respect, 413 patient-clinician interactions were included in the analysis. Each patient-clinician pair had 1 audio-recorded encounter. On average, there were 9 patients per clinician, with a range of 1 to 16.

Clinician ratings of respect

Figure 1 shows the distribution of clinicians' self-reported ratings of respect for patients. Clinicians strongly agreed that they had a great deal of respect for 155 (38%) patients, agreed for 182 (44%), neutral for 66 (16%), disagreed for 8 (2%), and strongly disagreed for 2 (1%). In subsequent analyses, these responses were dichotomized as "higher respect" (strongly agree or agree) and "lower respect" (neutral, disagree, strongly disagree). Sensitivity analyses were also repeated using three categories for respect, "high" (strongly agree), "middle" (agree), and "low" (neutral, disagree, strongly disagree), and there was no substantive change in the findings. Analyses using the dichotomized responses are reported below.

Clinician ratings of respect demonstrated heterogeneity among patients. Numerical scores for respect were assigned as 1=strongly agreed that they had a great deal of respect for the patient, 2=agreed, 3=neutral, 4=disagreed, 5=strongly disagreed. Most clinicians reported a range of respect, from 1 for some patients to 3 for others. Of the 45 clinicians, only 4 had no variability. Of these 4 clinicians, 1 assigned all 9 of their patients a score of 1; 1 assigned all 4 of their patients a score of 2; 1 assigned all 2 of their patients a score of 3; and 1 had a single encounter with a score of 2. Only 9 clinicians reported disagreeing (score of 4) or strongly disagreeing (score of 5) that they had a great deal of respect for a particular patient. All of these 9 clinicians reported a range of scores, assigning scores of 1 or 2 to other patients.

Associations between clinician respect and patient/clinician characteristics

Table 2 shows patient and clinician characteristics associated with clinicians' level of respect for patients, in unadjusted analyses. Clinicians' self-reported respect for the patient was associated with patient race (78% of highly respected patients were non-white vs. 67% of

less highly respected patients, $p=0.044$) and drug use (27% of highly respected patients were actively using drugs vs. 43% of less highly respected patients, $p=0.004$). Highly respected patients were more likely to see a non-white clinician ($p<0.001$) and more likely to see a younger clinician ($p=0.024$). (66% of highly respected patients saw white clinicians vs. 88% of less highly respected patients white clinicians reported higher respect for patients 66% of the time vs. lower respect for patient 88% of the time, $p<0.001$), clinician age (mean age 44 years among highly respected patients vs. 46 years for less highly respected patients, $p=0.024$), and Clinician respect for the patient was also associated with length of relationship (31% of highly respected patients had known their clinician for more than 5 years vs. 45% of less highly respected patients, $p=0.019$). Clinicians' respect for patients was not associated with patient age, gender, working status, marital status, receiving antiretroviral therapy, viral suppression, or clinician gender or clinician type.

Associations between clinician respect and communication behaviors

Table 3 shows associations between clinician respect and communication behaviors of clinicians and patients, and the patient-clinician encounter. In multivariable analysis, clinicians with higher respect when clinicians had higher respect for a patient, they engaged in more rapport-building [IRR 1.18 (1.04-1.33), more social chit chat [1.78 (1.11-2.84)], and more positive talk [1.20 (1.04-1.39)]. Patients of clinicians with higher respect whose clinicians reported higher respect for them engaged in more rapport-building [1.21 (1.07-1.39)], more social chit chat [2.03 (1.16-3.56)], more positive talk [1.22 (1.08-1.39)], and gave more psychosocial information [1.60 (1.26-2.04)]. Encounters between patients and clinicians with higher respect for them had more positive clinician emotional tone [regression coefficient 2.97 (1.92-4.59)], more positive patient emotional tone [2.71 (1.75-4.21)], less clinician verbal dominance [0.81 (0.68-0.96)] and more patient-centeredness [1.28 (1.09-1.51)]. There was no significant difference in the length of the encounters.

4. Discussion and Conclusion

4.1 Discussion

Respect is associated with more positive and patient-centered communication behaviors during medical encounters by both clinicians and patients. When clinicians reported higher respect for patients, both clinicians and patients had more positive affect, engaged in more rapport-building, more social chitchat, and more positive talk. Patients who were highly respected by clinicians gave more psychosocial information. Overall, their encounters had less clinician verbal dominance, indicating that patients did more of the talking. These results demonstrate the effect of attitudes on communication processes, underscore the highly reciprocal nature of communication and suggest that patients who are more highly respected may be more engaged in clinical encounters with their healthcare practitioners.

Respect can be a difficult-to-define concept and challenging to distinguish from other related concepts, such as liking or positive regard. It can also be hard to separate feelings of respect for patients in general from respect for a particular patient. To address this issue, clinicians were asked to rate their respect for individual patients "as compared to other patients".

However, it is unknown what clinicians were thinking in making this judgment or which aspects of the patient or their interactions were considered in the assessment. The fact that our data show variance in clinicians' reports of respect for different patients suggests that clinicians were reporting respect as a specific characteristic with each patient rather than a global characteristic. Patient perceptions have been assessed in other studies of respect [2, 3] and do tend to correlate with clinician assessments, though not always. Patient perception of respect from clinicians is an area worthy of further investigation.

In both the previous study done in the primary care context [11] and this current study done in HIV care, higher clinician respect was associated with a more positive affect or emotional tone for patients and clinicians. Prior studies in primary care have shown that positive emotional tone plays an important role in the development of trust between patients and clinicians and that this association is particularly strong for African American patients [33]. In past studies, African American patients and their clinicians demonstrated less positive affect in medical encounters than white patients and their clinicians [34]. In our study, clinician respect for patients was associated with more positive patient and clinician affect even after controlling for patient and clinician race.

In contrast, the association between clinician respect and patients' psychosocial information-giving is seen in HIV care but not in primary care settings. Primary care physicians with higher respect for patients tend to give more information *to* those patients, rather than eliciting more information *from* them. Giving information to patients can be interpreted as a manifestation of respect, specifically in honoring patient autonomy to be involved in healthcare decisions or in an attempt to empower patients through education and counseling. However, overwhelming the patient with information without checking the patient's perspective may have the opposite effect and demonstrate clinician dominance rather than a patient-centered approach.

Eliciting more information from patients may be a more effective manifestation of respect than giving information. may also be a manifestation of respect. For example, patients who feel more respected may be more comfortable sharing psychosocial information with their clinicians, if they are confident this information will be received in an open, non-judgmental manner. This sharing may be facilitated by perceptions of respect in HIV care, as compared to primary care, due to the potentially sensitive nature of discussions of substance use, mental health, or sexual behaviors. Attitudes and communication behaviors likely also have some degree of reciprocal influence. Patients who give more information may elicit more respect from healthcare practitioners. If being more engaged in the encounter is considered a desirable patient trait, it could engender more positive clinician attitudes toward those patients. Therefore, a limitation of this study is that directionality of these interactive phenomena cannot be determined. Patient perceptions **of their clinicians' level of respect for them** have been assessed in other studies of respect [11, 30] and do tend to correlate with **clinicians' reported levels of respect for them**, though not always. Future work could examine these questions in more depth by assessing both clinician-reported respect for a particular patient and that patient's perceptions of clinician respect to evaluate for concordance, including which clinician communication behaviors may impact patient perceptions of respect, and follow patient-clinician relationships longitudinally.

Unconditional positive regard for patients as persons has been proposed as a moral obligation of healthcare practitioners. [1] However, clinicians' self-reported respect for patients is not equal. In primary care, clinicians report higher respect for older patients and those they know well [11] and obese patients may overestimate clinicians' respect for them [3]. In HIV care, clinicians' respect for patients was not associated with patient age, but was associated with patient race and illicit drug use, clinician race and age, and the length of the patient-clinician relationship. The finding of lower clinician respect for patients reporting active substance use is consistent with previous studies documenting limited clinician comfort discussing illicit substance use [35, 36] and may explain suboptimal communication behaviors during clinician encounters with patients who actively use illicit substances [23]. HIV-related stigma and stigma against persons with substance use disorders can present significant barriers to PLWH in seeking healthcare. [20-25] By demonstrating respect in communicating with patients, clinicians could take steps toward overcoming these barriers, particularly for patients who have prior experience or expectations of disrespect from healthcare professionals.

Clinicians were more likely to report lower respect for patients they had known for more than five years, which appears counter-intuitive when knowing a patient well has been correlated with higher respect in the primary care setting. [11] Knowing a patient "as a person" has also been associated with more positive clinical outcomes in HIV care. [9] It should be noted that length of relationship and quality of relationship are not necessarily the same. Ideally, patient-clinician relationships would strengthen and deepen over time, but getting to know patients better could also reveal traits or behaviors that negatively impact clinician respect for them. Longitudinal assessment of clinician respect for the patient over time is needed to examine these questions more thoroughly. There may also be unmeasured confounders that explain this association.

PWLH of racial/ethnic minorities often face additional discrimination and healthcare disparities, which undermines the trust at the core of patient-clinician relationships. [12-19] The findings of our study regarding variation in clinician respect with patient and clinician race bear further examination. White clinicians were more likely than non-white clinicians to report lower respect for patients. In addition, clinicians were more likely to report higher respect for non-white patients than white patients, which appears to conflict with non-white patient experiences of lower respect and discrimination in healthcare settings [37, 38] and observer ratings of clinicians demonstrating higher respect for white than non-white patients in medical encounters. [39] No prior studies have measured clinician self-reported respect for patients in HIV care, which makes comparison and extrapolation challenging. In primary care contexts, no differences in clinician-reported respect have been seen with patient race, clinician race, or race concordance. [11] There were insufficient numbers of non-white clinicians in our study to investigate a potential role for race concordance between patient-clinician pairs. This is also an area meriting further investigation. Future work assessing clinician-reported respect for patients in diverse contexts, both in HIV care and other settings, is needed to examine the role of patient and clinician race/ethnicity in respect and its manifestations in medical encounters.

Efforts to foster respect for patients are being investigated in medical education. In particular, the RESPECT model for patient interviewing and clinical precepting has been used to help trainees build trust with patients. [40] Developing respect for patients is proposed to be an important means of addressing health disparities, as a key component of effective cross-cultural communication. Respect is defined in this model as a “demonstrable attitude communicating the value and autonomy of the patient and the validity of his/her concerns”. A focus on behaviors, as a demonstration of positive attitudes, is of practical benefit in evaluating trainees and monitoring their progress. However, attention has also been paid to the attitudes underlying behavior. In applying the RESPECT model to faculty development, the explicit assumption is that trainees who feel respected by their preceptors may be better able to treat patients with respect. Within medical education, the “hearts or minds” debate continues, regarding whether the appropriate focus should be on changing trainees’ attitudes or their cognitive processes and skills. [41] The current study offers further evidence that healthcare practitioners’ self-reported attitudes of respect are associated with observable differences in their communication with patients during clinical encounters. Efforts to foster respect for patients, with a focus on respect itself or its manifestations, may promote patient-centered communication.

This study has some limitations to consider. Respect can be a difficult-to-define concept and challenging to distinguish from other related concepts, such as liking or positive regard. It can also be hard to separate feelings of respect for patients in general from respect for a particular patient. To address this issue, clinicians were asked to rate their respect for individual patients “as compared to other patients”. However, it is unknown what clinicians were thinking in making this judgment or which aspects of the patient or their interactions were considered in the assessment, or whether social desirability bias may have made these reports less accurate. The fact that our data show variance in clinicians’ reports of respect for different patients suggests that clinicians were reporting respect as a specific characteristic with each patient rather than a global characteristic. As noted previously, using a single time-point in established patient-clinician relationships means that the direction of effects cannot be determined. Social desirability bias may be present in asking clinicians about their level of respect for patients, although the variability found in these data mitigates this concern to some extent. Audio recording does not allow assessment of body language or eye contact in patient-clinician interactions, and it is also possible that awareness of being audio-recorded may alter patient or clinician communication behaviors (i.e. a potential Hawthorne effect). However, prior communication studies in the general medical population have not demonstrated significant differences between provider behaviors when they were aware versus not aware of being recorded. [42, 43] Finally, patient experiences of respect, and their subsequent patient behaviors or health outcomes beyond the communication itself were not assessed, and could be the subject of further investigation.

4.2 Conclusion

This is the first study, to our knowledge, to assess HIV care practitioners’ respect for patients and communication behaviors in clinical encounters. Clinicians with more respect for patients When clinicians had more respect for particular patients, they demonstrated many more positive communication behaviors and elicited positive communication behaviors from

those patients. Next steps would include longitudinal studies in newly formed patient-clinician relationships, which would allow insight into directions of effect. Further work to investigate interventions to enhance clinician attitudes of respect may help improve communication and the quality of care for patients.

4.3 Practice Implications

Clinicians' attitudes of respect for patients can vary with patient characteristics, such as race and substance use. Furthermore, clinician's respect for patients is associated with observable differences in communication behaviors from both clinicians and patients during their encounters. Clinicians should be mindful of their attitudes of respect and attentive to the influence they may have on patient interactions. In particular, those who train clinicians should work to foster respect for patients as a potential means to promote more patient-centered communication between clinicians and patients.

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Highlights

- We studied links between clinicians' respect for patients and communication behaviors.
- We analyzed visits between 413 HIV-infected patients and 45 primary HIV care providers.
- When clinicians had higher respect for a patient, they used more positive behaviors.
- Visits with clinicians with higher respect for patients were more patient-centered.
- Fostering respect for patients may improve patient-clinician communication quality.

Figure 1.
Provider ratings of “a great deal of respect” for this patient, as compared to other patients

Table 1**Patient and Clinician Characteristics**

Patient Characteristics		N=435
Age, Mean (SD)	45.4	(9.4)
Female, n (%)	147	(34)
Race/Ethnicity		
Black, n (%)	254	(58)
Hispanic, n (%)	62	(14)
White, n (%)	106	(24)
Currently working, n (%)	110	(25)
Married, n (%)	53	(12)
Active drug use, n (%)	128	(29)
CD4 count, Mean (SD)	538	(866)
On ART, n (%)	334	(79)
Suppressed viral load if on ART, n (%)	192	(58)
Clinician Characteristics		N=45
Age, Mean (SD)	44.5	(8.6)
Female, n (%)	25	(56)
Race/Ethnicity		
White, n (%)	30	(67)
Asian, n (%)	11	(24)
Other, n (%)	4	(9)
Physician, n (%)	34	(76)
Relationship Characteristics		
Known for more than 5 years, n (%)	137	(33)

Table 2

Patient and Clinician Characteristics Associated with Clinicians' Level of Respect for Patient

	Higher Respect	Lower Respect	p-value
Patient Characteristics			
Age, Mean (SD)	45 (0.5)	46 (1.1)	0.883
Female, (%)	34	33	0.902
Non-white race, (%)	78	67	0.044
Currently working, (%)	27	22	0.428
Married, (%)	14	7	0.091
Active drug use, (%)	27	43	0.004
On ART, (%)	81	72	0.115
Suppressed viral load if on ART, (%)	56	56	0.967
Clinician Characteristics			
Age, Mean (SD)	44 (0.5)	46 (0.8)	0.024
Female, (%)	60	51	0.154
White race, (%)	66	88	<0.001
Physician, n(%)	70	78	0.185
Relationship Characteristics			
Known for more than 5 years, n (%)	31	45	0.019

Table 3

Differences in observed measures of patient-clinician communication based on clinicians' self-reported respect for the patient

	Higher Respect ¹
Clinician Behaviors	IRR (95% CI) ²
Rapport-building	1.18 (1.04-1.33)**
Socio-emotional talk	
Positive talk	1.20 (1.04-1.39)*
Emotional talk	1.08 (0.92-1.27)
Social chit-chat	1.78 (1.11-2.84)*
Question-asking	0.93 (0.77-1.13)
Information-giving/counseling	0.99 (0.87-1.12)
Psychosocial	1.25 (0.97-1.63)
Biomedical	0.94 (0.82-1.07)
Patient Activation	1.06 (0.89-1.27)
Patient Behaviors	IRR (95% CI) ²
Rapport-building	1.21 (1.10-1.34)***
Socio-emotional talk	
Positive talk	1.22 (1.07-1.39)**
Emotional talk	1.14 (0.90-1.45)
Social chit-chat	2.03 (1.16-3.56)*
Question-asking	1.08 (0.90-1.28)
Information-giving	1.10 (0.94-1.29)
Psychosocial	1.60 (1.26-2.04)***
Biomedical	0.88 (0.72-1.07)
Patient Activation	1.16 (0.98-1.39)
Patient-Clinician Encounter	Regression coefficient (95% CI) ³
Clinician positive affect	2.97 (1.92-4.59)***
Patient positive affect	2.71 (1.75-4.21)***
Clinician verbal dominance	0.81 (0.68-0.96)**
Patient centeredness	1.28 (1.09-1.51)**
Visit length (minutes)	3.52 (0.26-47.07)

¹ Higher respect defined as clinician response of strongly agree or agree vs. neutral, disagree, or strongly disagree to having a great deal of respect for this patient, as compared to other patients

² p-values and incidence rate ratios obtained using negative binomial regression and GEE to account for clustering of patients within clinicians, adjusting for site, patient race and drug use, clinician race and age, length of relationship; *p<0.05, **p<0.01, ***p<0.001

³ p-values and regression coefficients obtained using linear regression and GEE to account for clustering of patients within clinicians, adjusting for site, patient race and drug use, clinician race and age, length of relationship; *p<0.05, **p<0.01, ***p<0.001