EFFECTS OF EXPECTANCIES AND PHYSICIAN VERBAL MESSAGES ON GAY/LESBIAN/BISEXUAL PATIENTS' SATISFACTION WITH THE MEDICAL CONSULTATION

By

Helen Frances Bidol

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ABSTRACT

EFFECTS OF EXPECTANCIES AND PHYSICIAN VERBAL MESSAGES ON GAY/LESBIAN/BISEXUAL PATIENTS' SATISFACTION WITH THE MEDICAL CONSULTATION

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This study examined the expectancies that gay/lesbian/bisexual patients hold for typical physicians and their effects, in conjunction with physician verbal communication, upon patient satisfaction. Two primary communication expectancy theories (Burgoon, 1993; Burgoon & Miller, 1985) predict communication behavior that violates expectancies will result in more extreme outcomes (in the direction of the violation) relative to communication that confirms expectancies. This was tested on physician verbal communication with gay/lesbian/bisexual patients. Hypotheses regarding expectancy violations were not supported. Results show a strong significant main effect for physician verbal message, and smaller significant main effect for patient expectancy of the physician. These findings are discussed along with practical implications and future research directions.

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CHAPTER ONE

Introduction

Communication between physicians and patients is the basis of the medical consultation. Physicians need to gather information that is relevant to each patient's health state and pertinent to specific concerns patients bring (Allman, Yoels, & Clair, 1993). Patients need to access physician expertise sufficiently to make informed health management decisions, including informed consent (Ley, 1988). Communication between physicians and patients must be clear and accurate so that understanding is achieved, correct diagnoses are made, and proper therapies are adopted and effectively performed (Ley, 1983; Waitzkin, 1985).

There are times when patients reveal information to physicians about themselves or their activities which "deviate from mainstream expectations about appropriate behavior" (Waitzkin, 1991). Sexual information is an example. The nature of the medical consultation is such that seemingly intimate personal details of the patients' lives are appropriate to share. Physician and sociologist Howard Waitzkin (1991) observed that "in the intimacy of the

doctor-patient relationship, social problems arise and get dealt with, often in ways that are unwitting and unintended" (p. xiii). How physicians respond to disclosures of sexual information and the patients' reactions to these responses are questions that have not yet been answered, and that need investigation. These investigations should help health professionals find ways to respond that are effective rather than inadvertent.

This is a report on the issue of physician response in physician-patient interactions, in the context of the medical consultation with gay, lesbian, or bisexual patients who have just revealed their sexual orientation to the physician. This study intends to show that the patients' expectations about physicians, and the physicians' verbal responses to patients upon this disclosure should have an impact on patients' satisfaction with medical consultations.

This thesis consists of four chapters. Chapter One reviews literature on physician-patient interactions; issues for patients who are gay, lesbian, or bisexual; expectancies, and their effects in communication interactions. Two hypotheses drawn from expectancy theories are proposed. Chapter Two presents the research method, and Chapter Three reports the results. Chapter Four provides a discussion of results, limitations, implications, and future directions for research.

Literature Review

Physician-Patient Interactions

Beyond the examining room, interactions between physicians and patients have effects on patients' satisfaction outcomes (Ley, 1988) and on the expectations physicians and patients have of one another for future interactions (Leigh & Reiser, 1992). Recognition of this has resulted in a shift from a strictly biological approach to medicine toward a more psychosocial approach, which depends on open mutual communication (Cockerham, 1993). Such an approach takes into account how patient behaviors affect health, the stresses and psychological needs of the patient relative to health, and the social conditions of the patient that affect support and care the patient receives regarding health (Squier, 1990).

An approach to medicine that includes psychosocial concerns uses the medical consultation to share medically-relevant information and establish rapport between physician and patient. DiMatteo(1993) argues that

> medical care does not involve simply the straightforward application of technology by one person to another. Rather, medical care is an interpersonal process out of which emerge the technical phenomena of diagnosis and treatment (p. 301)

Rapport is thus viewed as facilitative of effective medical consultation outcomes.

The Medical Consultation

The medical consultation is the clinical encounter, the meeting between physician and patient. For the traditional physician, the primary objectives of the medical consultation are (1) determination of diagnosis or definition of possible diagnoses; (2) development of an evaluation and treatment plan; (3) communication of the plans to the patient; and (4) development of relational rapport with the patient (Allman, Yoels, & Clair, 1993). The development of the relationship with the patient should be most salient in the initial medical consultation, in which the physician and patient are strangers to one another, and guided by generalized expectations of one another.

The Physician Role

Parsons (1951) described five expectations held in U.S. society about the physician role. These are that the physician is (1) technically competent; (2) universalistic toward patients, rather than preferential toward patients with certain characteristics; (3) functionally specific, using acquired patient information only for the purpose of medical care; (4) affectively neutral, not emotionally involved with patients, not allowing liking or disliking of patients to influence their treatment; and (5) collectively

oriented, placing service to his or her patients above personal goals. The image presented here is of a competent physician patients can trust with sensitive information, who would not betray or belittle patients, nor express personal criticism of the patient.

Consistent with these expectations of the physician is advice to physicians to work toward a relationship with each patient that is marked by a professional manner "based on mutual respect and dignity" (Purtilo, 1990, p. 193). In 1948, the World Medical Association adopted a modern version of the Hippocratic Oath, which directed physicians to respect their patients and not discriminate against any patient for social reasons (Pollak & Underwood, 1968). Increasingly, new physicians are being advised to be professional but not bereft of warmth and empathy in their interactions with patients (Maguire, Fairbairn, & Fletcher, 1989). New medical school curricula are being proposed and adopted that focus more on patients' expectations and concerns, hopefully resulting in more patient-sensitive, humanistic health professionals (Evans, Stanley, & Burrows, 1992; Frankel & Beckman, 1993; Schofield & Arntson, 1989; Todd, 1989).

Patient Satisfaction and Communication

Patient satisfaction is a concept that is defined in different ways, depending on the goals of the researchers.

Essentially, it is an outcome variable of a medical consultation, reflecting a patient's perceptions regarding the physician, the encounter and their effects upon the patient's thoughts and intended behaviors.

Patient satisfaction is described as a broad multi-faceted concept, with cognitive, affective, and behavioral aspects (Ley, 1988). Cognitive elements of satisfaction include beliefs about physician, and understanding of health condition; affective elements include feelings of acceptance, feeling safe and respected; and behavioral elements include perceptions of competent physician actions and decisions within the examination (Burgoon, et al., 1987). Some concepts that have been used as indicators of patient satisfaction include perceptions of physician's respect (Greene, Adelman, Friedmann, & Charon, 1994), informativeness (Hsieh & Kagle, 1991), emotional support (Bertakis, Roter, & Putnam, 1991), and task-directed skill (ibid.). In addition, the physician-patient relationship may be conceptualized from a consumerist perspective (Haug & Lavin, 1983; Lupton, Donaldson, & Lloyd, 1991; Reeder, 1972), as encompassing not just evaluation of the preceding medical encounter but also intention to use the particular physician's services again and to recommend him or her to family and friends. These consumerist satisfaction measures of <u>intention</u> (versus actual behavior) are of the type used

in consumer psychology research (Bitner, 1990; Goodwin & Ross, 1992; Oliver, 1981).

Previous research has linked physician communication to patient satisfaction (Roter, 1989). Both verbal and nonverbal communication behaviors have been examined. In a study of physician verbal communication, audiotapes of 550 medical consultations were coded for physician communication variables, and patient satisfaction was measured (Bertakis, Roter, & Putnam, 1991). Physician communication behaviors such as question-asking about biomedical topics and question asking about psychosocial topics were coded. A major finding was that talk related to psychosocial issues was positively related to patient satisfaction, while biomedical question asking was negatively related (ibid.). This suggests that strict task-directed biomedical talk (symptoms, etiology, etc.) should be supplemented with psychosocial topics.

Nonverbal communication of the physician has also been found to have significant positive correlations with patient satisfaction. Larsen and Smith (1981) videotaped 34 actual physician-patient interactions and coded these for nonverbal immediacy behaviors such as closeness and leaning toward patient. The patients responded to post-interaction satisfaction scales, and were assigned to low and high satisfaction groups. The physicians who consulted the high satisfaction patients were found to have displayed

significantly more nonverbal immediacy than the physicians who consulted the low satisfaction group (ibid.) Another nonverbal immediacy and satisfaction study administered a written questionnaire to 117 undergraduate students (Conlee, Olvera, & Vagim, 1993). Respondents were asked to rate their own physician. Respondents' scores on a satisfaction with physician scale were correlated with their responses to a nonverbal immediacy scale. Results showed a significant positive correlation between patients' ratings of satisfaction and their ratings of perceived physician immediacy (ibid.). Both of these studies suggest that patients' perceptions of physician nonverbal communication are strongly related to patient satisfaction.

Issues of Sexual Orientation

People with a sexual orientation that is gay, lesbian, or bisexual face an issue that most people do not; they have a hidden, highly stigmatizing attribute. Goffman defines stigma as a "deeply discrediting" attribute (1964, p. 3). The stigma of homosexuality is the view that such people are "sick, dangerous, sinful, effeminate, and mentally ill" (Gentry, 1982, p. 207)

Homosexuality is not only socially stigmatized but it also presents legal problems (Maher, 1984). Sexual components of homosexuality are criminalized in about half

of the United States (Hunter, Michaelson, & Stoddard, 1992). Some of the laws used against homosexuality are: sodomy (Arkansas, District of Columbia, Georgia, Kansas, Maryland, Utah); consensual sodomy (New York); crime against nature (Arizona, Nevada, North Carolina, Oklahoma, Rhode Island, Virginia); buggery (South Carolina); homosexual conduct (Texas); deviate sexual conduct (Missouri); unnatural or perverted sexual practices (Maryland); and unnatural and lascivious act (Florida) (ibid.). In addition to sexual behavior, individuals who are identified as gay, lesbian, or bisexual are barred from military service. In most communities, gay,lesbian, or bisexual people (and heterosexual people labeled as such) can legally be fired from their jobs, lose custody of their children, and be evicted from rental units solely on the basis of sexual orientation, since sexual orientation is not a protected civil right in the United States.

Gay, lesbian, and bisexual patients must make decisions about communicating this attribute, sexual orientation, to others and they must face the outcomes of such disclosures (Cain, 1991). Disclosure of a same-sex sexual orientation has been called "coming out" (DeMonteflores & Schultz, 1978), a phrase reflecting the hidden nature of this attribute. Because of the invisibility of one's sexual orientation (Dardick & Grady, 1980), and the assumption that

everyone is heterosexual, people who are gay, lesbian, or bisexual are

> actively misclassified by others as heterosexual..(and) are thus required to negate explicitly this classification by disclosing their identity (Strommen, 1989, p. 39).

Unless individuals communicate their sexual orientation, others cannot be certain of it.

Gay/Lesbian/Bisexual Patients

Based on the possible social and legal consequences of disclosure of a homosexual or bisexual orientation, there seems to be considerable motivation to keep this information protected and hidden in many contexts. One context in which it is important to reveal one's sexual orientation is within the physician-patient relationship. Knowledge of a patient's sexual orientation provides the physician with diagnostic and therapeutic information that can produce better health outcomes (Caiazza, 1984; Noumoff & Farber, 1989; Owen, 1980; Ross, 1992; Rowan & Gillette, 1978).

Sexual orientation can be defined in terms of cognitive, affective, and behavioral components in various ways (Laumann, Gagnon, Michael, & Michaels, 1994). A definition of homosexuality that has been used by medical professionals is sexual activity (Pomeroy, 1968) or erotic behavior (Bieber, 1964) between members of the same sex .

This definition overlooks the related psychological and social factors beyond the sexual behavior that affect health outcomes. Pomeroy (1968) identified a psychological dimension of homosexuality that is independent of overt behavior, "psychologic homosexual reactions"(p. 367). Laumann and colleagues(1994) defined sexual orientation as a combination of one's levels of desire, behavior, and identity as a heterosexual, bisexual, or homosexual person.

A patient and physician must communicate about sexuality with explicitness and sufficient elaboration that the physician can accurately assess the biological, psychological, and social dimensions of the patient's health status. This allows the physician reliance on the patient's information rather than on generalizations or stereotypes. Therefore, it is important that within the medical consultation, barriers of stigma and criminality are eliminated so that open exchange of medically relevant information is unimpeded.

Physician Attitudes Toward Patients

Physician attitudes toward homosexuality are often negative. According to research on physicians, residents, and medical students, negative attitudes toward gay, lesbian, and bisexual patients were held by about half of physicians and physicians-in-training (Chaimowitz, 1991; McGrory, McDowell, & Muskin, 1990; Prichard, et al., 1988).

This large proportion of negative attitudes may result from a number of factors, including general socialization, lack of professional training and information on sexual orientation (DeCrescenzo, 1984; Good, 1976; Schwanberg, 1990) and lack of any professional experience treating self-identified gay/lesbian/bisexual patients (Dardick & Grady, 1980). One study found that only about half of gay and lesbian patients had ever disclosed their sexual orientation their physician (ibid.).

A physician who holds negative attitudes toward patients who are of a homosexual or bisexual orientation faces a challenge to the success of the medical consultations with gay, lesbian, or bisexual patients. Upon a patient's disclosure of his or her sexual orientation, the physician is then in a position requiring a professional response consistent with the physician's socially defined role. Disclosure of the sexual orientation is not likely to be expected by the physician, who then must balance professionalism against personal opinion. The physician's role mandates respect for the patient and maintenance of the patient's dignity, and this would need to be communicated to the patient. The satisfaction of the patient, who has just disclosed risky personal information, and holds expectations for how the physician will react to the disclosure, is likely to be affected by the physician's response.

Expectancy Theories

The Expectancy Construct

Expectancies have been conceptualized and studied in a variety of disciplines and contexts, including education (Dusek, 1985), social psychology (Darley & Gross, 1983; Jones, 1986), industrial psychology (Thompson & Siess, 1978), courtroom processes (Siegel & Mitchell, 1979), and communication (Burgoon, 1993). Expectancy has been defined as

> any belief, hypothesis, theory, assumption, or accessible construct that is brought from previous experience and used, either consciously or unconsciously, as a basis for interpreting or generating behavior (Ditto & Hilton, 1990).

Expectancies may be generated based on direct experience, indirect knowledge, social norms, and stereotypes (Burgoon & LePoire, 1993). General expectancies are based on the social classification of people similar to the target, at the sociological level (Miller & Steinberg, 1975). Person-specific expectancies are based on general expectancies combined with direct and/or indirect knowledge of the specific target (Burgoon & LePoire, 1993). General expectancies and person-specific expectancies are also known as category-based and target-based expectancies (Jones & McGillis, 1976).

Expectancies are guides to predictions and interpretations of others' actions (Ickes, Patterson, Rajecki, & Tanford, 1982). Expectancies are necessary because "people could not function effectively if they had to approach each situation anew" (Ditto & Hilton, 1990). A benefit is that they simplify interactions, a danger is that inaccurate expectations can bias interactions (Darley & Gross, 1983; Ditto & Hilton, 1990).

In physician-patient interactions, expectancies will play a role in communication and outcomes (Ditto & Hilton, 1990). In the initial medical consultation, general expectancies about "patient" and "physician" will be more salient. As the physician and patient interact and become acquainted, person-specific expectancies will increasingly operate.

Expectancy Violations

Expectancy violation occurs when an actor's enacted behaviors are discrepant from expected behaviors (Burgoon, Birk, & Hall, 1991). Studies of various expectancy violation phenomena have been conducted in the field of psychology. In these studies, expectancy violations have sometimes been referred to as expectancy disconfirmations. Contexts of such studies included organizational settings (Wanous, Poland, Premack & Davis, 1992), the classroom (Rosenthal, 1974; Rosenthal & Jacobson, 1968), interpersonal settings with

dissonance (Worchel & Brand, 1972), and interpersonal attraction settings (Jones & Wein, 1972).

Some research was conducted examining the concept of *met expectations* in organizational settings, particularly in the situation of the assimilation of new employees (Wanous, et al., 1992). The met expectations hypothesis was defined as the presence of a discrepancy between the situation encountered and the situation expected, resulting in withdrawal (Porter & Steers, 1973). The met expectation hypothesis was focused on unmet expectations, or violations of expectations in which the encountered behavior is worse than the expected behavior.

Unmet expectations, or expectancy violations, were identified as overfulfilled and underfulfilled expectations (Wanous, et al., 1992). An overfulfilled expectation corresponds to a positive violation of expectancy. An underfulfilled expectation corresponds to a negative expectancy violation. Wanous and colleagues (1992) reviewed 31 met expectations studies and noted inconsistent operationalizations and failure to distinguish between overfulfilled and underfulfilled expectations. In addition, they recommended that ideas from social cognition could better inform this area of inquiry (ibid.)

Interest in expectancy disconfirmation or violation effects prompted development of models to predict the

processes and outcomes of expectancy violations in communication. These communication frameworks are M. Burgoon's expectancy theory, which focuses on verbal communication (Burgoon, 1990; Burgoon & Miller, 1985); and J. Burgoon's nonverbal expectancy violations theory, later called expectancy violations theory (Burgoon, 1978, 1993; Burgoon & Hale, 1988).

M. Burgoon's expectancy theory examines effects of targets' expectations of sources' language use on persuasion attempts, and specifies the outcomes of violations of expectations. When a source's verbal communication behavior in a persuasive attempt violates the expectations of the target, the direction of the violation (positive or negative) interacts with evaluation of the source (positive or negative) to produce various outcomes (Burgoon, 1990). Positive violations are predicted to produce attitude or behavior changes advocated by the message source; negative violations are predicted to produce no change or change in opposition to the advocated position (Burgoon, 1990).

In a project using expectancy theory to predict violation outcomes, Burgoon, Birk, and Hall (1991) examined communication in the physician-patient context through a series of studies. First, patient expectations of male and female physician compliance-gaining language use were collected. A written scenario describing a medical

consultation was used, and messages reflecting various compliance-gaining strategies were rated by respondents for likelihood of use by male and female physicians. Certain strategies were determined to be expected of male physicians, some were expected of either sex, and other strategies were expected of female physicians. In general, expected strategies of male physicians were moderately aggressive; expected female physician strategies were low in aggression. In the next study, a group of respondents read several versions of the scenario, which varied physician's sex and the aggression of the compliance-gaining strategy used. Patient compliance was the dependent measure. In this study, female physicians confirmed or negatively violated expectancies. Male physicians confirmed or positively violated expectancies. ANOVA results showed a significant interaction effect for compliance, and means for male and female physicians were consistent with the predictions for expectancy violations.

J. Burgoon's expectancy violations theory was originally developed to examine proximity behaviors (Burgoon & Jones, 1976). Since then, a number of studies have examined nonverbal expectancy violations (Aune, Levine, Ching, & Yoshimoto, 1993; Burgoon & Aho, 1982; Burgoon & Hale, 1988; Burgoon & LePoire, 1993; Burgoon, Stacks, & Woodall, 1979; Manusov, 1984).

Expectancy violations theory states that when a communicator's enacted behavior is discrepant from expected behavior, a process of arousal, evaluation, and interpretation occurs in the receiver; this process is influenced by communicator reward valence and violation valence; and influences the receiver's outcomes (Burgoon, 1993). Expectancies are formed based on social norms and person-specific information. When the other is a stranger, expectancies "are identical to the societal norms and standards for the particular type of communicator, relationship, and situation" (Burgoon & Hale, 1988). The arousal produced by an expectancy violation results in

> greater alertness and orienting to the source of the arousal...making the violator's characteristics and the implicit meanings in his or her behavior more salient (Burgoon, Coker, & Coker, 1986)

Mediating the interpretation of the violation is the communicator reward valence. This reward valence is determined by an estimation of the rewardingness of the communicator, consistent with the social exchange theory idea of "benefits of interacting with the communicator outweighing the costs" (Burgoon & Hale, 1988). In the event of an expectancy violation, the perceiver takes into account the communicator's rewardingness in interpreting the

violation. Communicator reward valence exerts most influence when the communicator behaviors are ambiguous in valence, in which case

> acts committed by a high-reward communicator may be assigned positive meanings, and the same acts committed by a low-reward communicator may be assigned negative meanings (Burgoon, et al., 1986)

When an act is unexpected, thus producing arousal, and the communicator reward assessment ensues, positive meanings lead to positive violations of expectancy; negative meanings lead to negative violations (ibid.).

Hypotheses

A key process posited by both M. Burgoon's expectancy theory and J. Burgoon's expectancy violations theory is that expectancy violations result in an intensification effect upon outcomes, in the direction of violation's valence. J. Burgoon reports that her experiments

> have repeatedly attested to positive violations yielding more desired outcomes and negative violations yielding less desired outcomes than expectancy confirmation (Burgoon, 1993).

Applied to the context of physician verbal communication to gay/lesbian/bisexual patients, this process should affect patient outcomes. The following hypotheses were formulated.

H_1: Patients with negative physician expectancy who receive a positive message will have higher satisfaction than patients with positive physician expectancy who receive a positive message.

H_2: Patients with positive physician expectancy who receive a negative message will have lower satisfaction than patients with negative physician expectancy who receive a negative message.

Table 1 represents the predicted levels of patient satisfaction for each cell of the experimental design.

Table 1

Predicted Patient Satisfaction

	Message Valence	
Expectancy	Negative	Positive
Negative	Low	Highest
Positive	Lowest	High

CHAPTER TWO

Method

Overview

This study was conducted in multiple phases, using a total of 260 gay, lesbian, and bisexual participants. The purpose of the first phase was to establish an instrument for the measurement of expectations about the attributes of the typical physician. This physician expectancy instrument identifies the valence of a person's expectations regarding the typical physician. The second phase was a collection of reports of actual physician verbal responses that gay, lesbian, and bisexual patients experienced upon disclosure of their sexual orientation to the physician. The third phase was ratings of actual physician verbal responses (collected in phase two), in terms of how negative or positive they were perceived to be. The final phase, a 2 x 2 ANOVA design, engaged subjects in a written hypothetical scenario of a medical consultation with a typical physician. Subjects had either a negative or positive physician expectancy, and were randomly assigned to a negative or a positive physician verbal response. At the

end of the written scenario, patient satisfaction outcomes were measured for each condition.

Participants

Collection of data from a sample of the population of gay, lesbian, and bisexual people presents challenges because of their hidden nature, or the difficulty of identifying and accessing members of such groups. Although gay, lesbian, and bisexual people may represent from about 3% to 10% of the general population (Kinsey, Pomeroy & Martin, 1948; Laumann, Gagnon, Michael, & Michaels, 1994), they are not outwardly identifiable and are not easily contacted except through specialized sampling techniques (Sudman, Sirken, & Cowan, 1988). One such method of contact is through access to settings that have concentrations of people who are homosexual or bisexual. Such settings include gay/lesbian/bisexual community centers, social groups, religious organizations and political committees (Martin & Dean, 1990).

A listing of these groups and organizations was compiled through a search of a national telephone directory CD-ROM listing and through several published directories of such organizations. Leaders or directors of these types of groups and organizations were contacted by telephone and/or a letter and permission was sought to ask their members to participate in this study. Upon receiving permission,

several in-state groups were approached in person, and members were given questionnaires to complete. Groups outside of Michigan received questionnaires through the mail.

In several cases, individuals who were recruited into the study offered personal referrals to others in their social networks who might choose to participate. Martin and Dean (1990) justify a sampling frame combining recruitment from a diverse selection of primarily gay/lesbian groups with some personal referral recruitment, stating that the groups provide breadth to the sample, while personal referrals allow the researcher "to reach deep into the gay population, (and) locate hard-to-find social networks" (p. 550). Including some personal referrals in this study results in a sample that is less biased by motivations or circumstances that lead some people to join primarily gay/lesbian/bisexual organizations. This should produce a sample with somewhat better generalizability to the broader population of gay, lesbian, and bisexual people.

Procedures

In the first phase of this study, participants responded to a questionnaire which was designed to assess the image held of the typical physician. This was to establish a physician expectancy scale, for use in the final phase of the study. A brief scenario describing an initial

visit to a new, typical physician was provided, and the respondents were asked to rate the physician . Seven-point semantic differential scales (Table 2) were included within a brief scenario describing an initial medical consultation with a typical physician. The word pairs were chosen based on a number of concepts drawn from the literature that are relevant to interpersonal communication and the socioemotional dimension of medical consultations, including the elements of perceived physician receptivity, friendliness, and openness (DiMatteo, 1993; Leigh & Reiser, 1992; Parsons, 1951; Purtilo, 1990; Roter, 1988; Ruben, 1992).

Table 2

Physician Expectancy Scale

Semantic Differential Items		
Cold	/	Warm
Discouraging	/	Encouraging
Closed-minded	/	Open-minded
Unfriendly	/	Friendly
Rigid	/	Flexible
Judgmental	/	Nonjudgmental
Tense	/	Relaxed
Untruthful	/	Truthful
Gay-hostile	/	Gay-friendly

The second phase of this study was the collection of reports of actual verbal messages that physicians produced in response to the patient's disclosure of sexual orientation (see Appendix B). Reports of actual responses were sought so that the messages used in the final phase of

this study will be realistic and reflect as closely as possible what physicians actually say to patients who tell them that they have a homosexual or bisexual orientation. As prompts, respondents were asked to report a "positive physician response" if any, and a "negative physician response" if they had had any. In this way, a range of verbal messages was collected which the receivers globally perceived to have been positive or to have been negative.

In the third phase of the study, a selection of the responses from phase two were presented on a questionnaire with rating scales to measure the relative positiveness and negativeness of each message (see Appendix C). The purpose of the ratings in phase three was to determine which physician verbal responses would be consistent with a negative or a positive physician expectancy, and which verbal messages would be in violation of those expectancies. Some of these messages had been reported by more than one respondent in phase two, and there was a mix of reported negative responses and reported positive responses. The rating of positiveness and negativeness was based on a selection of four pairs of seven-point semantic differential words: negative/positive; judgmental/nonjudgmental; closed-minded/open-minded; and unfriendly/friendly. These word pairs were chosen as representative of the physician expectancy instrument. It was abbreviated in this way due to

length/time constraints on the questionnaire and concern about respondent fatigue.

In the final phase of the study, subjects responded to a questionnaire featuring a written hypothetical scenario of an initial medical consultation. The scenario presented either a positive or a negative message, based on the previous message ratings (see Appendix D). Prior to the message, subjects responded to the physician expectancy scale. This determined the expectancy the patient holds about the typical physician. Following the scenario, subjects responded to a 17-item patient satisfaction instrument, which was constructed based on items and concepts drawn from previous patient satisfaction instruments and the literature (Anderson & Dedrick, 1990; Bertakis, Roter, & Putnam, 1991; Conlee, Olvera, & Vagim, 1993; DiMatteo, Prince, & Taranta, 1978; Hsieh & Kagle, 1991; Lupton, Donaldson, & Lloyd, 1991).

CHAPTER THREE

Results

Overview

The results for the three pre-test phases of the study and the final phase, which analyzed effects of expectancies and message valence upon patient satisfaction are reported in this chapter. The test of hypotheses was conducted using factorial analysis of variance (ANOVA).

Profile of Participants

The four phases of the study used a total of 260 respondents. The first phase used 53 respondents, ranging in age from 20 to 58, with a mean age of 33.13 (s.d. 9.03). This sample was 49.1% male, 50.9% female; 84.9% homosexual (gay or lesbian), and 15.1% bisexual. The second phase used 28 respondents, with an age range of 19 to 51, with a mean age of 31.46 (s.d. 7.62). The sample was 39.3% male and 60.7% female. Sexual orientation of this sample was 82.1% homosexual and 17.9% bisexual. The third phase used 42 respondents. The age range was 19 to 58, with a mean age of 29.48 (s.d. 8.08). The sample was 59.5% male, and 40.5% female. Sexual orientation was 85.7% homosexual, 14.3%

bisexual. The final phase used 137 subjects, with an age range of 17 to 67, and a mean age of 30.79 (s.d. 10.10). This sample was 52.6% male, and 46.7% female. Sexual orientation was 83.9% homosexual and 15.3% bisexual.

Results of the Pre-tests

Phases one through three of this study were: (1) pre-test of the physician expectancy scale, (2) collection of actual physician verbal responses as recalled by patients, and (3) ratings of collected responses for positiveness or negativeness, using a subset of the physician expectancy scale.

The physician expectancy scale underwent confirmatory factor analysis as a single factor. A standard alpha of 0.89 was obtained. The factor loadings for the nine items Comparing expected to obtained correlations, it was found that in all correlations, none of the correlation error exceeded sampling error. Reliability analyses indicated no item deletions would improve the scale. The decision was made, however, to change the final item, "gay-hostile/gay-friendly" because it may prime the subjects to be sensitive to the issue. Because the intention of the physician expectancy scale is to create negative and positive categories of expectancy, the semantic differential of "negative/positive" was added to the scale for the final phase of the study.

Phase two of the study resulted in the collection of 15 different messages; several reported by more than one respondent. Thirteen of these were retained for phase three. Two were omitted because they seemed less useful to the researcher, in terms of practical application and likelihood of use by physicians. These rejected messages were: "I'm gay too!" and "You don't look like one of them!" The thirteen messages used in phase three are listed in Table 3, along with the ratings they received by respondents to phase three of the study.

In phase three, the physician's verbal messages divided into negative and positive, based on ratings. Table 3 lists them, by mean, from most positive message to most negative message. The three most positive messages had means that were close, although the standard deviations varied among them. The decision to choose the second message for use in phase four was based on its positive rating (22.65 on a scale of 4 to 28, s.d. 6.08) plus the following practical considerations: (1) the highest ranked message is too informal in its use of slang, and (2) the third message may be deceptive and inaccurate. The chosen message is both positive and plausible. The negative message chosen has a negative rating and is consistent with past views on homosexuality as taught in the medical profession (Pomeroy, 1968).

Table 3

Ratings of Physician Verbal Messages

Mean	SD	Message
23.37	3.81	"That's cool. No problem."
22.65	6.08	"I'm glad you feel comfortable enough to tell me this. It should help with your treatment."
22.28	4.88	"I have a large number of gay and lesbian patients."
21.77	5.32	"I have several same-sex couples that I treat."
20.42	7.97	"OK. It really helps me to know this, so that I can make good diagnoses."
17.23	5.92	"OK."
17.02	7.05	"Don't feel uncomfortable about that. In fact I am sympathetic."
11.12	5.60	-- no verbal response to disclosure --
9.23	5.21	"When was your last HIV test?"
7.98	4.21	"Are you sure about this? Often it is simply a phase people go through."
7.47	3.89	"Are you sure? How long have you 'thought' you were gay?"
5.58	3.16	"Oh. I see. There is a psychiatrist I can recommend who helps people with this sort of problem."
5.33	3.70	"That type of promiscuity will put you at risk for AIDS."

Note. Messages were rated on a scale of 4 - 28.

Final Phase of Study

In the last phase of the study, a questionnaire was administered (see Appendix D) in which subjects read an introduction to a scenario, then rated their expectancy for the typical physician. These ratings, using the physician expectancy scale, were measured on a 9-item scale, with a possible range of 9 to 63. Results were: a range of 9 to 63, a mean of 40.90 (s.d. 8.82), a mode of 40, and a median of 40. The decision was made to perform a median split, at 40, dividing the sample into those with positive physician expectancy, and those with negative physician expectancy.

Two hypotheses were tested in a 2 x 2 factorial design. The cell means, standard deviations for patient satisfaction, and the numbers of subjects per cell are reported in Table 4.

Table 4

Cell Means and Standard Deviations for Patient Satisfaction

Expectancy	Message Valence: Negative	Message Valence: Positive
Negative	Lowest 44.46 (26) s.d. 16.89	High 82.98 (43) s.d. 16.67
Positive	Low 55.05 (38) s.d. 16.39	Highest 91.86 (28) s.d. 17.80

Note. Subjects per cell are reported in parentheses.

Table 5

Analysis of Variance for Patient Satisfaction by Expectancy, Message

Source of Variation	Sum of Squares	DF	Mean Square	F	Signif. of F	eta^2
Main Effects	46013.12	2	23006.56	80.80	.000	
Expectancy	3045.31	1	3045.31	10.70	.001	.037
Message	45849.42	1	45849.42	161.02	.000	.550
2-way Interactions						
Exp Mess	23.65	1	23.65	.08	.774	
Explained	46036.76	3	15345.59	53.89	.000	
Residual	37300.76	131	284.74			
Total	83337.53	134	621.92			

A 2 x 2 factorial ANOVA was performed on the data. The results, reported in Table 5, are a strong significant main effect for message valence ($F(1,131)=161.02$, $p<.001$, $eta^2=.550$), and a significant main effect for expectancy ($F(1,131)=10.70$, $p<.001$, $eta^2=.037$). No significant interaction between expectancy and message valence was found.

Hypothesis 1, that a positive expectancy violation effect would occur, was not supported. This effect required that a positive message produce higher satisfaction in those with a negative expectancy, compared to those with a positive expectancy. The mean was higher for those with a positive expectancy.

Hypothesis 2, that a negative expectancy violation effect would occur, also was not supported. This effect

required that a negative message produce lower satisfaction in those with a positive expectancy, compared to those with a negative expectancy. The mean was lower for those with a negative expectancy.

CHAPTER FOUR

Discussion

This study was designed to examine the effects of expectancy and physician verbal communication on patient satisfaction, testing expectancy violation theory in this context. The results of the study were inconsistent with the expectancy violation hypotheses.

A strong main effect for the valence of the physician's verbal message was found. The positive message produced high patient satisfaction. The negative message resulted in low patient satisfaction. These results suggest that physician verbal communication can affect patient satisfaction.

A weaker significant main effect was found for the expectancy patients have about physicians. Patients who had positive physician expectancies had higher levels of satisfaction for both messages, compared to patients who had negative physician expectancies. This suggests that the valence of patients' expectancies about typical physicians will be associated with their satisfaction outcomes following interaction with a new physician.

Limitations and Implications

The expectancy effects evident in this study do not conform to expectancy violation predictions. One possibility is that expectancy violations were not effectively operationalized. Assuming that expectancy violations did occur, then it is possible that (1) these effects do not occur in this context and/or (2) the expectancy violation model upon which the absent effects were predicted needs further adjustment in identifying the types of expectancy for which violations would produce effects.

Perhaps expectancy violations did not sufficiently occur. A major limitation to this study is that a post-test manipulation check was not performed to assess whether the subjects had or had not experienced expectancy violations. Instead, there was reliance on between-person measures of expectancy violation, based on the negative or positive pre-test ratings that the messages had received. A violation was presumed to occur when the message was negative and the expectancy was positive, or when the message was positive and the expectancy was negative. A different method of assessing expectancy violation would be the use of within-person measures of discrepancy (Wanous, et al., 1992). One such measure for expectancy violation was used by Manusov (1984), in which subjects were asked to rate the interactant's behavior with 11 semantic differential pairs,

such as expected/unexpected, good/bad, and anticipated/ unanticipated. This is still an indirect means of measuring the arousing event that is the violation of expectancies. An advantage for the use of between-persons measures is that, "in a strictly psychometric sense, between-person discrepancy measures are less error prone than within-person measures (Jones, 1981)" (Wanous, et al., 1992).

The issue, then, is whether it is useful to study within-person expectancy violations for pragmatic application to the context of medical consultations. Physicians cannot realistically be expected to adjust to generations of expectancy violations at the idiosyncratic individual level. It is more practical to train physicians to be sensitive to the general expectancies that a population carries. This would result in physicians who can communicate in a manner that is offensive to the least number of members of the population.

Relying upon the between-person assessment that expectancy violations have been generated, these results suggest that this context may not be prone to expectancy violation effects. The communicator reward valence that should operate, according to the model, may be problematic here. Defining communicator reward valence as a cost/benefit assessment (Burgoon & Hale, 1988) it is possible that the clinical reward of treatment for a serious medical condition

is not most salient for members of this population. The communicator rewardingness of physicians might not be generally invariant for this group. Instead, the role-based reward of the clinical interaction might be less-heavily weighted than other cognitions these patients have about the interaction.

If the negative expectancy patients viewed the physician as less rewarding than the positive expectancy patients did, then results consistent with those found here are hypothesized, according to another part of expectancy violation theory. The prediction for communicator reward valence is: "all else being equal, rewarding individuals achieve more positive communication outcomes than non-rewarding individuals" (Burgoon, et al., 1986). This leads to the next issue: there is a need for further specification in the expectancy violations model, so that the distinction between one's expectancies and the communicator reward valence of one's interactive partner is made clear. As it is now, the distinction is fuzzy. As a result of this, significant results in this type of study can be interpreted to support some aspect of expectancy violation theory whichever direction the outcomes go. To correct this, specific classes of expectancies need to be explicated, and their relationship to specific classes of communicator behavior need to be made clear.

Future Directions

The presence of main effects for verbal message and expectancy within the context of gay/lesbian/bisexual patient interactions with physicians can be seen as good news theoretically and practically. It provides evidence that what a physician says can affect patient outcomes, and it provides impetus to communication theorists to direct efforts to this area. These are issues that should be further studied. Other aspects of physician communication beyond immediate verbal response to disclosure of sexual orientation are likely to affect gay/lesbian/bisexual patient satisfaction, as well. For instance, whole classes of utterances, such as question-asking, have been found to affect patient satisfaction in general (Maduschke, 1994).

This type of research can yield recommendations for physician communication behavior that would benefit many types of patient groups presenting sensitive issues to their physicians. These include adolescents' disclosures of sexual information to physicians, disclosures about sexually transmitted diseases, and disclosures by people who have disabilities. Identification of the verbal and nonverbal communication that is most satisfying for these patients would form a curriculum that medical schools may adopt, in their efforts to train physicians who are more psychosocially sensitive.

APPENDICES

APPENDIX A

First Questionnaire

The purpose of this study is to determine the types of expectations that people have of doctors in this society. We are concerned with the way people view doctors in general, and the image they call to mind when they expect to interact with a new doctor.

This is an anonymous questionnaire. All of the information that you provide us will be kept strictly confidential. Therefore, please be as honest as you possibly can in responding to the questions that you will answer.

In this questionnaire, you will be asked to think of a "typical" doctor you might meet in an office visit. You will be asked to describe the doctor. There are no right or wrong answers. We are strictly interested in your beliefs about the "typical" doctor.

Imagine that you are at a doctor's office because you have a health problem that needs treatment. This is a **new doctor** you have never met before. The reason you are here at this new doctor's office is that your regular doctor has moved out of state. You found this doctor's name in the phone book, and noted that the location of the office is convenient for you.

You are sitting in the waiting room of this new doctor's office, wondering what the doctor will be like. As you sit there, you find yourself developing a mental image of what you expect the doctor might be like. Given your general experience with doctors, which characteristics will most likely describe the doctor you meet? Using the following scales, rate the characteristics that most accurately describe your mental image of the doctor. Circle the number on the scale that indicates the rating you give.

Unfriendly	1	2	3	4	5	6	7	Friendly
Closed-minded	1	2	3	4	5	6	7	Open-minded
Discouraging	1	2	3	4	5	6	7	Encouraging
Cold	1	2	3	4	5	6	7	Warm
Tense	1	2	3	4	5	6	7	Relaxed
Untruthful	1	2	3	4	5	6	7	Truthful
Judgmental	1	2	3	4	5	6	7	Nonjudgmental
Rigid	1	2	3	4	5	6	7	Flexible
Gay-hostile	1	2	3	4	5	6	7	Gay-friendly

When you think of the image you have about this new doctor you are meeting, what is the doctor's sex?

____ Male
____ Female

How old do you picture this doctor being? ____

APPENDIX B

Physician Responses

The purpose of this study is to determine the kinds of messages that physicians communicate to patients who disclose sensitive information to them. We are concerned with how physicians respond to a patient's disclosure of sexual orientation within the medical consultation.

You will be asked to think of the times you have been to see a physician in which you have disclosed your sexual orientation to the physician. You will be asked to remember the reaction the physician had to that information, and to write what you recall as the actual verbal response the physician had. **We want to know exactly what the physician said** immediately after your disclosure of sexual orientation.

Have you ever told a physician your sexual orientation?
____ Yes
____ No

If you answered "No" please stop. If you answered "Yes", please continue.

Have you had what felt like a positive physician response to your disclosure of your sexual orientation? (By "positive" we mean a supportive response that made you feel comfortable.)
____ Yes
____ No

If you have had a positive physician response to the disclosure of your sexual orientation, please write **exactly what the physician said to you** immediately following your disclosure (Do not describe the general attitude or behavior of the physician, but do write the words the physician used).
My physician's response was:

"_____
_____
_____
_____"

Have you had what felt like a negative physician response to your disclosure of your sexual orientation? (By "negative" we mean an unsupportive response that made you feel uncomfortable.)

____ Yes
____ No

If you have had a negative physician response to the disclosure of your sexual orientation, please write **exactly what the physician said to you** immediately following your disclosure (Do not describe the general attitude or behavior of the physician, but do write the words the physician used).

My physician's response was:

"_____
_____
_____"
_____

APPENDIX C

Rating of Responses

This study examines medical consultations between physicians and patients who are homosexual or bisexual. The focus is on the quality of communication between the physician and the patient. In a situation in which a patient discloses his or her sexual orientation to a physician, the physician's immediate response to this disclosure can vary from a positive response (i.e., a reaction that may make the patient feel comfortable) to a negative response (i.e., a reaction that may make the patient feel uncomfortable.)

In a recent study on patient-physician communication, we asked people to recall actual situation in which they, as patients, disclosed to a physician that they are homosexual or bisexual. These patients provided us with the actual responses that they remember the physicians saying to them. Now, we would like to evaluate theses individual physician responses in terms of the reactions they might produce in patients. This is the purpose of our current study.

This current study asks you to imagine a situation in which you are in a medical consultation with a typical physician. Imagine that you have just disclosed your sexual orientation to the physician. Then read each actual physician response below, imagining that the physician is saying this to you. Imagine how you would feel about each physician response.

The statements that follow are the actual physician responses that were reported in our earlier study. Please rate each of the actual responses listed below as if it is what the physician tells you right after you disclose your sexual orientation. For each physician response, please rate how negative/positive it seems, how judgmental/nonjudgmental, etc. Make your evaluations by circling the number corresponding to your feelings about the physician's response.

PHYSICIAN RESPONSES TO DISCLOSURE OF SEXUAL ORIENTATION:

"I'm glad you feel comfortable enough to tell me this. It should help with your treatment."

This response seems:

Negative	1	2	3	4	5	6	7	Positive
Judgmental	1	2	3	4	5	6	7	Nonjudgmental
Closed-minded	1	2	3	4	5	6	7	Open-minded
Unfriendly	1	2	3	4	5	6	7	Friendly

"Are you sure about this? Often it is simply a phase people go through."

This response seems:

Negative	1	2	3	4	5	6	7	Positive
Judgmental	1	2	3	4	5	6	7	Nonjudgmental
Closed-minded	1	2	3	4	5	6	7	Open-minded
Unfriendly	1	2	3	4	5	6	7	Friendly

"When was your last HIV test?"

This response seems:

Negative	1	2	3	4	5	6	7	Positive
Judgmental	1	2	3	4	5	6	7	Nonjudgmental
Closed-minded	1	2	3	4	5	6	7	Open-minded
Unfriendly	1	2	3	4	5	6	7	Friendly

"I have several same-sex couples that I treat."

This response seems:

Negative	1	2	3	4	5	6	7	Positive
Judgmental	1	2	3	4	5	6	7	Nonjudgmental
Closed-minded	1	2	3	4	5	6	7	Open-minded
Unfriendly	1	2	3	4	5	6	7	Friendly

"Don't feel uncomfortable about that. In fact I am sympathetic."

This response seems:

Negative	1	2	3	4	5	6	7	Positive
Judgmental	1	2	3	4	5	6	7	Nonjudgmental
Closed-minded	1	2	3	4	5	6	7	Open-minded
Unfriendly	1	2	3	4	5	6	7	Friendly

"Oh. I see. There is a psychiatrist I can recommend who helps people with this sort of problem."

This response seems:

Negative	1	2	3	4	5	6	7	Positive
Judgmental	1	2	3	4	5	6	7	Nonjudgmental
Closed-minded	1	2	3	4	5	6	7	Open-minded
Unfriendly	1	2	3	4	5	6	7	Friendly

"OK."

This response seems:

Negative	1	2	3	4	5	6	7	Positive
Judgmental	1	2	3	4	5	6	7	Nonjudgmental
Closed-minded	1	2	3	4	5	6	7	Open-minded
Unfriendly	1	2	3	4	5	6	7	Friendly

"That type of promiscuity will put you at risk for AIDS."

This response seems:

Negative	1	2	3	4	5	6	7	Positive
Judgmental	1	2	3	4	5	6	7	Nonjudgmental
Closed-minded	1	2	3	4	5	6	7	Open-minded
Unfriendly	1	2	3	4	5	6	7	Friendly

"I have a large number of gay and lesbian patients."

This response seems:

Negative	1	2	3	4	5	6	7	Positive
Judgmental	1	2	3	4	5	6	7	Nonjudgmental
Closed-minded	1	2	3	4	5	6	7	Open-minded
Unfriendly	1	2	3	4	5	6	7	Friendly

"That's cool. No problem."

This response seems:

Negative	1	2	3	4	5	6	7	Positive
Judgmental	1	2	3	4	5	6	7	Nonjudgmental
Closed-minded	1	2	3	4	5	6	7	Open-minded
Unfriendly	1	2	3	4	5	6	7	Friendly

"Okay. It really helps me to know this, so that I can make good diagnoses."

This response seems:

Negative	1	2	3	4	5	6	7	Positive
Judgmental	1	2	3	4	5	6	7	Nonjudgmental
Closed-minded	1	2	3	4	5	6	7	Open-minded
Unfriendly	1	2	3	4	5	6	7	Friendly

"Are you sure? How long have you 'thought' you were gay?"

This response seems:

Negative	1	2	3	4	5	6	7	Positive
Judgmental	1	2	3	4	5	6	7	Nonjudgmental
Closed-minded	1	2	3	4	5	6	7	Open-minded
Unfriendly	1	2	3	4	5	6	7	Friendly

In our previous study, a large number of respondents stated that upon their disclosure of their sexual orientation, their physician made no verbal acknowledgment of the disclosure. How would you rate a physician reaction of silence, with no verbal response?

This response seems:

Negative	1	2	3	4	5	6	7	Positive
Judgmental	1	2	3	4	5	6	7	Nonjudgmental
Closed-minded	1	2	3	4	5	6	7	Open-minded
Unfriendly	1	2	3	4	5	6	7	Friendly

APPENDIX D

Final Questionnaire

This study examines the communication that occurs between physicians and patients. We are interested in the way physicians and patients communicate about health matters related to sexuality.

This is an anonymous questionnaire. All of the information that you provide will be kept strictly confidential. Therefore, please be as honest as possible in responding to the questions. There are no "right" or "wrong" answers.

In this questionnaire, you will be asked to imagine that you are a patient visiting a physician's office. You will be visiting a physician you have never met before, but who is a typical physician one might meet in an office visit.

As you complete this section, imagine that you are a patient visiting a physician's office for a health problem that needs immediate treatment. This visit is to a new physician you have never met before. The reason you are here at this new physician's office is that the physician you have seen in the past has moved out of town. Due to the circumstances, you feel you need to find a new physician right away.

You asked some close friends for recommendations of physicians, but have been unable to get an appointment with the physicians they recommended. Finally, you found the name of this physician in the phone book. The location of the office was convenient for you, and when you phoned, the receptionist said you could get an appointment for the same day.

Now, you are sitting in the waiting room of this new physician's office. It looks like most other waiting rooms you have been in. As you sit here, you wonder what the medical consultation will be like with this new person, and you wonder what treatment you will receive for your health problem. You find yourself developing a mental image of what you expect the physician will be like. You imagine that this will be a fairly typical physician, with typical characteristics.

Using the following scales, rate the characteristics that most accurately describe how you expect this physician to be. Circle the number on the scale that indicates the rating you give.

This physician will probably be:

Cold	1	2	3	4	5	6	7	Warm
Discouraging	1	2	3	4	5	6	7	Encouraging
Closed-minded	1	2	3	4	5	6	7	Open-minded
Unfriendly	1	2	3	4	5	6	7	Friendly
Rigid	1	2	3	4	5	6	7	Flexible
Judgmental	1	2	3	4	5	6	7	Nonjudgmental
Tense	1	2	3	4	5	6	7	Relaxed
Untruthful	1	2	3	4	5	6	7	Truthful
Negative	1	2	3	4	5	6	7	Positive

Sitting in the waiting room at this physician's office, your mind wanders as you glance at the various magazines that are stacked on the end tables. A door opens and a nurse calls your name. The nurse escorts you to one of the examining rooms. As you sit in the examining room waiting for the physician to come in, you think about the health problem that has brought you here today. It is a problem that is related to your sexual health. You feel that the problem is not only uncomfortable, but it is something that ought to be treated at once. That is why you came to this physician today.

You want to tell the physician everything that you can about the problem, to be sure that you receive the appropriate care for this sexual health problem. Therefore, you decide that you will tell the physician your sexual orientation, since it may help the physician, in terms of understanding your sexual history and making proper diagnosis and correct treatment recommendations.

As you are thinking about these matters, there is a knock on the examining room door. The physician enters the room. You exchange introductions and greetings. You shake hands. Next, the physician begins the medical interview, asking various questions about your health and health history. When the physician gets to the sexual history part of the medical interview, you feel it is time to disclose your sexual orientation to the physician. After you disclose your sexual orientation, the physician says:

"Are you sure about this? Often it is simply a phase people go through."

The medical interview continues for several more minutes, and you answer a few more questions. The physician briefly examines you physically. After the physical examination, the physician gives you a prescription for some medication.

Now, please answer the following questions, based on your role as patient in the interaction you have just read (above). Think about how you, as the patient, felt in the visit with the physician. Answer each of the following questions as honestly as possible, based on those feelings.

For each item, circle the number that corresponds to how you feel.

1. This physician seems to have good interpersonal skills.

Strongly Disagree	Disagree		Unsure		Agree	Strongly Agree
1	2	3	4	5	6	7

2. I trust this physician.

Strongly Disagree	Disagree	Unsure	Agree		Strongly Agree
1	2	3	4	5	6	7

3. The physician seemed uneasy discussing my sexual history.

Strongly Disagree	Disagree	Unsure	Agree		Strongly Agree
1	2	3	4	5	6	7

4. I would recommend this physician to my friends.

Strongly Disagree	Disagree	Unsure	Agree		Strongly Agree
1	2	3	4	5	6	7

5. I'm glad I disclosed information about my sexuality to this physician.

Strongly Disagree	Disagree	Unsure	Agree		Strongly Agree
1	2	3	4	5	6	7

6. This physician seems to be professionally competent.

Strongly Disagree	Disagree	Unsure	Agree		Strongly Agree
1	2	3	4	5	6	7

7. If I were to become ill in the future, I would return to see this physician.

Strongly Disagree	Disagree	Unsure	Agree		Strongly Agree
1	2	3	4	5	6	7

8. This physician seemed likable to me.

Strongly Disagree	Disagree	Unsure	Agree		Strongly Agree
1	2	3	4	5	6	7

9. This physician did not speak to me with respect.

Strongly Disagree	Disagree	Unsure	Agree		Strongly Agree
1	2	3	4	5	6	7

10. I am very likely to comply with the therapies prescribed by this physician.

Strongly Disagree	Disagree	Unsure	Agree		Strongly Agree
1	2	3	4	5	6	7

11. I am confident that this physician has given me proper treatment.

Strongly Disagree	Disagree	Unsure	Agree		Strongly Agree
1	2	3	4	5	6	7

12. In the future, I would feel uncomfortable providing further information about my sexuality to this physician.

Strongly Disagree	Disagree	Unsure	Agree		Strongly Agree
1	2	3	4	5	6	7

13. The care I received was the best that this physician could provide.

Strongly Disagree	Disagree	Unsure	Agree		Strongly Agree
1	2	3	4	5	6	7

14. If anyone I knew said that they were going to visit this physician, I would try to persuade them not to.

Strongly Disagree	Disagree	Unsure	Agree		Strongly Agree
1	2	3	4	5	6	7

15. This physician put me at ease.

Strongly Disagree	Disagree	Unsure	Agree		Strongly Agree
1	2	3	4	5	6	7

16. This physician is someone I would not trust with my sensitive health information.

Strongly Disagree	Disagree	Unsure	Agree		Strongly Agree
1	2	3	4	5	6	7

17. I believe that this physician treats all patients with equal respect.

Strongly Disagree	Disagree	Unsure	Agree		Strongly Agree
1	2	3	4	5	6	7

18. How would you describe this physician?

_____

_____

_____

_____

_____

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