Review Article

Error and Discord in Helping Alliances: How to Negotiate Patient-Provider Relations in Medical Encounters

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Abstract

This mini review considers patient-provider relations with regard to some of the inherent challenges providers face in their choices and interactions. It draws on diverse literatures to highlight the potential for error in decision-making and affective discord in human relations, including systematic biases (as well as random noise), contextual complexities, affect and emotion effects, motivational conflicts, and cultural differences. The review introduces findings and principles from psychotherapy research on rupture repair of helping alliances and concludes with some practical recommendations.

Keywords: Patient-provider relations; Decision-making; Psychotherapy

Introduction

Much has been written regarding the importance of patient-provider relations (often referred to as "bedside manner") for treatment adherence and outcome (see Ha et al. [1]; Ratelle et al. [2]; Riedl and Schüßler [3], for systematic reviews). However, the literature remains relatively thin regarding how to develop such "helping alliances" especially with regard to how to negotiate some of the inherent challenges for providers that arise due to error in decision-making and discord in human relations (see Muran and Eubanks [4]). In this mini review, we will introduce these challenges by reviewing some critical contributions from diverse evidence-based literatures: specifically those concerning a) systematic and random error in judgement and decision-making, b) the effect of affect and emotion on judgement and communication, c) the potential for motivational and emotional conflict in the individual and in relationships, d) the relevance of cultural difference and complexity, and e) the significance of alliance rupture and repair. We will conclude with some practical recommendations that aim to facilitate providers' alliance-building abilities and thus to promote treatment adherence and outcome.

Systematic and Random Error

The literature on judgment and decision-making paints a complicated picture, especially in the face of stress and ambiguity. It is colored by error, both systematic and random, which has important implications when we consider provider performance in the clinical situation. Here we would like to highlight the contributions of Daniel Kahneman and colleagues (see Kahneman [5], Kahneman et al. [6], for reviews) and to emphasize the importance of context, the nature of the tasks to be undertaken and the settings in which decisions must be made [7].

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Kahneman [5] described the systematic bias to focus on existing evidence and ignore absent evidence –the tendency to make decisions based primarily on known knowns, rarely on known unknowns, and typically oblivious to unknown unknowns. Kahneman [5] identified this as WYSIATI or "what you see is all there is" which generally reflects various heuristics he seminally demonstrated with his colleague Amos Tversky (e.g., Tversky and Kahneman [8]), such as *representativeness* (the use of existing memories to identify associated characteristics of an object), *availability* (the use of existing memories to identify the probability of an outcome), and *anchoring* (overreliance on pre-existing information or the first information found). Other more specific biases identified include the tendency to draw conclusions from small numbers ("law of small numbers"), to not consider regression to the mean or random error ("anti-statistics" bias), to look to confirm beliefs ("confirmatory bias"), to neglect our competition and their abilities ("competitor neglect"), to simplify by a story or theory ("narrative fallacy"), to overfocus on benefits and under focus on costs ("optimism bias"), and to reconstruct based on hindsight ("hindsight effect"). In addition, Kahneman [5] has described the "overconfidence bias" or the tendency to overestimate our assessment of our own agency and knowledge and underestimate the complexity and chance as perhaps the most pernicious.

More recently, Kahneman with colleagues Olivier Sibony and Cass Sunstein [6] has concentrated on random error or "noise" in the system –which refers to unpredictable and directionless, variation without pattern. To exemplify its significance, they reviewed research demonstrating that physicians can disagree with themselves over 50% of the time –often due to differences in the physician's mood, energy, or the context associated with the patient or physical environment. They also cautioned that random error does not generally cancel itself out but can pathologically accumulate leading to adverse outcomes.

Another important consideration when it comes to decision-making can be illustrated by Robin Hogarth's [7] distinction between "kind and wicked learning environments." Kind environments are characterized by predictable scenarios that present a limited array of possible patterns (more structured tasks as encountered in various games or sports). At the other end of the spectrum are wicked learning environments, which refer to unpredictable scenarios with unlimited patterns (such as human interactions, which are inherently complicated).

Even with its clear healthcare expectations and protocols, patient-doctor encounters are often rife with uncertainty and complexity. They can be understood as lying more towards the wicked end of the spectrum and as particularly susceptible to all kinds of error or bias in judgement by both provider and patient.

Communication and Affective Discord

The picture we presented above regarding clinical judgement becomes more complicated when we consider the effects of affect and emotion on the decisions we make. Kahneman [5] noted that understanding such effects represents the new horizon for understanding our intuitive judgements and decision-making.

A number of cognitive scientists have demonstrated the effect of affect and emotion (including regulation) on how we attend to, appraise and remember events –how we are often oblivious to how these effects shaped a previous action when deciding to perform the same action again [9-11]. Baumeister and colleagues [12] have also suggested a disposition to negative emotion ("bad is stronger than good"), demonstrating that we have more words for negative emotions, we engage in more cognitive processing with such emotions, and we better remember negative emotional events. There is also a good deal of research on how we can negatively respond to stress and "choke" under pressure: that is, become dysregulated and paralyzed (see Beilock [13], for a review).

The effect of affect and emotion becomes even more complicated when considering the influence of others: in other words, how much one's emotional state is regulated by the emotion of another. There is research demonstrating the reciprocity of emotion: how much we influence and are influenced by others in interpersonal encounters, including how contagious anxiety or emotional dysregulation can be and how hostility begets hostility [14-17].

In addition, there is the research by Edward Tronick and colleagues [18,19] on mother-infant interactions that evidences the importance of mutual regulation and characterizes human relations as comprised of a "million moments" of attunement and misattunement. Attunement refers to the matching of verbal and nonverbal expressions (from vocal coordination to mutual gaze) that can occur in a dyadic interaction. In his research, Tronick demonstrates the prevalence of affective misattunement (up to 70% of the time) and the relevance of reattunement for the development of self-efficacy and -resilience. His findings highlight the inherent "messiness" in human relations.

Motivational and Emotional Conflict

To provide more dimension to our understanding of judgment and communication, we would also like to describe a couple motivational and emotional conflicts that can complicate patient-provider relations.

One concerns the motivational needs for agency (self-definition and -efficacy) and communion (relatedness or connection), originally defined by David Bakan [20]. These needs have been operationally defined and empirically supported [21,22]. Accordingly, these two motivations can

serve as a framework for understanding all communications and choices (including those by both patient and provider). Often these motivations can work at odds: They have been described as dialectical and demonstrated to be orthogonal. Thus there is inherent tension in pursuing these at once: For example, the pursuit of self-definition ("look at me") can risk connection with others ("forget you"). Although much has been written about the pursuit of these needs by patients (specifically with regard to understanding psychiatric disorders: (see Blatt and Blass [23]; Beck and Bredemeier [24]), less has been written about providers in such pursuits and how their own motivations shape their decisions and actions (see Muran and Eubanks [4] for an exception).

The other potential conflict we will highlight here concerns the simultaneous experience of contradictory valences (e.g., a conflict of the self that may include wish and fear) and movement toward and away from something (behaviorally described as approach/avoidance by Dollard and Miller [25]. Most recently, William Miller and Stephen Rollnick [26], (see also Braga et al. [27]) have addressed this conflict as "ambivalence" regarding treatment and change. Others have discussed ambivalence in relational terms with implications for patient-provider interactions (e.g., Mikulincer et al. [28]; Urmanche et al. [29]). Ambivalences can reflect conflicts based on personal histories as well as social constructs. Note it is important to recognize providers can bring their own ambivalences to their encounters with patients.

Cultural Differences and Complexity

Differences in culture (here we use "culture" in the broadest sense to include gender, race, ethnicity, sexuality, religion etc.) have also been shown to shape our decisions and actions. Much has been written in this regard (see Cooper [30]), probably less so with regard to the provider and clinical practice.

Here we want to highlight how such cultural differences can result in personal dispositions or implicit biases (i.e., unconscious features of prejudicial judgement and social behavior, automatic attributions of qualities to a member of a certain cultural group, derived from past experience or social media: see Greenwald and Banaji [31], which introduce further systematic error in clinical judgement. The influence of such biases has been observed across a variety of clinical care contexts, including diagnostic status, treatment planning and intervention [32-37]. They have also been tied to expressions of "microaggression" –indirect and unintentional communications of discrimination against someone from a marginalized or underrepresented group (see Sue [38]).

It is also important to consider the evidence regarding affective differences by culture that can further complicate communication: that is, the research demonstrating cultural-specificity with regard to expression and recognition of emotion (see Elfenbein and Ambady [39]; Scherer et al. [40]; Shao [41]). And finally, it is important to consider the concept of "intersectionality" –the recognition of the individual as comprised of multiple cultural identities. This presents a critical and complicating dimension to the decision-making process, not only in the ways one's own identities combine, but in how they converge or clash with those of others in an interpersonal encounter.

Rupture Repair in Helping Alliances

One of the most consistently robust predictive factors of change in the psychotherapy literature is the quality of the working alliance between patient and provider: A recent meta-analysis by Christoph Flückiger and colleagues [42] reported on 295 independent studies that covered more than 30,000 cases and demonstrated its significant relationship to treatment adherence and outcome. The alliance has been defined as a "purposeful collaboration" and "affective bond" between patient and therapist (see Bordin [43]; Hatcher and Barends [44]). Purposeful collaboration refers to what extent the patient and provider agree on the treatment protocol (or tasks) and the treatment objective (or goals). The affective bond refers to what extent there is mutual trust and respect. One can readily apply this definition to any patient-provider relationship or "helping alliance" (see Fuertes [45]).

There is now an expanding literature on rupture in the alliance. Ruptures have been defined as disagreement on tasks or goals and distrust in the bond between patient and provider, as well as differences regarding their respective implicit needs and cultural identities (Safran and Muran [46]; Muran and Eubanks [4]). Importantly, when ruptures go unnoticed or unaddressed, there is a much higher likelihood of treatment failure. This understanding highlights the importance of providers familiarizing themselves with rupture markers, which include interpersonal behaviors (such as movements away or against the other, expressions of ambivalence or aggression: with examples ranging from minimal responding and acquiescence to more outright skepticism and criticism) and intrapersonal markers (including provider experiences of anxiety and dysregulation). Research has demonstrated that interpersonal rupture markers are quite prevalent (up to 50% of psychotherapy sessions based on self-report, 100% of session by observer-rating) and predictive of nonadherence and poor outcome (see Eubanks et al. [47], meta-analysis).

Rupture repair has been defined as a) clarification of misunderstandings and ambivalences, b) renegotiation of tasks or goals, and c) exploration of rupture, including expectations or fears regarding the treatment process (see Muran and Eubanks [4]; Muran et al. [48], for provider guidelines). Research has shown that rupture repair can lead to positive outcomes [47] and provided empirical support for stage-process models that define principles to guide provider

intervention. There is also research demonstrating the positive effect of an alliance-focused training on treatment process and outcome [49,50]. Principles for providers promoted in this training protocol include awareness (self-reflection and self-regulation), humility (acceptance of one's own limitations), curiosity (about self and other, including implicit expectations and fears), and collaboration (pursuit of shared decision-making).

Concluding Recommendations

In his translation of Tversky and Kahneman's [8] research to the medical setting, Daniel Redelmeier et al. [51,52] made a number of important recommendations to improve clinical care, beginning with greater humility and including the continuous use of feedback, follow-up systems, supervision and peer review, plus review of probability and error and pursuit of contrary evidence and the latest research. We would like to support his efforts with the following "simple but not easy" recommendations that build off the topics and research reviewed in this mini review (see also Muran and Lipner [53]).

We recommend that providers:

1. ***Be aware*** – remember the potential for errors and biases in decision-making, including the influence of emotions [8,12,16,31 for example]. In this regard, we suggest the use of mindfulness meditation (e.g., a personal practice or a brief three minute exercise before any encounter) and journaling (where one attempts to label emotional experiences with patients with some granularity, daily or weekly [13, 54]).

2. ***Be humble*** – in particular consider carefully the overconfidence bias, the tendency to overestimate your knowledge and abilities. Remind yourself of your limitations, the probability of systematic and random error, review by (re)reading this literature. Seek feedback from experts, consultation and supervision from peers and senior colleagues. (Familiarize yourself with the findings from Kahneman and colleagues [5,6]).

3. **Be collaborative** – with your patients (and colleagues), invite their feedback, look for indications of ambivalence (and alliance rupture: any markers of disagreement or distrust), attend to your own anxieties (as possible rupture markers), inquire about their expectations and fears, and engage in shared decision making. This is essential to a good working alliance. (Review the research on interpersonal "messiness" [18] and rupture repair [4]).

In sum, error and discord are inherent to our choices and interactions with others –and thus to clinical practice. In other words, they are rules of the game. So, try to play within them.

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