An Exploration of Doctor and Patient Agendas in General Practice Consultations: Principal Agendas and Problem Solving.

Thesis submitted in accordance with the requirements of the University of Liverpool for the degree of Doctor of Philosophy.

by

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June 1992

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PREFACE

> "The meaning of an episode was not inside like a kernel but outside, enveloping the tale which brought it out only as a glow brings out a haze, in the likeness of one of these misty halos that sometimes are made visible by the spectral illumination of moonshine" J. Conrad Heart of Darkness.

Over the last twenty years or so there has been a burgeoning of literature and research devoted to aspects of the doctor- patient relationship. Most of the literature has reported the results of research, but one or two texts have described the relationship from perspectives other than the strictly medical (for example, Balint, 1964; Berger, 1967; Sacks, 1973, 1981, 1984, 1985; Sanders, 1991). The research mostly has followed the usual tradition of applied medical investigation. That is to say it is generally objective in approach and quantitative in nature. The latter, reflecting a positivistic philosophical orientation, results in three central commitments. These are fundamental to the methodology it employs. The first is that conventional natural science research should be the model for all social investigation and that the logic of the experiment is the only acceptable logic for scientific enquiry. The corollary of such an assumption is that only knowledge acquired in this way may be accepted as 'scientific' knowledge. The second commitment identifies a 'gold standard' towards which medical researchers should strive. The aim of the researcher is thus to establish general laws of the kind found in classical physics. In demonstrating such laws, investigation is able not only to explain phenomena retrospectively, but is able to predict the future occurrence of phenomena falling within their remit. Lastly, a positivist stance commits the investigator strictly to observation, and only observable phenomena may be accepted as knowledge. Accordingly, if they are to be regarded within the realm of the latter, feelings, motivations and attitudes must be rendered in some way observable (Bryman, 1988; Murphy & Mattson, 1992; Von Wright, 1971). The foregoing commitments necessarily circumscribe the methodology used in scientific endeavour. The hypotheses are formed a priori, and by comparing one or more experimental samples with a control sample the null hypothesis is either confirmed or refuted. If it is refuted the probability of the result being obtained by chance is calculated. The observer thus takes all

possible precautions to minimise any influence he may have over the observed, and when reporting his results, the investigator aims primarily to inform a narrowly specialised readership. Hence the style he uses when reporting will generally reflect his methodology: it will be impersonal, impartial, and rather flat. Often it will be extremely dull and always rather repetitive. Within such a positivistic orientation there is no language for the subject; no discourse of which the subject may partake. The terms of reference are clear cut, organic, mechanical, and finite: locations, durations, quantities admitting only to precise definition, enumeration, estimation and measurement (Sacks, 1973 p.204). Both observer and observed are depersonalised into 'It'.

Qualitative research claims to offer an alternative to this reductionism, and the extreme of this alternative is found in phenomenology. Here the writer strives to describe an experience so that it will not be distorted or falsified by any abstract theoretical framework. Phenomenalism derives meaning from the individual's reaction to and relationships with real world events. Its language is therefore essentially descriptive. The subject's understanding and everyday discourse alone can intimate his 'being in the world'.

In methodological terms, phenomenology has given way to what has come to be regarded as qualitative research, and this challenges the appropriateness of natural science as a model for all investigation (Bryman, 1988). This is particularly so where enquiry is concerned with understanding people as social beings rather than as mechanistic entities. Behaviour is seen not simply as an outcome of determining variables, but as arising from the individual's interpretation of events and experiences (Murphy & Mattson, 1992; Lessnoff, 1974).

As quantitative research is underpinned by three conceptual commitments, so qualitative research relies on three key issues (Good & Watts, 1989). Firstly, it is seldom appropriate to use only one source of data: any conclusions will be far more secure when supported by direct and indirect measures such as 'objective' records and personal accounts. The use of multiple sources of data to confirm an interpretation is referred to as triangulation (Campbell & Fike, 1959). Secondly, it is important that the researcher should be clear whether he is hypothesis-testing or at an earlier, more exploratory phase of the investigation. The hypothesis must always be delineated clearly to ensure it is testable but must develop out of the enquiry. Lastly, the qualitative investigator must always take care

to examine his personal connection to what he is studying. Ideally he should be sufficiently in tune with the culture he is investigating to be able to grasp its subtle nuances, but his commitment to scientific validity should be unclouded. Such a commitment to making public peoples' private worlds leads inevitably to a comparatively unstructured research strategy. The researcher is unlikely to decide a priori what precisely is to be studied, and will be open to unexpected cues which arise from the enquiry. Qualitative research methods, often called techniques, will inevitably pose particular problems in terms of interpretation and generalisability: although one of its strengths, the very richness of its data, usually precludes the possibility of establishing robust associations.

Sacks (1974) observes that, while we know much of the devices of disease and indeed allow and collude with disease, we know very little about the powers of health that lie within us. Yet health and disease are mutually expressed by us in what are essentially metaphysical terms; "terms which neither require nor admit definition and which are at once exact, intuitive, obvious, mysterious, indefinable and infinite 'How are you ?', 'How are things ?' so essential to the doctor's discourse are metaphysical, not mechanical, terms" (Sacks, 1974 p.203). While it is no doubt to generalise grossly, nevertheless it seems that quantitative research has a predilection for a finite, mechanical, impersonal language, while qualitative research has more of an affinity with the language of metaphysics - the discourse of health as well as disease. Although both types of discourse are complete in themselves, they are complementary, and both are vital to understanding the world. Sacks (1974 pp.204-5) quotes Leibniz in saying that, "Writers who take these diverse routes should not speak ill of each other ... The best plan would be to join the two ways of thinking", but, with Leibniz, he underscores the primacy of metaphysical over mechanical language. To dismiss metaphysical discourse is to dismiss what it is to be *us*. Yet this is precisely what some modern medicine, replete with mechanistic language seeks to do. The latter especially, fuels the belief that disease is distinct from the person. The therapeutic correlate of this, as Sacks points out, is the notion that the disease must be attacked, and that the attack can be launched with impunity and without due consideration for the *person* who is ill. The language of medical investigation, which paradoxically can never be considered apart from its subject, at once satires its victims and is itself the object of satire: "Sit there, 'subject'. Now, here is a questionnaire with five hundred questions on it. They are written

in stone and encompass the entire realm of possible questions concerning these realities. There are only five possible responses to each one. All you have to do is meekly indicate for each of my pre-conceived computer card holes where your peg fits - that and absolutely nothing more. Then be gone with you" (Douglas, quoted in Murphy & Mattson, 1992). But where in satire the prevailing vices or follies are explicitly held up to ridicule, the mechanistic language of some present day medicine renders its assumptions implicit. The attack on the disease thereby comes perilously close to being an attack on the person, and on *personhood* itself.

Because family medicine at its best is concerned with treating people as partakers in health and social beings rather than as carriers of disease, Murphy & Mattson (1992) suggest that the principles of qualitative research reflect many of the concerns of general practice. Both stress the primacy of understanding the individual within his context and both, in theory, are concerned with individuals as 'wholes' rather than as the sum of their parts. However, these writers also illuminate the inevitable trade-off between quantitative and qualitative approaches, reminding us once again that it is ill advised for one diverse route to speak ill of the other. Moreover, although qualitative research methods are ideally suited to explanations and to the generation of hypotheses, positivism, which underpins quantitative research, has been criticised for failing to give adequate recognition to the role in many scientific theories of hypothetical entities which may not be directly observable. It is not uncommon for writers of quantitative research to use analogies and metaphors to facilitate an understanding of the causal mechanisms of observable phenomena, but, because they are not observable, such rhetorical devices run counter to the positivist account of the scientist (Bryman, 1988). Quantitative research at its best may not be so removed from metaphysics as the blind application of its modus operandi might imply. And indeed this perspective has been argued for (Bryman, 1988).

The commonality of these apparently discrete approaches is wonderfully demonstrated in one of those bizarre coincidences of history. Almost within ten years of one another, two men wrote two stories. In one, a novelist observes the life of John Sassall, a general practitioner, whose intimate contact with his rural patients, combined with his passion and knowledge, enable him to speak for his deprived community (A Fortunate Man, J. Berger 1967). In the other a doctor writes a novel about what it is to

become a patient, and in so doing affirms the intensely personal nature of patienthood and the community of human experience (A Leg To Stand On, O. Sacks 1984). What is so curious and so fascinating about the two accounts is their language. The novelist cites doctor and social commentator to inform his work while the doctor quotes from preacher, poet and philosopher. Each author adopts a language which is antithetical to his formal perspective.

Accordingly, the professional writer uses an objective and rather detached discourse. The reader experiences himself watching Sassall, rather as an observer might observe an experiment. Indeed at times the writer interjects to caution the reader, "At certain times my own subjectivity may distort", "I can only claim after years of observation ". (p. 110). Although able to feel for Sassall, the reader rarely feels *with* him. For while the fictitious doctor faces the depths of human suffering, he does so once removed. The language, almost clinical at times, inhibits the reader's sensitivity. And in so doing it inhibits his responsiveness and removes him both from Sassall's predicament and from the doctor's patients. The writer reflects at one point that doctors distance themselves not only as a defence against blood and guts, but because they use a second technical, and entirely unemotional language. He also points out that in the eighteenth century and earlier, the doctor was frequently regarded as a cynic. Thus the language and perspective of the writer's account tends often too convey the disclaimer of a report and the tone of one who doubts.

The professional doctor, in contrast, an advocate of the principles of general practice at its best (cf. Migraine pp. 230-245) conveys his journey into patient-hood with great evocative power. He describes movingly the way that his injury, which begins the journey, is an assault on his physical and his metaphysical being. The reader is brought to the heart of what it is to be a man reduced and dependent on his doctor. The language is rich, protean, restlessly in tune with the subject, at one with the subject, faltering as the subject despairs and quickening as his strength returns. Words for the doctor-writer are not just tools or techniques, they are something altogether other; words bring the reader to the experience, through the experience, and give to the reader the serenity of surviving the experience. But the doctor-writer does not stop there: he reflects, he ponders, he locates his experience within his professional language, he speculates. His language is at once

pragmatic and universal. He makes an impassioned plea for for the subject to be restored to medicine, and for the self to re- discover the ground of its experience.

The point I hope to draw out in referring to these accounts is that however rooted in fact they may be, each is rendered first and foremost as story. Almost, one might say, in anecdotes. Each narrative is concerned with the unique and paradoxical relationship of the doctor and the patient. This relationship is unique because both doctor and patient cherish experiences and characters uniquely their own; unique because of the language that divides them; the doctor representing all doctors, unique in his role as healer; the patient, representing all patients, uniquely isolated in his distress. It is a paradoxical relationship because, in their uniqueness, doctor and patient are able to partake of the other's language and to share a common experience. That they are able *to* so unite does not mean that doctors and patients will readily do so. The paradox is inherent rather than declared, and the language between them is provisional because it is profound and deeply perplexing. Earlier I gave a thumbnail sketch of the theoretical foundations for quantitative research, and suggested that the methodologies employed by each may not be so far removed. Indeed I would argue that the former, becoming at times redundant in the light of new physics (and perhaps weary from use), is very very slowly being replaced with the latter, and that the raison d'etre for the latter pays at least lip service to the former. I do not mean, in speculating so rashly to denigrate qualitative research. Nor, for that matter, do I wish to denigrate quantitative research. As has been said above, each has their place and qualitative research, with its inclination more to the metaphysical, provides a welcome corrective. But care is required. For as Sterne so brilliantly illuminates, the hypothesis is organic and greedy: "It assimilates every thing to itself, as proper nourishment; and from the first moment of your begetting it, it generally grows the stronger by every thing you see, hear, read, or understand" (Tristam Shandy,1759, II xix). Such entropy is a characteristic also to be found in the disease: diseases, "hold consultations and conspire how they may multiply, and join with one another's force". (Donne, quoted in Sacks, 1974 p.231). Thus in the generation of hypotheses the investigator begins, imperceptibly at first, to become the central character: central, because in control, but diminished because the subject, upon whom his hypothesis rests, is made increasingly dependent on the hypothesis. In

simplifying the subject, however, the investigator, too is simplified. The wheel comes full circle, both observer and observed are depersonalised as 'It'.

But there is language. In a wonderful little essay, Harris (1991), himself a general practitioner, enquires into the nature of descriptive research, asks if there is anything in it which could grow, and wonders what kind of writing it might foster. He is particularly concerned to explore the possibilities it may hold for research in general practice. Using a refreshing, almost conversational style he shows how language is able to effect methodology. He speaks of "word magic" and shows how writing which seeks to affect the reader is of far greater interest than writing aiming only to inform. With a hint of sadness, he observes that descriptive research is rarely found nowadays because most medical journals will not publish it, and with regret he tells us that the mode has fallen into disrepair. Then, startlingly, out of his own vigorous writing, he indicates how descriptive research may provide an opportunity both to apprehend the "peculiar genius" of the good descriptive researcher, and to appreciate the crucial interplay of his senses, his experience and his thinking. Harris points out that the interplay is creative and that such writers will require a command of language seldom demanded of the investigator whose data consist of measurements. The great pathologers of the past were blessed in just this way, and nourished their perceptions through its artistry. In one sense, descriptive research is an extension of qualitative research, and qualitative researchers, I am sure will claim it for their own. But it is also of a higher order and cannot be possessed in this way. In it the reader feels the presence of the writer as a real person, sometimes palpably. There is charity in this writing, a trust: a willingness to give to the reader what the reader will make of it. The subject is awakened and there are moments to be associated more with the novel than the scientific report. Indeed Harris (1991) cites Sacks as our best contemporary descriptive researcher. But he does not leave the matter there. He goes on to characterise the process through which descriptive research makes provisional conclusions on the basis of long observation. It cannot be likened to phenomenology, for in descriptive research the *writer* is free to suggest a meaning for the observations in question. And whereas the qualitative researcher will also generate hypotheses and even discard his hypotheses, the descriptive researcher will speculate on the meaning of the hypothesis and will be ready to discard *his*

speculation in the light of fresh observations: the hypothesis is not all. Harris is aware that the distinction is fine but points out that the former has further to retreat.

Allied to descriptive research, and indeed part of it according to Harris, is the salience of the clinical anecdote. The teller of the clinical anecdote is that - a teller -and his stories will always have personal meaning for otherwise they would not be told. Moreover, the teller of a clinical anecdote will always reveal his *own interpretations* in time. The 'Anecdote' comes from the Greek, meaning to make public something that was private, and it is apparently a mode of communication much favoured by general practitioners (Bradley, 1992). Harris sees the anecdote as having a connection with pathography and being akin to descriptive research in general practice. In the latter "the research intention is implicit rather than explicit; and the literary artistry found in the best descriptive research has its counterpart in the skills that a good raconteur will bring to the telling of an anecdote. Just as Moliere's M. Jourdain was surprised to find that what he had been speaking all his life was prose, so, as anecdotalists, we must recognise that we are all pathographers now". (Harris, 1991 p.96)

The present research describes a method of interaction analysis for the doctor-patient relationship. Although a *method* of interaction analysis, designed to be applied in the tradition of quantitative research, its categories were devised in the spirit of qualitative hypothesis testing. The method is assessed naturalistically, according to a number of formal hypotheses, but seeks to address meaning in the consultation as well as process. The results are presented conventionally, but, since each chapter speculates rather widely upon a small population, the interpretations are somewhat anecdotal.

While I am confident that my reader is secure enough in 'himself' to understand that the masculine form is a standard way of implying the genus *Homo*, nevertheless I am bound by current convention to explain carefully that throughout this thesis, apart from instances when gender is delineated clearly by context, I have used the pronoun 'he' to mean masculine and feminine, the noun 'man' to include men and women, the adjective 'male' to incorporate female, and the possessive 'his' to subsume her(s).

N.M.B.

ABSTRACT

A method for the interaction analysis of the doctor-patient consultation is described and applied to six naturally occurring general practice interviews by three raters. The method is reliable given sufficient training and satisfies the stringent criteria for any method of interaction analysis of medical interviews proposed by Wasserman & Inui (1983). Seventy three general practice consultations are then analysed according to the above method. Results for the three principal agenda types (Physical, Emotional and Social) are presented in terms of the control exerted either by doctor or patient in determining the content of the interview. Both doctors and patients address Physical agendas to a high degree, but patients present Emotional agendas to a far greater extent than doctors address these concerns. The handling of Social agendas is intermediate for both parties. It is argued that doctors are able to facilitate or limit the expression of psychosocial issues by giving implicit or explicit permission for their presence in the interview.

The same series of consultations are further analysed in terms of doctor and patient handling of principal agendas according to the nature of the presenting problem, individual doctor, and interview duration. Results show that the presenting problem, defined as Acute Physical, Chronic Physical, Emotional or Social, effects both doctor and patient handling of these agendas. The emotional domain is particularly sensitive in this respect. When emotion is clearly defined, doctors address the agenda to a higher degree. However, patients seem to share doctors' reluctance to address emotional concerns when the presenting problem is Acute Physical. Individual doctors differ in the way they approach the three principal agendas. Longer consultations are associated with more attention being paid to the social domain only.

The interviews are then analysed according to consultation Procedures and Information Processing. Procedures are defined as behaviours which are brought to bear on interview content by means of information processing. Doctors tend to follow the diagnostic and prescriptive phases of the consultation, marked by Seeking Information in the first half and Giving Information in the second half. Although they give more information in the first half of the consultation, the divide is not so marked

for patients. There is evidence that doctors process Physical agendas first, Emotional agendas second, and Social agendas third. Giving Information is associated with Treatment for both doctors and patients.

A method for analysing doctor and patient problem solving behaviour in the consultation is then described. It is shown to be very reliable, to have good face validity and to be sensitive to all three principal agendas. Results show that doctors demonstrate a wide range of problem solving skills in the physical domain. They are able to use a fairly wide range of these skills in the emotional domain when emotion is clearly defined. Doctors do not use problem solving very much in the social domain. Patients more often raise their Emotional agendas cautiously, but when they do so, doctors do not problem solve later in the interview to the same extent as when patients initiate these agendas clearly. Doctors limit initial emotional expression to a high degree. Problem solving later in the consultation appears to be a function of the initial problem solving strategies which either party bring to bear on a given agenda.

ACKNOWLEDGEMENTS

Without many people the work for this thesis would not have been possible. It certainly would not have been completed. To them all goes unending thanks. In the early days it was the faith placed in me by the late Mr John Facer, and the inspiration of my supervisors Professor Peter Slade and Mr Brian Nellist, which spurred me on. The enthusiasm and advice of the latter has been unwavering.

The research would not have been feasible without the support of the Leverhulme Trust and the Nuffield Foundation, nor would it have been possible without the co-operation of the participating general practitioners together with their consenting patients. Their contribution was crucial to the study. Without the insights of Professor Tony Cox and Dr Peter Campion the work would be vastly inferior and their influence is present throughout.

I will not forget the forbearance of Mr Eric Bromley in accommodating the writing up of this thesis in its final stages; the kindness of the Rev. Dr Ian Carter; the understanding of Mr Phil Smith at the R.L.D.H.; the generosity of the staff at the University of Liverpool Sports Centre in allowing me access to its studio, or the encouragement I found there from my fellows in training. Neither will I forget the staff of Quo Vadis, Liverpool 1, in their quest for the perfect cappuchino coffee.

I am indebted also to my father, Mr Ronald Butler, for his constancy and support over the years; to Mr Bo Chin for his loyalty, and, in the last weeks of writing-up, to Dr Sid Fowles for his guidance. The perception and remarkable creativity of Mr Billy Shears at Ocean Boulevard, WC2, contributed more to my confidence (and sense of fun) than he perhaps knows. To him and Lorraine Adams a very special regard. There is one, however, whose good humour and patience could never be expressed in words. Without the love and unfaltering solidarity of my husband, Dr Tim Newton, I would long ago have abandoned this work. To Tim I dedicate my thesis.

Nina M. Butler, June 6th 1992.

CHAPTER 1 : OVERVIEW

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The body of literature pertaining to the doctor-patient consultation and its attendant relationship is now substantial. Because the salient features of this literature are systematically and thoroughly explored in the context of chapters to follow, the present chapter is concerned to orientate the reader and to direct the reader's attention to important themes which have emerged in the field.

A. INFORMATION EXCHANGE IN THE MEDICAL CONSULTATION

There are many arguments for better informing patients in the medical consultation. It has been reasoned that more information should be given because patients are dissatisfied with the amount they receive (Hawkins, 1979; Fletcher, 1973), Cartwright, 1981); that satisfaction about information received enhances patient compliance with treatment (Ley & Spelman, 1967; Korsch, 1968); that information which aids understanding is able to reduce pain, speed recovery and lower blood pressure (Egbert et al, 1964; Janis, 1958; Kaplan et al, 1989); and that lack of information actually prevents patients from complying (Svarstad, 1974). Additionally, it has been argued that because negative effects can be expected from many medical interventions, patients need to be involved more fully in decision making and encouraged to assume greater responsibility for health care decisions (Hart, 1976; Tuckett, 1979; Tuckett & Williams, 1984). It has been proposed that the fundamental feature of the medical consultation is to help patients to order and understand their symptoms in terms of their existing cultural framework (Rosestock, 1974; Becker, 1977; Kleinman et al, 1978), and that the consultation is essentially a negotiated exchange of information (Katon & Kleinman, 1981) or a meeting between sharing equals (Tuckett et al, 1985). Other, more sceptical, views have questioned the desirability of doctors and patients exchanging information freely: doctors tend to believe that patients forget much of what they have been told (Horder et al, 1972), and that there is a competency gap between doctors and patients which prevents any real sharing of decision making (Parsons, 1978). There are sociological ideas which suggest that the doctors' provision of information may be restricted for professional reasons and that information may be used

to keep patients in line or to exercise the function of social control on behalf of existing power structures (Friedson, 1972; Lorber, 1975), and there is the view that patients need to be able to perceive the doctor in some idealised way in order for any placebo response to be effected: rational exchange of information could undermine any such an effect (Pickering, 1990). A growing body of literature identifies the doctors' own psychopathology as a reason for limiting the provision of information to patients (Longhurst, 1989; Frenette & Blondeau, 1989; Weston & Lipkin, 1989). When they have been determined upon, the most effective ways of conveying information are debated (for example, Cox et al, 1981a, 1981b, 1988; Cox, 1989). Indeed the literature on doctor- patient communication is so disparate and so exploratory that it has been likened to a Rorschach test in which overall interpretations are likely to reveal as much about the reader as about the results themselves (Inui & Carter, 1985; Roter, 1989).

B. INFLUENTIAL METHODS OF INTERACTION ANALYSIS

Early studies of interaction analysis in the doctor-patient consultation coded minute aspects of the interview, in order to analyse the process of interaction between doctor and patient. For example, Advani (1973), Davis (1968, 1971) and Francis et al (1969) all adopted Bales' (1950) method of Interaction Process Analysis, first developed for understanding the functioning and decision-making of small groups. Both the Korsch group and Davis coded every statement observed in the consultation into one of twelve mutually exclusive categories. Each statement was rated as an expression of positive affect (showing friendliness, solidarity, showing tension release by joking or laughing, expressing agreement or understanding, paying attention); as an affectively neutral statement (giving instructions, opinions or information); as asking affectively neutral questions (requesting information, opinions or instructions); or as showing negative affect (disagreeing, showing tension or antagonism). Having been categorised, statements are summed and patterns of interaction identified. The Advani system is able also to distinguish information about treatment from information about prevention.

Roter adopted the systems used by Davis and Korsch, arguing that the latter were not specific enough to the 'patient-provider' dyad. Her modified coding system included indicating when in a consultation certain statements took place; recording certain categories of statements verbatim; distinguishing certain subcategories of statements in greater detail than in the systems of Davis and Korsch; and distinguishing patient interrogations which appeared to have no antecedents in what had been said from those which seemed to have such antecedents and which appeared to be 'bids' for clarification. This system was designed to be coded from audio tape, an innovation which made rating quicker than the earlier systems which had required verbatim transcripts.

Byrne & Long (1976) and Pridham & Hansen (1980) both developed systems for coding the interview which conceptualised the consultation in terms of problem solving phases. The interview was sampled at ten second intervals and then coded as belonging to one or other exclusive phase. Various aspects of phases were further discriminated as scanning, formulating, appraising, developing willingness or readiness to problem solve, planning, implementation and evaluation. Implementing included activities such as orienting, guiding, developing decision rules, problem solving strategies and practising. Byrne & Long focused exclusively on doctor behaviour, while Pridham & Hansen extended the method to include the patients' behaviour also. Both approaches thereby made it feasible to assess the consultation in terms of doctor-centred and patient-centred patterns, to identify how much time was spent in each, and to describe who initiated them. Byrne & Long's method has since been criticised by Buijs et al (1984) as being unworkable on five counts and has been modified by them. The latter maintain that Byrne & Long's classification was not designed for the consultation as a *whole*, since in every interview they identify two phases: the diagnostic and the prescriptive. The two discrete ordinal scales used by Byrne & Long for each phase (4 parts and 7 parts respectively) are obviated when they calculate the doctor's style making use of all units of speech. Buijs et al also find Byrne & Long inconsistent in their use of the terms doctor-centred and patient-centred; consider them unsystematic in their manner

of assigning values to categories; identify serious statistical problems in the way the system takes the relative incidence in a specific style as the starting point, to obtain a relative value in the prescriptive phase that differs from the value in the diagnostic phase, and object that it is not possible for a doctor to achieve the highest value style when it is calculated by the values given by Byrne & Long to the units of speech. However, Buijs et al consider that the system is useful, and that an increase in discriminatory power may be obtained if the idea is abandoned that a doctor's style must be rated on the single criterion of doctor/patient-centred. For example, categories may pertain to relations of power, empathy, giving information etc. as much as to doctor and patient centredness per se.

Stiles et al (1979) developed a systematic approach to the doctor-patient consultation deriving its rationale from linguistic ideas. Their unit of analysis is the doctor and patient 'utterance' and each unit of the consultation is coded according to its inferred communicative function, for example, as a disclosure, a question, an acknowledgement, an advisement, an edification, an interpretation, a confirmation or a reflection. The pattern of utterances is then examined in sequence. Because it is able to describe the extent to which a doctor's behaviour is attentive, acquiescent or prescriptive, overall or in different problem solving phases of the interview, the system identifies complex patterns of action but additionally may be simplified to show summary categories which characterise doctor and patient behaviours.

C. EARLY REVIEWS

In a challenging and extensive review of measurement of explanation and information giving in medical consultations, Tuckett & Williams (1984) express concern about a prevailing gap between theory and research. According to these authors, theorists contented themselves with exploration rather than systematic study, while empiricists have ignored both theory and the theoretical definitions of their measures. They propose that a more secure understanding of giving information to patients requires clear criteria about what should be told to which patients and in what circumstances, and ask why

such criteria are lacking. Reasons include the possibility that information giving in medical settings functions principally to control rather than to inform and that the social sciences' collaboration with medicine has produced 'empirical' research which unwittingly has contributed to the idea that explanation to patients is not about content but is about non-verbal cues and appropriate affective relationships. Tuckett & Williams maintain that if conceptualising and giving explanations continues to be a 'Cinderella' area of medical practice, it may be due, at least in part, to social scientists who prefer to theorise about why information is restricted rather than to contribute to how it can be helped to flow. Tuckett & Williams are concerned that systems such as those described in section B above are too broad and general in their approach. While they all code individual statements or small time units and in one sense are very detailed, all too often large proportions of statements fall into very few categories. For example, in the Davis and Korsch studies nearly half of what doctors said was placed into the category 'gives information' . Nor were the kinds of information distinguished. Separate statements were counted as being theoretically equivalent, two statements or questions being regarded as twice as informative etc. as one. The content of the interviews was therefore never addressed. It was not possible to say which topics were or were not explained and in how much depth, or to identify what sort of instructions were being given and in what detail. All the systems assess general characteristics of the way doctors and patients relate to one another: who does most talking or questioning, who listens to whom and who responds to whom. How doctors and patients relate is never considered. Tuckett & Williams point out that a major reason for the limited attention to content variables is the pervasive influence of the Bales' system. The Bales' categories were, in fact, never intended to measure the *kinds* of information or instructions given or sought by two people addressing themselves to the solution of one specific medical problem, but were developed to generate ideas about group functioning. Yet even the systems of interaction analysis, such as Roter's and Stiles', which have developed out of critiques of the Bales' approach, remain concerned mainly with behavioural aspects of the consultation. Inui et

al (1982) compared three of the systems discussed above, and examined their influence on outcome measures. The latter explored cognitive, affective and behavioural levels: the systems in question were the Korsch group's modified version of the Bales'; the Roter version, and the Stiles approach. These authors reported that none of the three systems was able to generate interaction variables which could explain the variance in outcome measures to any great extent. They used a multiple regression coefficient, corrected for the number of variables generated by each system, and found that the Korsch system accounted for 19 percent of the variation between patients who took medication correctly and incorrectly, compared to 28 percent for the Roter system and none at all for the Stiles system. Predictions of knowledge and satisfaction were lower still. At best, therefore, the variables identified by these approaches are only weakly predictive of the cognitive outcome measures against which they are tested. Moreover, when relationships are statistically significant the significance remains speculative. Because they are atomistic, the taxonomies do not effectively capture or distinguish the specifically medical activities such as obtaining a history, teaching, reassuring etc. Tuckett & Williams (1985) thus question the implicit expectation that general aspects of the doctor- patient relationship influence outcome irrespective of the medical context of what is said and decided: "What explanations are given, what is and is not covered, as well as how it is covered, also seem likely to exert an influence. What clinicians do and do not explain needs to be examined in depth before we can start to resolve debates about such matters as the 'best' method for informing, instructing, influencing and convincing patients and whether it is a worthwhile or productive activity" (p.575). These authors go on to look at alternative ways in which the consultation has been examined. They note the studies of Cartwright (1981), Hawkins (1979) and Ley (1983) and draw attention to problems of interpreting these studies. Cartwright asked patients if they considered they had received more or less than 'enough' information; if explanations were 'adequate' or if they would have liked to know 'as much as possible'. Hawkins asked for patients' views about the information they received in hospital in a similar way. The problem here, however, is that what

patients believed to be more or less, enough or adequate, is never explored. Such a lack of operationalisation, therefore, makes it difficult to interpret any desired change, or to know what 'enough' information might mean to patients. It is similar with the work of Ley (1983)). In a series of investigations the latter demonstrated that patients were better able to remember information when it had been organised simply. The problem here, however, is that Ley assessed patients' recall not of key points but of all statements made by the doctor. Nowhere was there the opportunity for patients to give meaning to what they had heard or for the patients' subjectivity to be analysed in any systematic way. The underlying assumption of Ley's work, and indeed all the interaction process analyses so far mentioned, is that all information is equivalent. Manifestly this is not the case: information which the doctor regards as important may be forgotten by the patient because it is not important to him or does not resonate with his lay ideas. The same problem exists with studies which have examined the effect of gender (Walton et al, 1979) and social class (Pendleton & Bochner, 1986) on information given in the consultation. The investigator's theory about what constitutes information will inform any interpretation of the number of words used or statements made. But if it is not known what information is worth having it is difficult to indicate who is discriminated against. This problem of evaluating the quality of information obtained in the medical consultation is at least in part a corollary of the application of quantitative research methods, and the implications of the latter are discussed in some detail both in the preface to, and the conclusion of, this thesis.

D. MODELS OF THE CONSULTATION

There are a number of ways in which the doctor-patient consultation has been approached. These approaches amount to models of the consultation, and are important to note for a number of reasons. Foremost among these is the way in which the investigators' model of the doctor-patient relationship is likely to inform his method of enquiry. An enquiry which starts from premises that are rooted in the traditional medical model, for example, is likely to adopt a quantitative methodology, and is unlikely to

allow for the patient's subjectivity. A social anthropologist, on the other hand, is more likely to abandon a quantitative research methodology, and will face a number of problems in interpreting his results (for further discussion see also the preface, chapter 3, and section D of chapter 9).

The traditional medical model's central hypothesis is that the function of the doctor is to diagnose the patient's disease. It is summed up by Sir Henry Brackenburg (1935) and Sir Morris Cassidy (1938) in the following quotations respectively: "It is not altogether easy for the doctor to realise the colossal ignorance of the laity of things which are to him ingrained or even axiomatic ... it is really extraordinary how such layman, even if what is commonly regarded as well educated, seem unable to form any clear image of anatomical or pathological conditions, or any true conception of physiological or pathological processes ...". And "A lot of valuable time would be saved if our patients could be taught that all we want to hear from them is an account of their symptoms as concise as possible and chronological !". The remnants of such perspectives are with us still, and are manifest in more subtle ways. Tuckett et al (1985), for example, draw attention to the way in which the work of Ley (1967, 1973, 1976, 1979) has been equated with the beliefs implicit in the medical stereotype. Ley set out to encourage doctors to improve their communication by making it clearer and better organised. He demonstrated that many patients did not possess adequate medical knowledge, but, because his methodology followed the tradition of objective research, he was not able to show that patients nevertheless have relevant knowledge about their condition. The consequence of this is that his recommendations have been seized by practitioners of the traditional medical model to illustrate the stereotypical patient: "After routine consultations the average patient remembers only half of what he has been told. This is really not surprising: some patients are too anxious to listen attentively. It is easy for doctors to forget that although what they say is commonplace to them, it is quite strange to patients who may know nothing about physiology, pathology or therapeutics" (Walton et al, 1980 p.22).

The Health Belief model proposed by Rosestock (1974) and developed by Becker (1977) is an alternative to a traditional medical model and has enjoyed influence. It is concerned to address variables such as the patient's health motivation, the patient's perception concerning probable consequences of leaving an illness untreated, and cues to the patient's motivation. However, as Tuckett et al (1985) point out the Health Belief model has unwittingly contributed to the medical stereotype of patients. The model began principally as an attempt to organise and make sense of the diverse relationships between social and cultural groups and patients' utilisation of medical services or compliance with treatment. The underlying assumption was that culturally based notions of susceptibility to disease and beliefs about the severity of disease would influence a person's motivation to act in the face of disease. If an individual's motives are not biomedically consonant, they are likely to be a causal factor in the person's failure to consult the doctor at the appropriate time. Advocates of the model have argued that in changing patients' ideas about severity, susceptibility and costs and benefits of action, patients will be more likely to follow biomedical recommendations. Rather than to examine the cultural implications of patients' particular belief systems, therefore, the model has tended to concentrate on advising doctors how to manipulate patients to take action. Suggestions for change have been concerned to experiment with the degree to which communications successfully arouse fear, or other emotions, in patients thereby encouraging them to action. Tuckett et al criticise the Health Belief model on this and two other accounts. Firstly, Health Belief Theorists have conceptualised beliefs as being the relatively stable properties of atomistic individuals, ignoring the extent to which beliefs function as part of an everyday cultural process from which individuals give meaning to experience. Secondly, theorists following this model have constructed role theory which focuses on the expectations and beliefs to which a patient must 'rationally' subscribe in order to achieve a role prescribed end.

Role theory has emphasised the mutual expectations brought by two or more persons to a particular context (Bochner, 1983; Secord & Backman, 1964). The rights

and obligations of each individual within a given situation are particularly addressed, and that doctors might expect particular actions from patients within the specifically medical setting (Argyle et al 1981a, 1981b). Different 'rules' would apply were doctor and patient to meet at a social function. The problem with the theory is that individuals must know the appropriate role and, in the medical context, must know the function of the medical consultation: it does not allow for an individual's deviation from the pre-prescribed role.

Tuckett et al propose a model of the consultation in which both doctor and patient are 'experts'. Patients, for example, can have expertise in the care of their children or in the functioning of their bodies. Campion (1987) and too often this expertise is overlooked by doctors. Tuckett et al demonstrated an association between patient's commitment to the doctor's advice and the extent to which the doctor had accepted a patient-centred point of view. Indeed the underlying philosophy of the model points to the consultation being patient led. However, Tuckett et al are clear that the patient is an *expert*, and the consultation is not simply patient-led.

The commonest model of the consultation redefines the doctor-patient consultation in terms of a market place transaction (Stewart & Roter, 1989). The patient here is not only expert, but holds the balance of power: it is up to the patient whether or not to purchase the prescribed care from the health 'provider'. This model is therefore, in effect, the antithesis of the traditional medical model of the consultation.

A systems approach to the medical consultation gave rise to Engel's (1980) biopsychosocial model. It derives from systems theory which observes that nature is organised in an hierarchical continuum. Each level in the hierarchy represents an organised and dynamic whole but each system is also a component of a higher system. Thus cell, organ, person, family each has a distinct characteristic and its own properties, but each is part of the others. Within the doctor-patient consultation, the term 'patient' will characterise an individual in terms of the larger social systems of which the patient is a part. For the doctor to diagnose the patient's condition he must be able to recognise not

only tissue or organ, but the dynamic ways in which the patient interacts with other systems in his life. The Biopsychosocial model, the patient centred model and the concept of the patient as expert have all fed into what has come to be called the Transformed Medical model (McWhinney, 1986; 1989). It is a demanding approach to the doctor-patient encounter because it requires the doctor to analyse a complex web of relationships from several domains (Stewart & Roter, 1989). Not only must the physician diagnose the disease, but he must attempt to understand the patient's expectations, feelings and fears. He must be able to listen, to empathise and be in tune with himself sufficiently to recognise when he is reacting to his own rather than to the patient's agenda. Conflict, when it is present (and this is likely to be more often than not, see chapter 8), must be negotiated around and reconciled.

Discussion of the above models may also be addressed. These are examined both with respect to the models discussed and in the light of the present study in chapters 3, 4, 5 and 6.

E. PATIENT CENTREDNESS

Inui & Carter (1985) note that from ancient times there has been an interest in provider-patient communication behaviours. To illustrate the point they quote from Plato's Laws:

> ATHENIAN: You agree that there are those two types of so called physicians [free men and slave- apprentices] ?
>
> CLINIAS: Certainly I do.
>
> ATHENIAN: Now you have further observed that, as there are slaves as well as free men among the patients of our communities, the slaves, to speak generally, are treated by slaves, who pay a hurried visit, or receive them in dispensaries ? A physician of this kind never gives a servant any account of his complaint, nor asks him for any; he gives him some empirical injunction with an air of finished knowledge, in the brusque fashion of a dictator, and then is off in hot haste to the next ailing servant - that is how he lightens his master's medical labours for him.

> The free practitioner, who, for the most part, attends free men, treats their diseases by going into things thoroughly from the beginning in a scientific way, and takes the patient and his family into his confidence. Thus he learns something from the sufferers, and at the same time instructs the invalid to the best of his powers. He does not give prescriptions until he has won the patient's support, and when he has done so, he steadily aims at producing complete restoration to health by persuading the sufferer into compliance. Now which of the two methods is that of the better physician or director of bodily regimen ? That which effects the same result by a twofold process or that which employs a single process, the worse of the two, and exasperates its subject ?
>
> CLINIAS: Nay, sir the double process is vastly superior.

Quoted in Inui & Carter (1985, p.521).

This "double process" is most probably the earliest definition of what has come to be known as 'patient centredness' in medicine. Patient centredness contrasts with a disease or doctor-centred approach to the doctor-patient consultation. In the latter the doctor pursues his own agenda and makes little attempt to understand the patient: it is the "single process" described by the Athenian to Clinias. Doctor centredness is rooted in the traditional medical model whereas patient centredness has come increasingly to be associated with the transformed medical model. These models of the consultation are discussed in chapter 3 and in section D above. Patient centredness is a concept which informs Balint's (1964) early and sensitive account of the doctor-patient relationship, and is used by Balint and his colleagues (1970) as an alternative to illness centred medicine.

Stevens (1974) elaborated the idea of patient centredness when he made a key address to the Royal College of General Practitioners. In contrast to the algorithmic processes involved in traditional doctor-centred medicine, he proposes the centrality of the doctor and the patient as persons, one of whom has a problem. Problem solving will be facilitated only by regarding the patient as a whole in a patient centred approach.

Byrne & Long (1976) developed the idea further and incorporated it into their method for categorising the doctor-patient consultation. As was reported above, the latter was divided into two phases and each phase assessed according to doctor-centred and patient-centred dimensions. Although Byrne & Long's *approach* has since been criticised (see above), the concept of patient centredness has not. Indeed it has gone from strength to strength.

The Levenstein group (1986, 1989) specify that the aim of the doctor should be to identify the patient's world and to attempt to reconcile that world with his own. Evolving out of these recommendations, Henbest & Stewart (1989) have developed a method for assessing the doctor-patient interaction in terms of its patient-centredness. They use Balint's reference to patient 'offers' to refer to everything the patient brings to the doctor which may have potential significance. Offers include symptoms, expectations, thoughts, feelings, prompts and non-specific cues. The doctor may respond to patient offers by ignoring the offer or by using either open or closed responses. Henbest & Stewart showed the method to be reliable and found that doctors responded in a less patient-centred manner to patients' feelings than to their symptoms. They also found that the doctors' score for the first two minutes of the consultation correlated highly with their score for the entire consultation ($r=0.806$), suggesting that doctors' style, in terms of patient-centredness, is fairly stable.

Assessing the utility of the patient-centred approach, Henbest & Stewart (1990) showed that patient-centredness is associated with the doctor having ascertained the patient's reason for attending the surgery, and with resolution of the patient's concerns. It was also associated with the patient feeling understood. Interestingly, however, they found that the patient outcomes were poorer after the open ended response. Henbest & Stewart therefore propose that the distinction between open and closed doctor styles is not as central as the facilitative role of the response, the latter being defined as when the doctor actively helps the patient to express thoughts, feelings and expectations about the offer. Patient-centredness is axiomatic with this, rather than with a specifically open style

of responding. These authors suggest that because a patient-centred approach is able to make a substantial difference to outcome it should be part of the healthcare package. The concept and its implications are discussed further in chapter 4.

F. RESEARCH ISSUES

Wasserman & Inui (1983) also take four representative systems of interaction analysis to demonstrate how each falls short of their proposed criteria for future research: the Bales', the modified Bales' by Roter, Stiles' Verbal Response Modes and Katz's system of Resource Exchange analysis. These are discussed in the context of chapter 3, as are the proposed criteria. The latter substantially inform the coding system described and tested naturalistically in the present series of studies. More recent assessments of research issues in the field have, in one way or another, further identified ways in which detailed interaction analysis must be balanced by an appreciation of how parts become a whole. Moreover, Korsch (1989), who was in part responsible for the widespread adaptation of Bales' interaction analysis to medical settings, has stressed that research must not only pass the test of scientific rigour but must have relevance and be useful to both doctors and patients. At a broad level of abstraction Hall et al (1988) and Roter (1989) conducted a meta-analysis of the empirically based literature on doctor-patient communication over the past 25 years. This characterised the literature in terms of study design, sample composition and size, instrumentation, and analytic strategy. While over 200 different independent variables describing communication process were reported, these authors were able to place the majority into one of six conceptual groupings. These groupings formed the basis of the meta-analysis which is able to provide greater statistical power in identifying true effects than is possible in most individual studies. They include information giving, information seeking, social conversation, positive talk and negative talk, and behavioural reflections of the primary function of the medical visit, including history taking, patient education, therapeutic management and counselling. Additionally, they are consonant with prior conceptual work in the field, and most especially with that of Parsons (1951), Bales (1950), Bloom (1983) and Ben-Sira

(1980), and represent the most common categories of behaviours addressed in interviewing guides and manuals (Morgan & Engel, 1969). Hall et al and Roter further subdivide these categories into task and socioemotional domains: information giving, information seeking, and technical competence serve the medically relevant task goals of the visit, while partnership building, social conversation, positive and negative talk, and interpersonal competence are within the socioemotional domain. These investigators hypothesise that compliance and recall will be relevant to the task focused aspects of the visit. Although the strongest relationships were found between corresponding domains of communication Hall et al's analysis demonstrated an asymmetric pattern between domains. The implications of this particular study are further explored in chapter 7. Inui & Carter (1989) continue their plea for research design to be continued more seriously by investigators. They asked the International Conference on Doctor-Patient Communication (1989) to identify the most important contributions to the scientific understanding of the relationship. Of 37 articles identified, three kinds of study emerged: developmental/descriptive studies, which included conceptual contributions as well as empirical investigations and comprised approximately half of the cited literature; subexperimental studies, which looked both at general process-outcome relationships and specific hypotheses, and contributed about a third of the citations and intervention studies which were relatively infrequent. The significance of the developmental/descriptive studies is to be judged with respect to their validity, reliability and feasibility. Inui & Carter note that there are several ways of validating a new instrument, however if an existing descriptive technique is available then the new instrument should be validated against that criterion. They also draw attention to an insufficient focus on face validity, best characterised as, "A serious attempt to resolve the question. Does all this make sense to clinicians, patients and/or clinician educators ?". They point out that unless a descriptive method is reliable, two observers may disagree about the content of a single event, or one observer may describe the same encounter in two different ways on two separate occasions. Feasibility might be judged in terms of

obtrusiveness, acceptability, work burden and other aspects of cost, as well as on the setting of care. Because basic theories and measures will often have been developed in disciplines remote from clinical practice, Inui & Carter recommend that descriptive/developmental investigations should be tailored to the clinical encounter; should be grounded theoretically in the events of clinical practice; should adopt clinical rating scales for interaction analysis instruments since these tend to express prevailing wisdom about affective behaviours; and should scrutinise 'meta-events', such as doctor-patient negotiations or clinicians' communication styles, not only because these might identify competing habitual approaches to talking with patients ('styles'), but because they would focus attention on sequential behaviours and patterns of events.

Subexperimental etiologic research also faces particular problems. These are identified by Inui & Carter as the result of multifactorial causal models which are likely to be most appropriate for outcomes of interest. Thus, communication is dominated by interaction, and doctor and patient behaviours will arise in response to one another's states or actions in an explicit but sometimes fruitless effort to achieve an outcome of interest. There is in addition the very real possibility of doctor and patient bias in retrospective reportage after an outcome has been achieved. Inui & Carter recommend that prior hypotheses should always be made in this work to minimise type 1 errors; that measures should be targeted for process and outcome which are most likely to demonstrate the hypothesised relationships; that change variables for the outcome of interest should be employed in prospective studies to mitigate against recall bias and reactive behaviours (pre-encounter characteristics of doctors and patients will serve as prior states for these); that meta-analyses should be conducted on data from several etiologic studies in order to identify common findings; that settings or occasions be more carefully selected to ensure it is the communication process rather than the setting that is responsible for the outcome and that case-control and cohort research on causal relationships would preferentially be implemented in a 'laboratory' that permits the prospective capture of process and outcomes. Interaction studies are particularly subject to additional problems. These

include moving targets, multiple influences on the outcomes of interest, subject-subject contamination and difficulty in assessing the clinical relevance. As many such experiments have been conducted with trainees, for whom the natural progression of communication effectiveness is to improve, the intervention competes with accumulating experience and teaching which of itself produces increased communication competence. Inui & Carter therefore recommend true experimentation, because before-and-after studies do not control for change that is produced by conditions external to the experiment (thus enhancing the need for descriptive studies as a necessary prelude to experimental investigation). They also suggest that powerful, salient interventions are preferable and should, where possible, be conducted simultaneously at like institutions to check for generalisability and to avoid contamination; that sensitive tailored measures of effect be used (for example, while simulation patients may be able to comment on between doctor differences, the more important outcomes of interest such as problem resolution, alleviation of anxiety and changes in functional abilities would be impossible for such individuals); and lastly, that outcomes of interest should be supplemented with other clinically relevant observations such as whether a suggested style of communication takes longer than a regular visit or whether an approach is likely to result in better diagnosis and more appropriate therapy. Reviewing the measures which have been used to characterise medical interaction, Stiles & Putnam (1989) organise the enormous variety of coding systems into a meta- classification scheme. From this they make recommendations for future research, referring their reader also to the thoughtful articles of Pendleton (1983), Wasserman & Inui (1983), and Inui & Carter (1985). They present a five way classification of coding strategies to measure doctor- patient communication. These include content categories generally based on topics of interest; speech acts or instrument categories which include questions, statements or compliments; non-verbal communication such as tone of voice, gaze, and body posture; activity counts of instrumental behaviours such as answering the telephone; and affective ratings to reflect the intensity of a particular emotional tone like degree of anger or friendliness.

Stile & Putnam propose their meta-classes in an attempt to clarify the need for investigators to arrive at some common definitions in the interview process. They liken the field of doctor- patient research to that of oncology before methods of classifying cancers were agreed upon. Then oncologists were unable to recommend treatment protocols because they had no way of determining who should be treated with what, when and what difference any treatment would make anyway. Having agreed a criteria for classifying and staging cancers they would begin to build on one another's clinical experiences. Stiles & Putnam suggest that because different classification systems serve different goals, rather than to consider developing one common scheme, it may be preferable to develop several standard schemes of coding the interview. These would then be recommended for different purposes. Beckman et al (1989) review outcome based research, and identify different outcome variables relevant to research in the field of the doctor-patient consultation. They note that the term 'outcome' in health care is defined as; "An observable consequence of prior activity occurring after an encounter, or some portion of the encounter is completed" (p.224). They propose that outcomes are best categorised by their point of occurrence in the process of health care delivery. Four outcomes are identified: process, short term, intermediate and long term. The first occurs within the medical encounter, as in Beckman & Frankel's (1984) study which demonstrates the effect of interruption on completion of the patient's agenda. This research has two objectives. The first is to identify successful interactional behaviour to improve the quality of the interaction process and thereby to improve longer term outcomes. The second is to demonstrate the cause and effect relationship of an intervention. (Such studies are discussed in chapter 7). Short term outcomes are assessed immediately the medical encounter has been completed. The standard short term outcomes have been patient satisfaction and intention to comply with treatment plans. They also have been used to test association between particular components of the consultation and their effects. Beckman et al point out that because associations have been identified between satisfaction and compliance, the former often has been

substituted for the latter. In fact compliance is more difficult to assess because a patient may be satisfied in the short term but may not comply with medical treatment in the long run. Intermediate outcomes measure response to therapy indirectly. Compliance is cited as an example since the achievement of the goal may not result in a significant health outcome. Beckman et al speculate that as concepts of patient negotiation and assertiveness are developed, doctors may encourage patients to criticise their recommendations in order to effect more realistic treatment plans and goals. These authors define long term outcome measures as, "Direct measures of therapeutic or evaluation responses" (p.226). They note that examples may be derived from the biological, psychological or sociological spheres, and include effects such as reduced blood pressure, improved quality of life, and survival. Starfield et al's (1979, 1981) studies are quoted to support subexperimental hypothesis testing involving long term outcomes. The outcome was problem resolution defined by both doctor and patient, and the variable that correlated most positively with problem resolution in both studies was agreement between doctor and patient on the problems requiring follow-up. Beckman et al present a menu of potential variables for the differing outcomes. These are reproduced below. The authors draw attention to the fact that the choice of a variable for any one study is inevitably value laden.

Table 1.1: Health care outcomes requiring study. (Taken from Beckman, Kaplan & Frankel, 1989 p.225).

PROCESS OUTCOMES 1. Coparticipation/mutuality 2. Patient assertiveness 3. Provider empathy/encouragement 4. Direct evaluation of medication compliance 5. Agreement on evaluation, treatment options 6. Solicitation for patients' attribution of concerns 7. Completed solicitation of patients' concerns 8. Frequency of interruption 9. Frequency of open ended questions
SHORT-TERM OUTCOMES 1. Patient satisfaction 2. Tension release 3. Health/disease knowledge acquisition 4. Doctor satisfaction 5. Intention to comply 6. Acceptance of recommended services
INTERMEDIATE OUTCOMES 1. Adherence/compliance 2. Accuracy of diagnosis 3. Anxiety reduction 4. Health/disease knowledge 5. Completion of recommended service 6. Increased self-esteem 7. Increased self-confidence 8. Altered locus of control
LONG-TERM OUTCOMES 1. Symptom resolution 2. Physiologic status 3. Behavioural status 4. Functional status 5. Anxiety reduction 6. Quality of life 7. Global health perception 8. Costs of care/utilisation 9. Work loss 10. Cure rate 11. Survival

G. THE CONSULTATION IN GENERAL PRACTICE

Until quite recently research into the doctor-patient consultation had overlooked the specific nature of the general practice interview. For example, the work of Davis (1968) was in a general teaching hospital and the studies of the Korsch group (1969) examined the nature of the consultation in paediatrics. More recently the investigations of Cox, Holbrook & Rutter (1981a, 1981b, 1988, 1989) have concentrated on the psychiatric interview. While it is no doubt the case that aspects of these studies, and particularly the latter studies, are generalisable to a high degree, the general practice interview is rather different. It is not, as the psychiatric interview, blessed with an hour to explore the patient's Emotional agendas and neither is it characterised by the formality which may attend the interview when a hospital doctor has little or no prior knowledge of the patient. The average general practice interview lasts a mere 6 to 6.6 minutes (Balint & Norrell, 1973; Royal College of General Practitioners, 1973) and therefore demands a particular kind of focus. This is best summarised by Risdale et al (1992) when they note that, "After the cost of drugs, the most expensive resource in primary care is the general practitioner's time, a central point of which is spent consulting patients" (p.57).

In recognition of the brevity of the doctor-patient contact in general practice, as well as the many opportunities in an interview when feelings may be identified by the doctor, Balint (1973) describes the 'flash' technique. Rooted in psychotherapy, this technique was developed by E. Balint (1973) to enable the intensity of the general practice interview to sustain a dynamic relationship in an ongoing situation. The idea is that patients will present the doctor with opportunities to 'tune in' to their wavelength and so offer flashes of interpretation and silence which may or may not give insight to the problem in hand. What distinguishes the technique is its deference to the limited time available to the general practitioner in any one consultation and the potential the doctor has to develop an ongoing and trusting relationship.

More recent studies have addressed the issue of time and the ways in which its limitation in general practice might influence the doctor's approach. For example Morrell

et al (1986) examined the content of interviews booked at 5 minutes, 7.5 minutes and 10 minutes. They found that at surgery sessions booked at 5 minutes, doctors spent less time with patients, identified fewer problems and that patients were less satisfied with the consultation. They also found no evidence either that patients who attended shorter consultations returned more often for further consultations within four weeks or that doctors experienced more stress when dealing with shorter consultations. Howie et al (1991) found that 'long' consultations were associated with doctors dealing with more psychosocial problems and more long term health problems, and with doctors carrying out more health promotion and also reported patients increased satisfaction with longer consultations. However, Risdale et al (1992) found that while some interventions were used more frequently by all doctors in longer consultations - perhaps as a function of the latter - doctors were more varied in their use of others. Thus, doctors who used facilitation frequently to start with used facilitation more often when greater time was available. These authors suggest that there is a differential doctor response to changes in time available in the consultation, with increased time being, "a necessary but not sufficient condition to promote the greater use of communication techniques which doctors use less frequently" (p.57). The issue of consultation time is explored further in chapters 6 and 8 and is returned to often throughout this thesis.

H. CURRENT ISSUES

It is not possible to identify one theme to have emerged over others in the current literature, but there is a possibility that research issues are substantially featured in the field of general practice (Murphy & Mattson, 1992; Shapiro, 1992; Bradley, 1992; Harris, 1991). Considerations pertaining to research are discussed in some detail both in the preface and in chapter 9. In terms of interview structure, Rost et al (1989) have examined the way in which doctors and patients introduce information each feels to be relevant to the definition of the patients' problem. They observe that past research suggests that doctors analysing problems within a biomedical framework seek multiple pieces of selected information to emphasise objective, largely de-contextualised features

of the patients' condition. Patients may not agree that information sought by the doctor is relevant and may have more personalised observations to make of their own. They hypothesise that since doctors and patients reveal personally relevant information through turntaking in conversation, information which is introduced in addition to information requested by the other party will have particular salience for the informant. Such information exchange is referred to as bi-directional information. These authors found that bi-directional information during the examination segment of the consultation explained more than half the variance in patient adherence to doctors' recommendations for new medication, and propose that the doctors' willingness to allow patients to contribute input may contribute to partnership building and hence inform treatment decisions which have meaning for both. Also concerned with interview structure, Winefield & Murrell (1991) recorded and analysed verbal interactions in two studies. The diagnostic and prescriptive phases of general consultation were analysed separately, first with doctor satisfaction as the outcome and then, with a second sample of doctors, with both doctor and patient satisfaction as outcomes. They demonstrated that patients and doctors differ in their views of what comprises a satisfactory consultation. Doctors prefer consultations in which the medical problem and its solution seem clear, while patients felt more satisfied when interviews had discussed their own experiences and opinions in the second, prescriptive, phase of the consultation. Continuing the concern with consultation outcome, Rashid et al (1989) compared doctor and patient satisfaction with interviews. They matched questionnaires for each consultation and showed that doctors and patients in their sample significantly disagreed about the doctor's ability to assess patients, to put patients at their ease, to offer treatment rationale, and to allow expression of emotional feelings about the overall benefit the patient had gained from the interview. In all cases of disagreement the doctor had a more negative view of the consultation than the patient. The whole question of satisfaction as an outcome measure was cast into doubt by May (1992). She points out that while this is a desirable measure, it is difficult to achieve with any accuracy. Global satisfaction with medical care is

composed of many different factors. These include ease of access, ease of communication, perceived cost, and perceived doctor competence. When using satisfaction as an indicator of outcome, it is difficult to determine which aspect of satisfaction is to be measured and to be sure that it is only the chosen aspect that is being measured. She notes also that lack of variability in the results of satisfaction questionnaires is common and that possible explanations include low expectations of the consultation that are being met and a reluctance to criticise the doctor. Although satisfaction questionnaires completed immediately after the consultation may not represent maintained satisfaction, they are nevertheless thought to be a better measure of the impact of the content of the consultation. May explored the relationship between detection of psychiatric illness during general practice consultations and patient satisfaction. She had hypothesised that patient satisfaction would be higher when psychiatric illness was correctly defined by the doctor than when psychiatric illness was missed. Psychiatric illness was defined as a score of 3 or more on the 12-item General Health Questionnaire. The general practitioners identified 76 of these 110 patients as having a psychiatric component to their illness, and 34 as having an entirely physical illness. Of six dimensions of satisfaction with interview content, only one significant result emerged. Patients whose psychiatric illness had been identified by the doctor reported only that they had been more helped - other dimensions of interview content such as doctor understanding, doctor explanation, and ability to communicate with the doctor were no different. Also assessing patient satisfaction, Savage & Armstrong (1990) randomised patients to receive either a directing or a sharing doctor style in the second, prescriptive, half of the consultation. The findings demonstrated that patients who had received a directing style reported higher levels of satisfaction on almost all outcome measures. The results were particularly striking for patients with physical problems. This was a carefully designed study, but it was flawed in its conception. The second half of the consultation is characterised by the doctor giving information (see chapter 7). The sharing style in the Savage & Armstrong study mostly takes form in

questions (p.969) which begs the question of how information is adequately conveyed in the sharing style. The outcome measure asked, among other things, if the doctor had shown understanding of the patient's problem. In the direct style the doctors made explicit their understanding whereas in the sharing style they did not. The outcome therefore seems rather to measure whether the manipulation of doctor style was successful: the independent variable (doctor style) is confounded with information giving. Because the directive style is more informative than the sharing style, the experiment seems to be measuring the same variable that was changed. Dale & Middleton (1990) randomly sampled 72 general practitioners' reactions to case vignettes designed to illustrate psychosocial and physical presentations. They found that two factors appeared to influence responses when assessed by attitude rating scales. These were positive attitudes to both psychosocial and physical problems, which were associated with postgraduate experience in psychiatry and with older age. The second, reflecting measures of flexibility and responsibility for outcome, was associated with younger age and not having received vocational training. The authors postulate that personal traits and qualities may be a stronger determinant of a general practitioners' reactions to patients' problems than formal training and qualifications. Risdale et al (1992) found that longer consultations were not necessarily associated with an increase in doctors' use of positive consultation skills (see section G above). Similarly, Arborelius & Bremberg (1972) were able also to demonstrate that positive consultations are no longer than negative consultations even though doctors spend more time discussing the patients' ideas and concerns in the former. Using consultation maps derived from Pendleton (1983) to supplement their study, they show that if the doctor asks for the patient's ideas and concerns he will receive more feedback which will facilitate further progress in the consultation. This will better enable the doctor to achieve the aims of the consultation which are important in mediating the doctors' satisfaction with his work. The method used by these investigators utilises the qualitative approach of Beckman & Frankel (1984). Some time after the recording of the consultation, the general practitioner and the

patient both observe the videotape. They are told to stop the tape as many times as they wish to comment spontaneously. All comments are audiotaped and timed. Arborelius & Bremberg find that both patients and doctors are able to offer adequate information about their experiences during the consultation and point to studies which demonstrate that patients' assessments are safer and more valid with respect to behaviour in the consultation than assessments made by independent raters (Kurtz & Grummon, 1972; Gurman, 1977). This approach has an affiliation with the problem based approach to teaching communication skills proposed by Gask et al (1991). Whereas the former uses the videotape to prompt information about interview events as they occurred, Gask et al use the video or audiotape with trainees and doctors to enable them to rehearse new skills. In this approach the idea is not to assess performance or to rate the consultation, but to stop the tape at intervals to discuss how a particular one may have been responded to in a different way. In exploring other possible ways to elicit a patient's response, new detection studies are encouraged. Gask points out that, when feedback is used in conjunction with the precise definition of skills in a supportive environment, confidence is engendered. The benefits of feedback in training are also demonstrated by Maguire et al (1989). However, while these investigators found that doctors who had received feedback in training had improved their interviewing skills over controls, and continued to do so four to six years later, they were not able to show that training had improved doctors' ability to begin and end consultations. The greatest evidence of training was in the doctors' ability to clarify patients' statements, using open questions, and responding to verbal cues about problems. In assessing residents' psychosocial performance in consultations, Shapiro & Schiermer (1991) found that although doctors' performance was at least adequate in basic interpersonal and medical interviewing skills on the majority of categories used, they performed less well in areas of greater psychosocial complexity. This was particularly evident in addressing the meaning or the implication of an illness with both patients and families. Doctors' feelings of uncertainty were identified by Arborelius et al (1991) as being a contributory factor in consultations when it was

clear that the doctor had not grasped the situation. Asking general practitioners to comment on their videotaped consultations, it became clear that doctors are reluctant to use their feelings of uncertainty as useful information about the situation. Smits et al (1991) used a standardised observation schedule to assess the correlation between medical and behavioural skills of general practitioners. Seventy-five doctors were videorecorded, each contributing 15 surgery contacts. The study demonstrated that the various skills appear to be equally developed: a positive correlation was found between performing obligatory physical examination and paying attention to psychosocial aspects of the patients' condition. However, they also found that psychosocial attention was associated with unnecessary therapeutic actions. The implications of this and other studies cited are explored in the remaining thesis.

CHAPTER 2 : RATIONALE OF THE STUDY

A. IMPLICATIONS OF THE LITERATURE REVIEW.

B. AIMS OF THE STUDY.

C. DEVELOPMENT OF INSTRUMENTS AND CODING.

D. ANALYSIS.

A. IMPLICATIONS OF THE LITERATURE REVIEW

The story which informs the present thesis can be summarised as follows. As a medical speciality, general practice is familiar to the vast majority of the population. There are few people who will not, at some point in their lives, have been to their family doctor for something or other. When the patient's consultation with the general practitioner is not routine or instrumental, referral to other medical specialities almost without exception is made through the family doctor. It could be argued, therefore, that for the public at large the general practice consultation is the most common medical encounter. With one or two exceptions, early research into the medical consultation developed methods of interaction analysis to study what was going on in the doctor-patient interview. The concern was to address what the doctor did or did not do in the consultation and to relate the frequency of certain behavioural categories to patient outcome measures. These may have been satisfaction, recall or compliance. The early investigations were extremely useful in identifying different ways in which a consultation might proceed, and were able to show that doctors would often show a preference for certain behavioural categories over others. A corollary of this was that it became impossible empirically to indicate that a physician was either doctor- centred or patient-centred in his approach to the consultation. As research into the nature of the consultation developed, the traditional medical approach to the consultation began to be criticised. Disciplines such as medical anthropology, psychology and sociology were able to throw new light onto the nature of the encounter, and medicine itself began to examine the consequences of the traditional approach. A number of alternative models were proposed, but the idea of the consultation being patient centred rather than doctor-centred began to take root and to flourish. In the enlightened departments the patient-centred approach was gradually incorporated into what has come to be accepted as the 'transformed medical model' of the consultation. In essence, this is a synthesis of old and new - the best of the old model with its emphasis on the doctor's diagnostic rigour married to the ideal of exploring the patient's world and understanding the systems in which the patient operates. As the

concept of patient-centredness developed, the early research into the field of doctor-patient communication began to be criticised. It had helped to show the ways in which doctor and patient interact, but it had done little to illuminate the meaning of these interactions. The meaning of the consultation could only be speculated upon. There was a need for research to address meaning in the consultation as well as process, and a number of studies examined meaning at the expense of process. Additionally there needed to be a focus on the consultation in primary care, coupled with the recognition of the particular ways in which consultations in this field differed from those in hospital or psychiatric medicine. Research methodology in general practice also began to be the rule rather than the exception. Quantitative research methodologies, the norm in hospital medicine and certain branches of the social sciences, began to be applied in the field. But so too did more qualitative approaches. Gradually an impulse to marry quantitative and qualitative assessment began to be manifest. Increasingly it became apparent that there needed not only to be more research into the nature of the general practice consultation, but that such research must make an attempt to accommodate past critiques and current approaches. A new system of interaction analysis was required, and it needed to be able to make empirical observations about process and content variables in the consultation, but should be developed in an exploratory and hypothesis testing manner. It should be reliable, valid and additionally should be sensitive to the nature of the health care setting. Of particular concern would be doctors' and patients' agendas in the emotional, social and physical domains. In identifying the way in which doctors and patients process sensitive agendas, and examining how each responds to the other's concern, it would be possible, at a later date, to modify doctors' style in such a way as to benefit undergraduate and postgraduate training programmes. Also of concern would be to examine the extent to which doctors problem solve in the aforementioned domains, and to devise a reliable system which would be able to distinguish between problem solving options. Again, if it were demonstrated that doctors problem solved in one domain but

did not do so in others, there would be a case for further experimental work to test the extent to which problem solving is able to effect consultation outcome.

B. AIMS OF THE STUDY

The aims of the study will be:

1. to construct a method for analysing general practice consultations to explore doctors' and patients' reference to the psychosocial domain;
2. to investigate the relationship between the behaviours of doctors and patients in the consultation, with special reference to psychosocial material, in order to generate hypotheses about interviewing techniques and patient behaviour which may be influential for the disclosure of such material;
3. to explore the relationship between 'affective' and 'social' data in the general practice consultations;
4. to examine the way in which consultation procedures interact with doctor and patient agendas.
5. to construct a method for analysing doctor and patient problem solving behaviour in the general practice consultation;
6. to investigate doctors' and patients' problem solving behaviours in the consultation, with particular reference to the emotional and social domains.

C. DEVELOPMENT OF INSTRUMENTS AND CODING

A system for categorising doctor and patient behaviour, both verbal and non-verbal will be developed. For this purpose consent will be obtained to video record a series of naturally occurring general practice consultations, and these will be transcribed in full. Operational definitions will be formulated, and the inter-rater reliability of the measures tested. Actions of both doctor and patient will be categorised both in terms of form and content. Content measures will distinguish whether a participant is communicating matters relevant to the psychosocial domains or the somatic domain or both concurrently. Particular attention will be paid to the transition points which occur between different modes of discourse, and these will be scored when either doctor or patient changes

communication behaviour. Attention will also be paid to whether the form of communications as well as how their content influences the probability that the patient will disclose matters relating to the social and emotional sphere. It will also be possible to detect whether doctors pick up cues to social and emotional problems, and whether one of the participants, doctor or patient, continues to refer to the psychosocial domain while the other persists in referring to somatic matters, or vice versa. Process variables will examine the way in which medical procedures are brought to bear on doctor and patient agendas. Of particular concern will be the way in which information processing, itself a consultation procedure, mediates between agendas and medical procedures. The body of videotape data will then be annotated in terms of speaker and category of behaviour, with both from and content using videotapes and transcripts in combination. The data will then be categorised further according to the nature of the presenting problem, and according to between doctor variation. In each case the particular focus will be the extent to which the affective and social domains differ from the physical domain, and the extent to which any initial patterns are sustained in further analysis. From the instrument described above will be developed a further instrument to assess doctors' and patients' problem solving behaviour. Again, operational definitions will be formulated and inter-rater reliability calculated. Actions of both parties in the consultation will be categorised in terms of the initial problem solving strategies they bring to bear on an agenda, and the extent to which problem solving strategies are subsequently used on the same agenda later in the consultation.

D. ANALYSIS

The following hypotheses, as well as others generated in the course of the research, will be tested using conventional statistical procedures.

1. Physical agendas will occur more often at the beginning of an interview (will be more frequent earlier in the interview than later in the interview).
2. The longer the interview, the greater will be the number of non-physical agendas contributed and raised by the patient.

3. The longer the interview, the greater will be the number of non-physical agendas raised by the doctor and responded to by the patient.
4. Either participant will more commonly follow a physical agenda raised by the other. That, is the rate of following for physical agendas will be greater than that for non-physical agendas.
5. When the patient has raised a non-physical agenda, and this has been followed by the doctor. The patient will be more likely to raise a non-physical agenda subsequently.
6. The doctor will be more likely not to follow a non- physical agenda if the agenda is emotional rather than if the agenda is social. That is, the rate of non-followings for emotional agendas will be higher than that for social agendas.
7. There will be a hierarchy of non-physical agendas which are not followed by the doctor: doctors will show the greatest rate of non-following for emotional agendas, then social agendas.
8. It is predicted that more procedures will be applied to physical agendas than to non-physical agendas.
9. It is predicted that procedures may be used to block the development of non-physical agendas. That is, the probability that either doctor or patient engages in a procedure will be higher where a non-physical agenda has been raised. Non-followings in the physical domain will be associated with the occurrence of procedures.
10. All of the hypotheses will differ according to the nature of the presenting problem when classified according to Acute or Chronic presentation.
11. All the hypotheses will differ according to the general practitioner being observed.
12. Emotional agendas are likely to occur immediately after Physical Examination.
13. Doctors will give more information in the second half of the consultation.
14. Patients will give more information in the first half of the consultation.

15. Doctors will seek more information in the first half of the interview.
16. Doctors giving and seeking of information will vary according to agenda type.
17. Discussing information will not often occur when compared with giving and seeking information.
18. Doctors will problem solve in the physical domain more often than they problem solve in the social and emotional domains.
19. Doctors will demonstrate a wide range of problem solving skills in the physical domain.
20. Doctors will demonstrate a narrower range of problem solving skills in the emotional and social domains, than in the physical domain.
21. The way in which an agenda is problem solved later in the interview will be a function of the initial problem solving strategy used in each domain.
22. Patient returning to an agenda later in the interview is likely to be a function of initial problem solving strategies used.

CHAPTER 3 : STUDY DESIGN AND RELIABILITY

A. LOCATION.

B. EQUIPMENT.

C. SAMPLE.

D. GENERAL PRACTITIONERS AND PATIENTS.

E. VALIDITY OF MEASURES AND GENERALISABILITY OF SAMPLE.

1. INTERNAL VALIDITY.

2. EXTERNAL VALIDITY.

F. DEVELOPMENT OF CONCEPTS AND CODING SYSTEM.

G. DEVELOPMENT OF SCORESHEET.

H. TRANSCRIPTIONS.

I. RULEBOOK.

J. RULES FOR CODING.

K. ASSESSMENT OF RELIABILITY. 1.

L. ASSESSMENT OF RELIABILITY. 2.

M. DISCUSSION.

1. DIMENSIONS OF DOCTOR/PATIENT INTERACTION.

2. FULFILMENT OF NECESSARY CRITERIA.

A. LOCATION

The study was carried out in the Academic Department of Child and Adolescent Psychiatry, Alder Hey Children's Hospital, Merseyside and in the Department of General Practice, The University of Liverpool. It was funded over two years by the Leverhulme Trust. The Department of General Practice funded a further six months of the study, and the Nuffield foundation funded the final three months.

B. EQUIPMENT

The consultations were recorded onto a series of Betacom tapes. As these require specialised equipment for viewing, they were transferred serially onto VHS standard video cassettes. Coding was carried out using a Panasonic NV-L28HQ digital video cassette recorder which had facilities for slow tracking, still advance, freeze frame plus minute and second timing (accurate to one second).

The videos were played on a 24" Panasonic high resolution screen. For transcription purposes the videos were transferred onto standard audio cassettes by the Television and Communications unit at the University of Liverpool. These were transcribed through a standard Sony audio cassette player.

C. THE SAMPLE

The Film and Television Unit of the Royal Society of Medicine collaborated with the Department of General Practice at the University of Liverpool to make a series of videotapes for use as teaching aids for General Practice Trainees and for the analysis of doctor and patient interaction in the General Practice consultation.

Teaching Aims:

1. To explore by means of interviews recorded before and after consultation with their General Practitioner, patients' views of illness and treatment.
2. To demonstrate the relationship between aspects of 'process' in the consultation, and the patients' perception of 'outcome'.

3. To encourage health professionals to value the patients' view of illness as an essential part of the autonomy of the individual.
4. To provide teachers of general practice with the resource of professionally recorded consultations.

Initial Research Aims.

1. To investigate the relationship between the behaviours of doctors and patients in the consultation, and the 'agenda' of that consultation.
2. To construct a method for analysing general practice consultations which takes account of patients' ideas and behaviours.
3. To examine the relationship between non-verbal behaviour and the verbal content of consultations.

Four practices which were already familiar with video recording in the surgery were selected. (They were, therefore, likely to be training practices also.) Three practices were chosen from the Mersey Region, and the fourth, to provide some geographical balance, was chosen from South East England. All social classes were included in the sample: one of the Mersey Region practices and the practice from South East England strongly reflected social classes one and two. The remaining two practices from the Mersey Region reflected the remaining social classes. From the findings of Tuckett et al (1985) it appears that the selection of training practices would not preclude finding a range of quality of effectiveness in consultations. This proved to be the case.

In each practice each participating doctor was videoed for one surgery and all patients attending that surgery were considered for interview. Patients were excluded if they were returning at the doctor's request specifically for follow-up or if they were unwilling to take part (a few declined). Chronic complaints were not excluded if the symptoms presenting were new to the patient. All participating patients signed a consent form (see Appendix A). Altogether 73 patients were recorded in surgeries consulting with 10 different doctors. Of these patients, 40

were interviewed beforehand and 31 had a second interview a few days later. It was not possible in the time available to interview all patients, so some selection was made on grounds of 'interest'. For example, patients whose complaint seemed more complex or unusual were selected in preference to those with minor or routine problems.

The recordings were made by a professional unit using three video cameras operated by remote control. Patients were made aware of the recording both by being asked to give consent and because half of them were also interviewed before seeing the doctor. Despite this some patients did not notice the camera. There was evidence in only one of the recordings that a patient had used the preconsultation interview as a rehearsal for the real consultation. A recent study demonstrated that the presence of a video camera does not make a difference to the physical and verbal behaviours of doctors. Nor does it influence secondary activities of doctors accustomed to being recorded (Pringle & Stewart-Evans, 1990).

The pre-consultation interviews explored the patients' reasons for consulting, what ideas they had about their symptoms, and what they expected from the General Practitioner. After initial comments designed to relieve the tension of being filmed, the interviewer asked, "Can we start by talking about what led to your deciding to see Doctor ..... today (or tomorrow)". The interviewer sought details of what the patient had noticed, what it meant to the patient, and what initial action had been taken. Each symptom was then explored in detail in lay terms, looking for the patients' explanation, worst fears, anticipated effects and expectation of treatment. The interview then moved on to a general discussion of access to the doctor, feelings when going into the consultation and any difficulties experienced in communicating with doctors. Finally, further informed consent was obtained for the recording of the surgery consultation and the follow-up interviews.

The follow-up interviews first sought the patients' recollection of the consultation, then explored their ideas and feelings about what had happened. Specific questions were asked about the diagnosis (did they understand it, or agree with it ?), the treatment, advice on prevention and the implications of these points for the future. The interviewer was unaware of the nature of the consultation and, if necessary, made this clear to the patient. At all times

during the interviews, the interviewer adopted a neutral attitude and avoided making any statements or answering patients' questions. The interviews were thus conceived of as being between 'laymen'. Campion (1987) described preliminary results of the pre and post interviews.

D. THE GENERAL PRACTITIONERS AND PATIENTS

There were ten participating doctors: six male and four female. Of the patients, sixteen were male, thirty three were female. Twenty one were mothers with children. There was one father with a child, and two consultations with two adults.

E. VALIDITY OF MEASURES AND GENERALISABILITY OF SAMPLE

1. INTERNAL VALIDITY

The three main categories of measures, agendas, procedures and processes, have good construct validity. That is to say that each category is a fairly obvious measure of what it is supposed to be measuring. For example, it is difficult to conceive of a Physical agenda being anything other than a Physical agenda. Similarly, for the trained rater, Emotional and Social agendas are fairly obvious constructs. Procedures and information processing are also fairly sound constructs. Although related to Treatment, for example, it is hard to conceive of Referral as anything other than Referral. When parties within the interview are processing information it is again quite clear what is happening. All measures were derived from a consideration by a General Practitioner, the present researcher, and a Psychiatrist, of what happens and what problems are addressed in the general practice consultation (see DEVELOPMENT OF CODING SYSTEM). It is not possible to assess the measures' criterion/concurrent validity as there are no other standardised measures of a similar nature with which to make a comparison.

2. EXTERNAL VALIDITY (GENERALISABILITY)

How generalisable are the results depends on how representative is the sample of general practice consultations in the United Kingdom. A number of problems need to be addressed in considering the present sample as representative. These are:

i. All patients and doctors had to agree to be recorded in consultation.

ii. Doctors and patients may modify their behaviour when they know they are being recorded.

iii. All interviews were first consultations for the presenting problem.

iv. A proportion of patients had been pre-interviewed (55%).

v. Patients were excluded if they were returning at the doctor's request specifically for follow-up.

vi. All participating doctors were from training practices.

vii. The coding system requires that agendas which occur together are coded in parallel rather than by suffixing one agenda by the second agenda.

viii. The number of consultations contributed by each doctor was not equal.

These problems could influence the sample validity in the following ways:

i. As all patients and doctors had to agree to be recorded, it is possible that patients with emotional problems did not volunteer. Patients with emotional problems may be more likely to decline to be recorded precisely because their problem is sensitive and emotional. Patients with such problems may be cautious as to the appropriateness of such problems for the general practice consultation (see chapter 4). Some patients did indeed decline to be recorded. Although all the participating doctors agreed to be recorded, it is likely that these doctors were more alert to those issues salient to 'good' doctoring - in particular, being open to the patient's perspective - than doctors from other practices who may have declined to be recorded.

ii. The 'Hawthorne' effect predicts that doctors and patients behaviour will change as a result of observation. As has already been mentioned, however, a recent study convincingly demonstrates that the presence of a video camera does not make a difference to the physical and verbal behaviours of doctors. Nor does it influence secondary activities of doctors accustomed to being recorded. All the doctors in the present sample were used to being recorded. The doctors were aware of the rationale for recording the interviews. As such it is conceivable that if they were wanting to

please the investigators the doctors would be more likely than the reverse to explore the patients' ideas for visiting the surgery. Some patients reported afterwards that they were unaware of the camera and wondered if they had been videoed. It remains a possibility that patient behaviour was affected as the result of being observed although the researchers' subjective impressions when scoring the tapes did not suggest that this was a substantial problem.

iii. Our results show that patients initiate agendas to a far greater degree than doctors. This may be because the patients recorded were consulting the doctor for the first time with their presenting problems.

iv. Patients who had been pre-interviewed may have had the opportunity to rehearse their symptoms and so be more fluent in the general practice consultation. Campion (1987), however, suggests that patients normally rehearse their symptoms with lay advisors, friends or relatives before seeing the doctor.

v. Since patients who were returning at the doctor's request were excluded, it is possible that these would be more likely to have chronic problems. Chronic presentation is therefore likely to be under- represented in the present sample. This is borne out by Tuckett et al (1985) who describe the way in which patients in primary care, by the very nature of primary care, are at different stages of care. They note that a very small number of patients will be seeing the doctor for the very first time; that a larger, but still relatively small, proportion of patients will be coming with a new episode of an old problem, and still more will be visiting to report progress about an ongoing episode. They note also that patients present their problems for some kind of certificate or resource (such as contraception or vaccination).

vi. As has already been mentioned, it is likely that doctors from training practices would be more likely than doctors from non-training practices to be alert to the issues of 'good' doctoring - particularly in practice. It is possible that the doctors in the present sample represent the 'best' of doctors in terms of following the patients' non-physical agendas.

vii. Any system of parallel coding means that agendas which appear to occur independently may in fact be related. Thus, a patient being unable to walk because of arthritis would in the present system be coded as having both a Physical and a Social agenda. The Social agenda is in fact the result of the Physical problem, and might better be coded with a system of suffixes; P_S.

viii. As the number of consultations contributed by each doctor was not equal, there is a risk that those whose consultations entered the study in greater numbers may have biased the results.

F. DEVELOPMENT OF THE CODING CATEGORIES

A review of the literature on the analysis of Doctor-Patient consultations (including two major reviews - Wasserman & Inui, 1983; and Tuckett & Williams, 1984) shows that previous work has not taken context sufficiently into account, and that interview content (being one way to look at context) has been insufficiently addressed. The coding categories were devised in an attempt to make content more context related by adopting a problem-solving perspective. In line with the work of Levenstein et al (1984) content is classified as Agenda, while context was coded by a variety of Procedural Modes describing the actions performed by Doctor and Patient in the interview. Context and content are related by coding each agenda and each Procedural Mode for doctor and for patient in any given floorholding.

Draft One

The first draft of the coding system consisted of two broad categories of variables; Agendas and Procedural Modes. Agendas are the content variables. Seven agendas were identified (see Table 3.1). These agendas were derived from a consideration of those concerns considered by a General Practitioner and a Psychiatrist to be the subject of general practice consultations. The twelve procedural modes were similarly described. Operational definitions were devised for each category and examples taken from naturally occurring general practice interviews to illustrate the coding. Rules for coding of the interviews were devised.

The coding system was pilot-tested on a sample of naturally occurring general practice interviews. All the interviews were rated by one person (the author). As a result of this several changes were implemented. First of all two new agendas were included. The Concluding agenda was introduced as a compliment to the Introduction agenda, and to mark those instances when either Doctor or Patient were closing the interview. The Uncertain agenda was introduced to cover statements made by Doctor or Patient which could not clearly be coded according to the criteria defining the existing agendas.

Secondly, the procedural mode Prescribing Treatment was considered unsatisfactory since both Doctor and Patient engage in many behaviours related to treatment which are qualitatively different from prescribing. Discussing information about treatment and making a referral to hospital would be examples. As a result of this observation the new procedural mode of 'Referral' was defined.

Finally, it was felt that the coding of social chit- chat which occurred in the interview as a Social agenda was both too inclusive and too inferential. Too inclusive because it would include as a Social agenda (problem) matters which were not the focus for problem-solving, and too inferential because the coding was based on the assumption that chit-chat reflected the expression of some underlying social concern. In order to avoid this problem, the new agenda of 'Conversation' was devised to code social chit-chat which did not have social impact.

The revised coding system was applied to three further interviews by three raters for purposes of estimating the reliability of the operational definitions. Following this it emerged that the procedural modes did not fully reflect the range of Doctor and Patient behaviours in the consultation. It was decided that rather than extend the range of coding categories, a new system of coding procedural modes was required. This constituted Draft Two of the coding system.

Draft Two.

Draft Two of the coding categories consisted of three components. Agendas, again, reflect the content variables of the interview. A system of subscripts was devised for agendas. This system was instigated in an effort to demonstrate links between agendas made explicit by

Doctor or Patient. For example, an Emotional agenda explicitly linked to a Physical agenda (for example an expression of concern about a Physical complaint would be coded E_p). Procedural Modes were sub-divided into two categories - Procedures and Processes. Procedures refer to categories of behaviour, within agendas, available in addressing agendas. The actions are coded according to their intended purpose or function within the setting of a problem-solving medical consultation. Four of the procedures are unique to the Doctor-Patient consultation (Treatment, Referral, Physical Examination and Investigation) while the remainder are common to a wide range of interview contexts. All categories are based upon the problem-solving perspective of the McMaster model of family functioning (Epstein, Bishop, & Levin, 1978). Processes are concerned with the processing of information within the interview. As such they are common to all interview situations and are not specific to the Doctor- Patient consultation. Processes are subcategories of action in that they refer to types of behaviour adopted within procedures. Procedures and processes are coded together, so that each process may occur with respect to each one of the procedures. For example, Giving Information about Treatment, Giving Information about Referral, and Seeking information about Physical Examination etc.

This coding system was applied to three naturally occurring general practice interviews by three independent raters and coefficients of reliability were calculated. Several problems emerged. Originally the Mental State agenda was used to accommodate verbal expressions of emotion made without non-verbal expressions of emotion. In the final coding system the Mental State agenda was replaced by including some of its aspects into the Emotional agenda type, and other (reported) aspects into a new category termed Historical Psychological. For example, it was extremely rare for current emotional statements to be unaccompanied by non-verbal expression of emotion and this necessitated their inclusion within the Emotional agenda category. However, there were occasions when past emotional or emotional 'milestones' were reported by either party without the non-verbal concomitants of emotion. In those cases the Mental State agenda was transmuted into Historical Psychological. This distinction was designed to separate those situations when emotion was referred to, from situations when

emotion was being expressed. It also distinguished those instances which occurred in the past and were not a focus for problem solving in the current interview.

The system of agenda subscripts allowed for greater disagreement between raters because raters may or may not have adopted the same subscripts. To overcome this the system of subscripts was discontinued and the raters required to make explicit instances of parallel agendas by coding all agendas present in the floorholding. Thus E_p would become E agenda in parallel with P agenda.

With respect to procedures and processes, the distinction between Treatment and Referral required further definition, since it emerged that the two categories were often confused. The definition of Referral was changed, noting that Referral is a subset of Treatment, but one which requires the explicit statement of an intention to refer to another agent outside the interview. This statement may or may not be accompanied by non-verbal behaviours such as writing a referral letter. Table 3.2 lists the Agendas, Procedures and Processes identified in the revised coding system.

Table 3.1: Draft One of the coding system.

AGENDAS	
Introduction	
Video	Physical
Emotional	Social
Mental State	Open
Uncertain	Conversation
Concluding	
PROCEDURAL MODES	
Introduction	
Seeking Information about an agenda	Giving Information about an agenda
Consulting Notes	Writing Notes
Active Listening	Prescribing Treatment
Asking Questions about Treatment	Giving Information about Treatment
Physical Examination	Ordering an Investigation
Proposing or Discussing Alternative Procedures	Referral

Table 3.2: Draft Two of the coding system.

AGENDAS	
Introduction	
Video	Physical
Emotional	Social
Mental State / Historical Psychological	Open
Uncertain	Conversation
PROCEDURES	
Introduction	Information Processing
Treatment	Physical Examination
Referral	Investigation
Concluding	
PROCESSES	
Seeking Information	
Giving Information	Prescribing
Discussing Information	Accepting Information (including Active Listening)
Recording Information	

In order to provide information concerning the interaction sequence of the consultation it was essential to include in the system some means of collecting additional information concerning the relationship between the agendas raised by one party in the interview with respect to the previous floorholdings of other parties. An Initiation refers to the inception of a new agenda by either doctor or patient, that is, an agenda which has not previously been raised in the interview. A Following refers to the adoption by one party of the same agenda used by another party in the immediately preceding floorholding. A Return is said to have occurred if an agenda previously raised by either party is adopted by a party, without the other party having adopted that same agenda in the immediately preceding floorholding. A Return may be regarded as qualitatively different for doctors and for patients. For the patient it may represent 'unfinished business' while for the doctor it may reflect a willingness to return to a patient's agenda which was previously noted but not immediately followed.

Table 3.3 lists additional descriptive information that is gathered for each interview. This can be used to categorise the consultations in various ways. For example interviews which involve an adult alone, and interviews where a parent consults with their child. Interview duration is noted as well as the sex of both doctor and patient(s).

Table 3.3: Variables used to describe the interview.

Interview duration (mins/secs)
Code identifying G.P.
G.P. Sex
No. of Patients
Patient(s) sex
Patient(s) age - child or adult
No. of floorholdings

Table 3.4: Variables used to describe each floorholding.

Floorholding No.
Floorholding Duration (secs)
Floorholder (Doctor or Patient)
Agenda(s)
Procedure(s)
Process(es)

The general practice consultation may be conceived of as comprising a series of naturally occurring units. These units are referred to as floorholdings and reflect the period of time when one participant is holding the conversational ground. The floorholding is a unit of linguistic sense defined as the period of time from one party in the interview commencing to speak, to the point where another party begins to speak. Naturally occurring floorholdings will vary widely in duration from periods of less than one second to several minutes. Any verbal interchange, and specifically the general practice interview, can be viewed as a succession or sequence of floorholdings. For these reasons the floorholding was chosen as the unit of analysis in the present coding system. Each floorholding is coded in terms of the content and form of the communication according to the predefined categories shown in Table 3.4. Each floorholding was also timed to the nearest second. This unit of analysis remained unchanged throughout the development of the coding categories.

The way in which the relationship between theory and data generated the development of the coding categories may be formulated in terms of Glaser & Strauss' 'grounded theory'.

G. DEVELOPMENT OF SCORESHEET

The first scoresheet was extremely simple. A column on the left identified doctor floorholdings, a column on the right identified patient floorholdings. These columns were subdivided to address doctor and patient agendas, procedures and modes. Two columns on the

extreme right were provided to note the timing of each floorholding and its duration. As the coding system developed, it became necessary to replace modes with processes and to include a column to indicate whether the agenda in question had been initiated, followed, returned to, or not followed. A column to the right of either party's agenda column identified the abbreviated agenda (for example E for Emotional or P for Physical), while the agenda column itself was used to identify the agenda in question. Thus, a patient's chest problem would be identified as 'chest' and the agenda would be noted as P. This enabled the rater to check whether an agenda had been previously initiated more easily. The scoresheets are shown in Appendix B.

H. TRANSCRIPTS

Written transcripts were made from audio recordings of the video tape. At first these were transcribed in the usual way. That is, speech was written down horizontally according to speaker, thus:

DR .....

PT .....

DR .....

PT ..... etc

As the coding system developed, however, it was decided that the more effective way of transcribing the consultations would be to reflect the parallel nature of many of the procedures as well as the sequential nature of the following or non-following of agendas. Transcript therefore followed a vertical as well as an horizontal patterning:

DR ..... PT .....

DR ..... PT .....

DR ..... PT ..... etc

The scoresheet (see above) echoed this method of transcribing. Appendix C shows an example of the transcripts.

I. RULEBOOK

The rulebook containing all the rules for the coding of the variables described in the coding system, can be found in Appendix D.

J. RULES FOR CODING

Rules for the coding of general practice interviews in the system described can be found in Appendix E.

K. ASSESSMENT OF RELIABILITY 1

Method

Three independent raters coded a total of three general practice interviews according to the unrevised system of interaction analysis (see DEVELOPMENT OF CODING SYSTEM). Percentage agreement, percentage disagreement and kappa (Cohen, 1963) were calculated as measures of inter-rater agreement. Where extremely low or extremely high rates of occurrence are found Cohen's kappa is a poor measure of agreement. However, with intermediate levels of occurrence it is the coefficient of choice since it corrects for chance levels of agreement. Values of kappa greater than 0.60 indicate satisfactory levels of agreement (Hollenbeck, 1978).

Results

The inter-rater agreement coefficients for the three raters are shown in Table 3.5.

Table 3.5: Summary of reliability coefficients for different variables under study (interviews 1 to 3 - first round of reliability)

Agenda	Rater 1 vs. Rater 2			Rater 1 vs. Rater 3			Rater 2 vs. Rater 3		
	%Ag.	%Dis.	kappa	%Ag.	%Dis.	kappa	%Ag.	%Dis.	kappa
I	99.6	0.4	0.92	99.6	0.4	0.92	100	0	1.00
P	89.4	10.6	0.78	82.6	17.4	0.65	79.8	20.2	0.60
E	59.6	40.4	0.09	52.0	48.0	0.11	78.7	21.3	0.37
MS	88.3	11.7	0.65	81.6	18.4	0.42	89.4	10.6	0.60
S	84.0	16.0	0.43	80.5	19.5	0.28	88.3	11.7	0.67
O	96.1	3.9	0.15	98.9	1.1	0.01	94,7	5.3	0.01
V	99.6	0.4	0.00	99.6	0.4	0.00	100	0	1.00
CV	96.1	3.9	0.00	99.6	0.4	0.00	96.5	3.5	0.16
U	99.6	0.4	0.00	96.8	3.2	0.02	98.2	1.8	0.00
C	98.2	1.8	0.87	96.8	3.2	0.80	97.5	2.5	0.84

Procedure	Rater 1 vs. Rater 2			Rater 1 vs. Rater 3			Rater 2 vs. Rater 3		
	%Ag.	%Dis.	kappa	%Ag.	%Dis.	kappa	%Ag.	%Dis.	kappa
I	99.6	0.4	0.92	99.6	0.4	0.92	100	0	1.00
T	85.5	14.5	0.52	85.1	14.9	0.51	95.3	4.7	0.78
PE	96.1	3.9	0.63	97.2	2.8	0.70	98.5	1.5	0.79
REF	97.5	2.5	0.62	95.7	4.3	0.12	97.5	2.5	0.65
INV	98.9	1.1	0.76	96.1	3.9	0.13	97.2	2.8	0.49
C	98.2	1.8	0.87	96.8	3.2	0.80	97.5	2.5	0.84

Processes	Rater 1 vs. Rater 2			Rater 1 vs. Rater 3			Rater 2 vs. Rater 3		
	%Ag.	%Dis.	kappa	%Ag.	%Dis.	kappa	%Ag.	%Dis.	kappa
GI	85.8	14.2	0.72	84.3	15.7	0.69	87.7	12.3	0.73
SI	93.3	6.7	0.80	90.1	9.9	0.70	93.3	6.7	0.80
RI	100	0	1.00	100	0	1.00	100	0	1.00
DI	91.5	8.5	0.48	86.6	13.4	0.31	87.9	12.1	0.23
P	96.8	3.2	0.51	95.4	4.6	0.41	95.7	4.3	0.52
AI	90.8	9.2	0.59	89.0	11.0	0.47	92.6	7.4	0.58

KEY:

Agendas:

I	Introduction
P	Physical
E	Emotional
MS	Mental State
S	Social
O	Open
V	Video
CV	Conversation
U	Uncertain
C	Conclusion

Procedures:

I	Introduction
T	Treatment
PE	Physical Examination
REF	Referral
INV	Investigation
C	Concluding

Processes:

GI	Giving Information
SI	Seeking Information
RI	Recording Information
DI	Discussing Information
P	Prescribing
AI	Accepting Information

Levels of agreement were high in all cases when figures for percentage agreement and disagreement were calculated. However, in several cases Cohen's kappa was low. This was the case for Video, Conversation and Uncertain agendas, but for these the rate of occurrence for the three interviews in the first round of reliability assessment was less than one percent of all floorholdings. Physical agendas, Introductory agendas, and Concluding agendas all showed satisfactory agreement by all three raters. Kappas for Emotional and Mental State agendas, as well as Social agendas, was low. This was worrying since one of the primary aims of the study was to rate these agendas reliably. It was of some interest, however, that rater 2, the author, reached satisfactory levels of agreement with both rater 1 and 3 on the Mental State agenda, and a satisfactory level of agreement with rater 3 on the Social agenda category. Rater 1 was a psychiatrist, Rater 3 was a general practitioner. It could be argued that the former had a bias towards mental state and emotional problems, while the latter had a professional interest in social problems. These differences were discussed for the second round of coding. Rater 1 was as it were 'trained' to recognise social impact more readily and rater 3 was similarly 'trained' to be aware of emotional cues. The coefficients on the Emotional and Mental State agendas were satisfactory in some cases, but the two categories were often confused (see DEVELOPMENT OF CODING SYSTEM). Procedures were reliable in some cases. Treatment procedure was nearly reliable, and improved in the second round of reliability assessment. What constituted Referral posed problems for raters 1 and 3. Rater 2, the author, reached satisfactory levels of agreement on this procedure with Rater 1 and Rater 3. There was a similar problem between Rater 1 and 3 on the category of Investigation. Physical Examination, Introductory and Concluding procedures were reliable between all raters. Processes of Giving Information and Seeking Information were reliable between all raters. Recording Information had an hundred percent agreement, and therefore a kappa of 1.00, between all raters. However it is important to note that in the first round of reliability assessment this category occurred only once in all three interviews. Discussing Information, Prescribing and Accepting Information needed to be improved for reliability to be acceptable.

L. ASSESSMENT OF RELIABILITY 2

As discussed in the section on the Development of the Coding System, the problems arising from the first round of reliability were discussed. It was decided that Active Listening, which had been included with Accepting Information, technically was agendaless. The two categories were distinguished by adopting the category Accepting Information for those instances when the doctor or patient was accepting information from the other and holding the conversational ground; in contrast the category of Active Listening was adopted when the doctor or patient was not holding the conversational ground. The Mental State agenda and the Emotional agenda, so often confused, were collapsed into the single Emotional agenda category. To enable emotional events which had occurred in the past, and the reporting of developmental 'milestones', to be coded, the new category of Historical Psychological agenda was introduced.

Method.

For purposes of estimating the inter-rater reliability of the revised coding system, a sample of six general practice consultations which included three different doctors was gathered. In total this gave 508 floorholdings to be rated. These were then coded by three independent raters. Percentage agreement, percentage disagreement and kappa (Cohen, 1963) were once again calculated as measures of inter-rater agreement. As noted above, where low or extremely high rates of occurrence are found, Cohen's kappa is a poor measure of agreement. Values of kappa greater than 0.60 indicate satisfactory levels of agreement (Hollenbeck, 1978).

Results.

The inter-rater agreement coefficients for the three raters are shown in Table 3.6. Levels of agreement were high in all cases when figures for percentage agreement and disagreement were calculated. However in several cases Cohen's kappa, which represents a measure of agreement corrected for chance levels of agreement, was low. Rater 1 identified a lower rate of Social agendas in comparison to the other two raters and used this coding category infrequently. Upon reviewing the operational definitions of Social agendas this problem was acknowledged. For Video, Conversation and Uncertain agendas the value of kappa was low. This results from

the very low rate of occurrence of these agendas in the six interviews sampled - all had rates of occurrence less than 1 percent of the floorholdings. For Emotional agendas raters 1 and 2 agreed satisfactorily. Rater 3, however, showed poor agreement with the other two raters. This was due largely to rater 3 applying overly conservative criteria for rating Emotional agendas. This problem was also acknowledged. Rater 2 showed good percentage agreement and satisfactory kappas with Rater 1 on both Physical and Emotional agendas, and showed good percentage agreement and kappas with Rater 3 for Physical and Social agendas. Raters 1 and 2 showed highly satisfactory and acceptable levels of agreement on all procedures and processes calculated by percentage agreement. Kappas were good on all except Discussing Information. This is a complex concept incorporating aspects of both Giving and Seeking Information. Disagreements between raters tended to occur when one rater had coded a floorholding as Discussing Information, while the other had rated the same floorholding as Seeking Information or Giving Information. The definition of Discussing Information was refined to accept the distinction. Rater 3 stands out as disagreeing with the other two raters for the procedures of Referral and Investigation, and the processes of Recording Information and Prescribing. However, since high levels of percentage agreement had been met between all three raters, and because Rater 2, the author, had reached both high levels of agreement with Rater 1 and satisfactory levels of agreement with Rater 3 on most categories, it was decided to proceed with coding the sample of video recordings (Cichetti, 1976).

Table 3.6: Summary of reliability coefficients for different variables under study (second round of reliability)

Agenda	Rater 1 vs. Rater 2			Rater 1 vs. Rater 3			Rater 2 vs. Rater 3		
	%Ag.	%Dis.	kappa	%Ag.	%Dis.	kappa	%Ag.	%Dis.	kappa
I	100	0	1.00	98.4	1.6	0.85	98.4	1.6	0.85
P	93.3	6.7	0.84	84.8	15.2	0.67	83.6	16.4	0.65
E	87.1	12.9	0.68	66.8	33.2	0.29	82.7	17.3	0.46
S	89.8	10.2	0.32	87.6	12.4	0.46	90.5	9.5	0.68
O	98.7	1.3	0	96.8	3.2	0	94.6	5.4	0
HP	100	0	1.00	100	0	1.00	100	0	1.00
V	99.4	0.6	0	99.4	0.6	0	100	0	1.00
CV	94.6	5.4	0	99.4	0.6	0	95.3	4.7	0.19
U	97.6	2.4	0	96.4	3.6	0	98.8	1.2	0
C	98.2	1.8	0.81	95.8	4.2	0.61	97.0	3.0	0.69

Procedure	Rater 1 vs. Rater 2			Rater 1 vs. Rater 3			Rater 2 vs. Rater 3		
	%Ag.	%Dis.	kappa	%Ag.	%Dis.	kappa	%Ag.	%Dis.	kappa
I	100	0	1.00	98.4	1.6	0.85	98.4	1.6	0.85
T	86.7	13.3	0.66	86.2	13.8	0.56	86.2	13.8	0.60
PE	96.8	3.2	0.74	96.6	3.4	0.69	96.6	3.4	0.67
REF	98.6	1.4	0.77	97.2	2.8	0.11	97.0	3.0	0.10
INV	97.4	2.6	0.72	94.1	5.9	0.34	95.5	4.5	0.49
C	98.2	1.8	0.81	95.8	4.2	0.61	97.0	3.0	0.69

Processes	Rater 1 vs. Rater 2			Rater 1 vs. Rater 3			Rater 2 vs. Rater 3		
	%Ag.	%Dis.	kappa	%Ag.	%Dis.	kappa	%Ag.	%Dis.	kappa
GI	89.9	10.1	0.80	86.1	13.9	0.72	85.9	14.1	0.72
SI	94.3	5.7	0.85	91.3	8.7	0.76	92.3	7.7	0.79
RI	99.8	0.2	0.93	98.6	1.4	0.22	98.8	1.2	0.25
DI	92.7	7.3	0.43	90.4	9.6	0.40	90.3	9.7	0.33
P	96.5	3.5	0.68	95.3	4.7	0.53	95.8	4.2	0.58
AI	90.2	9.2	0.60	94.1	5.9	0.69	92.2	7.8	0.67

KEY:

Agendas:

I	Introduction
P	Physical
E	Emotional
HP	Historial Psychological
S	Social
O	Open
V	Video
CV	Conversation
U	Uncertain
C	Conclusion

Procedures:

I	Introduction
T	Treatment
PE	Physical Examination
REF	Referral
INV	Investigation
C	Concluding

Processes:

GI	Giving Information
SI	Seeking Information
RI	Recording Information
DI	Discussing Information
P	Prescribing
AI	Accepting Information

Consensus Scoring.

There were 85 floorholdings across all 73 interviews in which it was difficult to categorise the agenda, procedure or process in question. On these occasions consensus scoring was carried out between the researcher and an independent rater. On all occasions it was possible to reach a satisfactory consensus.

M. DISCUSSION

A system for the interactional analysis of general practice consultations has been described. The system is reliable given sufficient training and satisfies the requirements for a valid system of interactional analysis described by Wasserman & Inui (1983). The system described will be discussed in terms of the dimensions of the doctor-patient consultation described in chapter one, and the fulfilment of criteria for a valid system of interactional analysis.

1. DIMENSIONS OF DOCTOR-PATIENT INTERACTION

In chapter one past models of the doctor-patient consultation were described. Each of these models theoretically may be distinguished by the extent to which a given model addresses three important dimensions: the extent to which it encourages the perspective of doctor or patient within the consultation; the extent to which it acknowledges the influence of one, either, or both parties within the consultation, and the extent to which the model demonstrates an awareness of the broader psychosocial issues within which illness occurs. It will be useful for later discussions briefly to note the way in which each of these models takes account of these three dimensions. The traditional biomedical model pays little attention to the patients' perspective or the patients' problem. The patient has little influence and the balance of power lies squarely with the doctor. Insofar as psychosocial issues are addressed they relate solely to the medical presentation. The traditional model therefore addresses the three dimensions listed above but in an unbalanced way. Although it sought to redress this imbalance by placing emphasis on patient variables such as health motivation, cues to motivation, and perceptions concerning the probable consequences of leaving illness untreated. In the Health Belief Model (Rosenstock, 1974; Becker et al, 1977) the balance of power continues with the doctor. This is

primarily because its proponents have advised doctors on how to manipulate patients to take action rather than to encourage doctors to attend to the subjective implications of the belief systems followed by patients. The broader psychosocial issues within which illness occurs are not addressed in any meaningful sense. As Role Theory (Bochner, 1983; Secord & Backman, 1964) emphasises the mutual expectations brought by two or more persons to a particular context, it would seem superficially that Role Theory would redress the balance on each dimension more successfully. However, the model presents problems to the concept of mutuality within the consultation. Because it focuses on the beliefs and expectations to which a patient 'rationally' should subscribe if he is to reach the role-prescribed end, any patient not subscribing to the relevant beliefs and attitudes may be construed as deviant in some measure (Tuckett et al, 1985). The assumption is that individuals possess 'correct' knowledge as to the role and function of the medical consultation, or no knowledge at all. As such, Role Theory takes little account of the broader psychosocial issues which attend illness presentation. Building on the Health Belief model, Pendleton (1983) construed the doctor-patient in terms of an input-process- outcome approach. Insofar as the model takes account of the patient's environment, the doctor-patient interaction itself, lay constructions of illness, the sick role, and locus of control, it accommodates a much more balanced approach both to doctor and patient perspective and to mutual influence within the consultation. The model seeks to integrate and locate studies of doctor-patient communication rather than to propose a system of analysis per se, but Pendleton's work subsequently is influenced by this approach. The underlying philosophy of Tuckett et al's (1985) proposition of the patient as an expert in the care of their children and in the functioning of their bodies points to the consultation being patient led. The title of their book Meeting Between Experts, as has already been noted, indicates the thrust of this model. Both doctor and patient perspectives are balanced and the model attributes considerably more power and control to the patient than the models so far discussed. Broader psychosocial issues and their salience to the presenting problems are also taken into account, and as such, Tuckett et al's model can be seen to lay the foundation for the Transformed Medical mode proposed by McWhinney (1989). Since the consumerist model of the doctor-

patient consultation inevitably redefines the medical encounter in terms of a market place transaction, the patient's perspective is all important (Stewart & Roter, 1989; Haug & Lavin, 1983). As it is the patient who chooses whether or not to 'purchase' the medical care, the model may be regarded as unbalanced in favour both of the patient's influence and the patient's perspective although it is easy to see how in this context the latter may be a superficial acknowledgement of the same on behalf of the doctor. The same would be the case where psychosocial issues are concerned: much would depend on the sincerity and integrity of the individual doctor. Engel's Biopsychosocial model provides a conceptual framework to enable doctors to operate rationally in domains which have previously been regarded as excluded from rational analysis. It motivates the doctor to become more informed and skilled in the psychosocial area and it counteracts the pursuit of what to the patient are often the more trivial determinants of illness. Because the psychosocial model is less concerned with the doctor-patient interaction than with the wider system within which that interaction occurs, the model is less tendentious than other models in promoting the doctor or patient perspective. Unlike other models it is more concerned with the broader psychosocial issues which inform the consultation. With the balance of power within the consultation: perspective and influence are secondary to the biopsychosocial system. The Transformed Medical model (McWhinney, 1989) addresses the three dimensions of influence, perspective and psychosocial awareness in a balanced way. As has already been noted in Chapter 1, power is something to be negotiated between doctor and patient. The physician's aim is to understand the patients' expectations, feelings and fears and so he must in this model take account both of the patient's perspective and the broader psychosocial issues which surround a given problem. Insofar as the model stresses the importance of differential diagnosis, the doctor's influence and perspective is also fully acknowledged. Central to the present system of interaction analysis are the concepts of initiating, following, not following and returning to agendas raised by either party. These concepts allow an assessment of the three dimensions described above to be made. When either party initiates an agenda he or she is introducing their own perspective on the problem. In following the first person's agenda the second person in the consultation is acknowledging the

first's perspective, and in allowing it, is making a statement about the balance of power within the interview. When either party does not follow an agenda, a statement about mutual influence is again being made. Returning to an agenda is a further indicator of perspective and influence. On the one hand if a doctor returns to an agenda previously raised by a patient, the return may be seen as a mark of the doctor acknowledging the patient's perspective. That the doctor is returning to this agenda may suggest that the doctor wields more influence than the patient: he or she is prepared now to concede an agenda which previously was not followed. On the other hand a patient's returning to an agenda previously raised by himself indicates that the agenda has not been sufficiently negotiated. This suggests that the patient's perspective has not adequately been allowed. This in turn may point to an imbalance of power between doctor and patient. However, insofar as the patient is returning, influence can not be seen to rest solely with the doctor: the patient is sufficiently in charge to re-initiate his agenda. The extent to which initiating, following or non- following occurs by either party on non-Physical agendas enables measurements to be made of the extent to which a consultation acknowledges wider psychosocial issues.

2. FULFILMENT OF NECESSARY CRITERIA

Many patients with psychological illness are undetected by general practitioners (Wright, 1990; Marks et al, 1979; Davenport, 1987; Freeling et al, 1985). Given that components in the doctor-patient interaction are able to reduce patient satisfaction (Stiles et al, 1979; Ley, 1976; Stewart, 1984) and given that patients prefer doctors who have more time (Howie et al, 1991; Smith & Armstrong, 1989), it is concluded that relevant social and emotional information is often undetected by doctors. Associated social and emotional information may be related to physical problems or may be important in its own right (David et al, 1990). It need not be related to psychiatric morbidity although its presence may suggest such a possibility (David et al, 1990; Sharp & King, 1989; Marks et al, 1979). To substantiate this postulate requires an instrument which measures what is said in a doctor-patient consultation (content), and how that information is conveyed (process). The instrument to be theoretically sound, must include

certain criteria, should be both reliable and valid, must be related to our health care system and, ideally, should be able to be used in teaching. Using a patient centred approach, Levenstein et al have moved some way to defining a workable procedure for their model (Levenstein et al, 1986). They define the interview in terms of patient expectations, feelings, fears and prompts. Doctor behaviour is measured in terms of facilitation, acknowledgement, cut-off and return. Their method showed good inter-rater reliability and is sensitive to changes which take place during training (Brown et al, 1986; Stewart et al, 1986). Although welcome and not without utility, this instrument has nevertheless several shortcomings. Firstly, the scoring system does not include non-verbal behaviour which means that potential cues to a patient's agenda are missed. Secondly, doctor content variables are not scored in the same way as those of the patient. Thus, while it can be argued that doctor and patient have different roles within the consultation (Bochner, 1983), the doctor's expectations, feelings, fears and prompts will be left out. The doctor may prompt a premature closure just as the patient may signal that not all his business has been dealt with. The fact that the interaction is a dynamic process is passed over. Similarly, as neither doctor nor patient behaviours are accessed, we do not know from the scoring system whether a doctor is prescribing, referring or doing a physical examination. All these procedures may be pertinent to the content variables being measured. Lastly, it is not clear from the system what is happening in terms of information processing. Although we can tell if a doctor is accepting the patient's information, we cannot know if either is giving information, seeking information, or negotiating around a problem. As such, mutuality in terms of problem solving is excluded from the system. In the system of interaction analysis described in the present chapter, both doctor and patient agendas are conceived of as implicit or explicit problems requiring problem solving processes for their resolution. Additionally agendas are the content variables of the system depending on the relationship level of communication for their meaning. Agendas are brought by patients to the doctor and to the general practice consultation but physicians also may have motivating agendas which need to be identified and, if applicable, negotiated about. Since doctor and patient agendas must be acted upon in some way in order for the consultation to proceed, those procedures generally

used within the doctor-patient encounter are described. These are conceived of as techniques, available to doctor and patient, which may be bought to bear on a given problem. Procedures provide a frame of reference for interview participants and form an important part of interview context. They are also significant markers in consultation sequence. The crucial link between agendas and the procedures brought to bear on them is supplied by information processing. Information processing is itself a procedure, but it describes also how procedures are linked to problems. Either party may seek information about a problem, may discuss information about a problem, may give information about a problem, may discuss information or may accept information about the patient's problem. A doctor will ask questions about the patient's problem in order to prescribe treatment: a patient may discuss the effects upon his social life of treatment previously prescribed and so on. Incorporated into the system are the concepts of initiation, following, non- following and returning to agendas by either party. The system is reliable and satisfies the requirements for a valid system of consultation analysis outlined by Wasserman & Inui (1983) and described in chapter 1. Coding is based upon the observational analysis of videotape and audiotape recordings. Operational definitions include aspects of non-verbal behaviour. The system takes into account the need for an integrated model, and allows for an in-depth analysis of the content, context and process of general practice interviews.

CHAPTER 4 : AN ANALYSIS OF PRINCIPAL AGENDAS AND PROBLEM SOLVING

A. CONCEPT OF AGENDAS.

B. AGENDA OCCURRENCE.

C. AGENDA INITIATIONS.

D. FOLLOWING OF AGENDAS.

E. RETURNS TO AGENDAS.

F. TIMING OF AGENDAS.

G. THE PAY-OFF FOR AGENDAS.

H. DISCUSSION.

APPENDIX: CORRELATIONS OF DOCTOR AND PATIENT BEHAVIOUR IN RESPECT OF PRINCIPAL AGENDAS.

A. THE CONCEPT OF AGENDAS

The concept of describing the content of the general practice interview in terms of agendas was introduced by Levenstein et al (1986). They propose that the key to understanding the patient is in terms of his agenda. The aim of the doctor should be to identify the patients' agenda, to attempt to enter the patients' world, and to reconcile that world with his own. The Levenstein group's work is "patient- centred" in approach. This contrasts with the disease- centred, or doctor-centred, method (elaborated in Chapter 1) in which the doctor pursues his own agenda and makes little attempt to understand that of the patient. Balint and colleagues (1970) used this term as an alternative to 'illness centred medicine'. In the latter, an understanding of the patient's complaint is based on illness centred thinking, and is referred to as 'traditional diagnosis'. In the former the understanding is based on patient centred thinking, and is called 'overall diagnosis'. This form of clinical method was elaborated by Stevens (1974). In a key address to the Royal College of General Practitioners he proposed an heuristic problem solving model in an open system of consultation. Central to such a system would be the doctor as a person and the patient as a person. Stevens compares this to the algorithmic diagnostic processes involved in a closed system of traditional medicine. The patient centred method was further developed by Byrne & Long (1976). In their study of 1,850 general practice consultations, using a method for categorising a consultation as doctor or patient centred, Byrne & Long showed that many physicians have developed a relatively static style, and that this tends to be doctor centred. Like traditional medicine, and indeed as part of it, doctor centredness requires that the physician seeks information in as objective a way as possible. His goal is to diagnose the disease in terms of his own frame of reference and to prescribe a management plan appropriate to the diagnosis. The Levenstein group, like Stevens (1974) and Tuckett (1985), stress that in applying the idea of patient centredness, the doctor must include the process of differential diagnosis. The aim of the consultation is therefore twofold: it must understand the patient and, if possible, must diagnose the patient's illness in terms of a medical frame of reference. The critical factor in this process involves the doctor ascertaining the patient's agenda, and integrating this with his own. The framework for the analysis of agendas

is provided by a problem solving approach. Problem solving is fundamental to the processes involved in differential diagnosis which as Levenstein et al point out, is a well tested clinical method for the recognition of diseases. Doctors are trained in the latter, and for physical presentations at least, problem solving is the norm for most general practitioners (Stevens, 1974). Problem solving may be regarded as neutral with respect to many of the current models of doctor/patient interactions. For example, although associated with the traditional medical model (Stevens, 1974), it is argued that unless the physician is prepared to accommodate a patient's perception of the problem, a solution satisfactory to both parties will not be forthcoming (McWhinney, 1989). Negotiation and identification of options for action will be less effective if only one party's agenda is addressed. Evidence for this comes from Byrne & Long (1976) who found that failure to ascertain the patient's reason for attending will lead to a dysfunctional interview. This was echoed in observations of the Levenstein group (1986) and by the findings of Tuckett et al (1985). Stewart (1984) has found that patient satisfaction was linked to patient centredness, and Campion (1987) has demonstrated that by listening to patients and by actively seeking their views, doctors are able to enhance their understanding of the patient's illness and may effectively improve their interview technique. Friedson (1970a; 1970b) and Lorber (1972) proposed that the provision of information by doctors to patients can be restricted by physicians for professional reasons and that the disclosure of information may be used either to exert social control or to keep patients in line. As suggested in the previous chapters the concept of control is potentially useful as a tool in the analysis of doctor/patient consultations. The specific content of an interview is determined by the balance of power exerted by doctor and patient in expressing their agenda, and also in suppressing any agendas which are seen as inappropriate. By assessing the dimension of mutual influence (see Chapter 3, Section M:1) the method of doctor/patient interaction analysis described in this thesis incorporates a means of assessing the control exerted by either party. Given that both doctor and patient express agendas, the method examines the way in which both doctor and patient initiate agendas and respond to the other's agendas. This is done by recording whether or not either party follows, does not follow, or returns to the other's agenda. The initiation of an

agenda refers to the first instance in an interview when an agenda occurs. When an agenda has been initiated, it may be followed by the other party. This is demonstrated by the other participant in the consultation continuing on the same topic as the first. Alternatively, an agenda may be non-followed. In this case the other party in the consultation will not continue the topic initiated by the first. An example of a followed agenda would be when the patient talks to the doctor about an aching shoulder, and the doctor, in the next floorholding, continues to talk about the patient's aching shoulder. A non-followed agenda would occur when the patient expresses anxiety about the loss of a relative and the doctor looks away writing notes. However, an agenda, if not followed, may be returned to at a later point in the consultation. In this case either party will raise an agenda which was previously not followed. For further definitions and a fuller description of these categories see Chapter 3. Initiations, Returns and Follows all represent attempts to legitimise agendas. Non-Following represents the 'blocking' of an agenda, even if only temporarily. In the results presented in this chapter, an agenda is defined as the explicit or implicit topic which is, or could become, the focus of the problem solving process. An agenda is the subject of an attempt by one party, through the use of consultation procedures and information processing, to raise the other party's awareness of particular circumstances. Almost without exception these circumstances are regarded as having salience to the consultation, and as having problem solving status. An agenda raised by either party may be either obvious and explicit, or covert and implicit. For example, a patient who presents to the doctor saying that he has come for a 'flu jab is expressing an obvious physical agenda. But the patient may announce that he has come for a 'flu jab in a tone of voice and with a demeanour that suggests the presence of some underlying emotional concern - an Emotional agenda which the doctor may fail to recognise. Agendas may occur alone or in parallel (see Rules for Coding, Appendix E). Thus in the example just given, the overt Physical agenda occurs in parallel with the covert Emotional agenda. Had the patient continued to mention his business folding in the same floorholding, a Social agenda would occur and would be scored additionally. Percentages therefore appear to add up to more than 100 when given in the results. This is the result of parallel coding. The results in this chapter describe in a series of

naturally occurring general practice interviews the use of agendas by doctor and by patient, and also how control over the content of the interviews is exerted by either party. Of particular interest are mismatches which occur when either party brings an agenda to the consultation, the extent to which either party is comfortable with the other's agenda, and the index of sensitivity represented by agenda following. Of principal interest will be Physical, Emotional and Social agendas.

B. AGENDA OCCURRENCE

Physical agendas represent the bulk of the interaction in this sample of 73 consultations, occurring in 81 percent of all floorholdings. The sample was not strictly representative of all G.P. consultations, since only those patients who consented were recorded. It is likely that those with emotional problems are more likely to have declined to be recorded. Nevertheless, almost 25 percent of floorholdings contained Emotional agendas, and about 14 percent contained Social agendas. Of patient's floorholdings (n=2040), 83 percent contained Physical agendas, 29 percent Emotional agendas and 17 percent Social agendas. Table 4.1 compares the frequency of the three principal agenda types for doctors and patients. Patients spoke about feelings, or demonstrated feelings non-verbally, significantly more often than doctors.

Table 4.1: Frequency and percentage of floorholdings containing principal agendas distributed by doctor and patient. Figures in brackets show the percentage of total floorholdings.

	Emotional	Physical	Social	Total
Floorholdings				
Doctor	392 (17%)	1661 (70%)	308 (13%)	2361
Patient	595 (23%)	1694 (64%)	349 (13%)	2638

Chi-square=29.38 $p<0.001$

C. AGENDA INITIATIONS

Table 4.2 shows the number of initiations of Physical, Emotional, Social and Open agendas by doctor and patient. Patients were much more likely to initiate Physical agendas than doctors. However, it should be noted that doctors nearly always begin the consultation with an open question or agenda such as, "What can I do for you ?" The patient tends to respond by initiating a Physical agenda. Thus a Physical agenda is usually the first agenda to be addressed, and the high level of patient initiating on Physical agendas represents the way people behave in the G.P. setting. Similarly patients were more likely to initiate Emotional agendas. Whereas patients very often initiated Emotional agendas non-verbally, the most common way for a doctor to initiate an Emotional agenda was by asking a question. There is thus a distinction between the way a problem is spoken about and what is said. This has implications for the distribution of Emotional agendas throughout the interview, and will be taken further in a later section. Both doctors and patients initiated similar numbers of Social agendas. Not including the Open agendas, a comparison of the number of Initiations of Emotional, Physical and Social agendas by doctors and patients was statistically significant (Chi- square=29.94; $p<0.001$). Table 4.2 shows the frequency and percentage of initiations of principal agendas, including the Open agendas, distributed by doctor and patient.

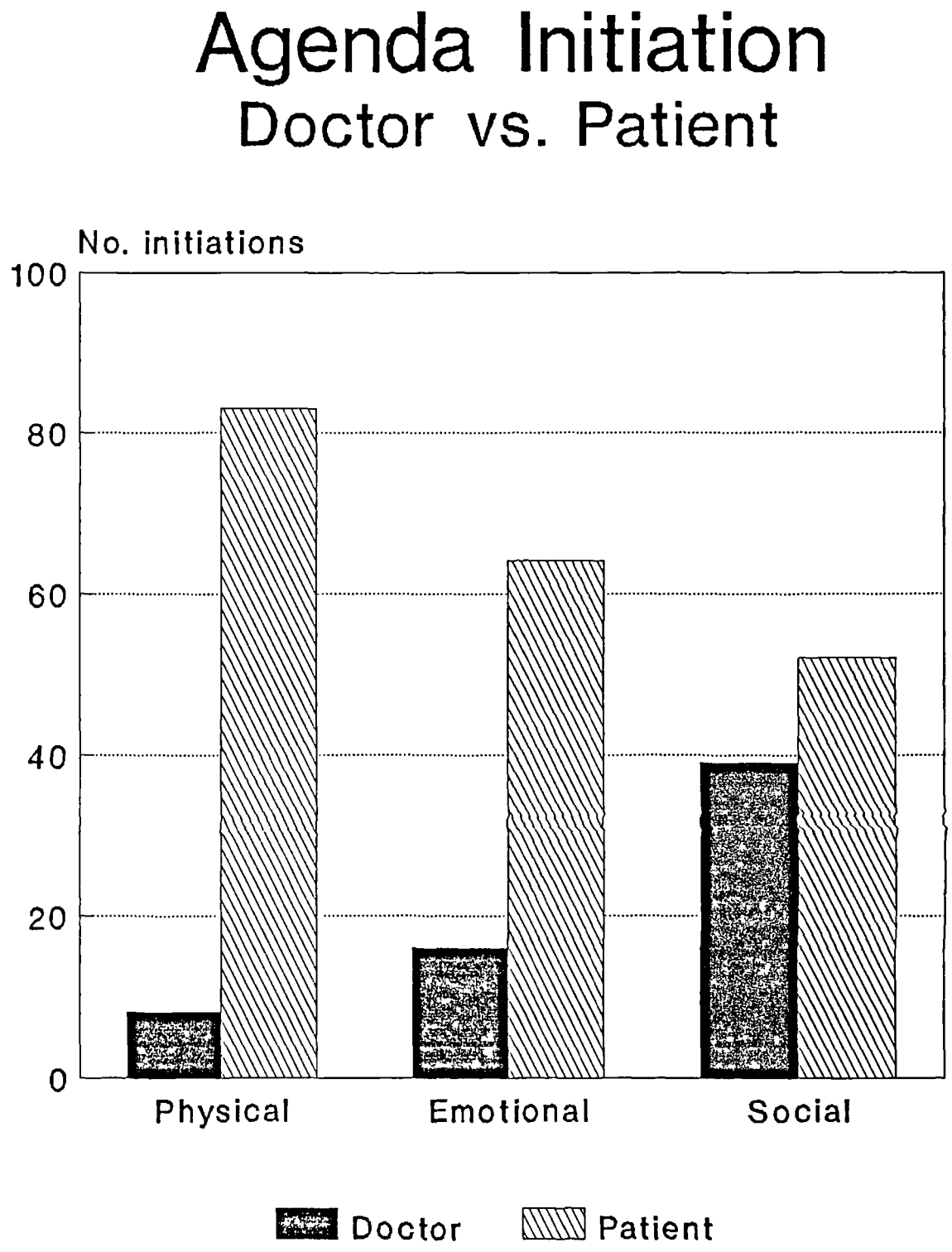
Table 4.2: Frequency and percentage of initiations of principal agendas distributed by doctor and patient. Figures in brackets show percentage of total initiations.

	Emotional	Physical	Social	Open	Total
Initiations					
Doctor	16 (11%)	8 (6%)	39 (28%) 7	7 (55%)	282
Patient	64 (23%)	83 (41%)	52 (26%)	2 (1%)	319

Chi-square=157.8 $p<0.0001$

Figure 4.1 shows doctor and patient initiations of principal agendas derived from the above table.

Figure 4.1: Doctor and patient initiations of principal agendas.



D. FOLLOWING OF AGENDAS

The majority of floorholdings contained follows of previously raised agendas, as would be expected from the normal structure of a conversation. For example, while doctors and patients between them initiated 91 Physical agendas and returned to 114 Physical agendas, they followed one another's Physical agendas through 3,150 floorholdings. Approximately 95 percent of all occurrences of Physical for doctors, agendas and 92 percent of all occurrences of Physical agendas for patients were follows of agendas that had been referred to by the other party in the previous floorholding. The proportion of Emotional and Social agenda occurrences which were follows of the other person's previously raised Emotional or Social agendas was lower. Sixty-nine percent of doctor's Emotional agendas and 81 percent of patient's Emotional agendas were follows of an Emotional agenda referred to in the previous floorholding by the other party: 60 percent of doctor's Social agendas and 41 percent of patient's Social agendas were follows of Social agendas referred to by the other party in the previous floorholding. Table 4.3 shows the frequency of follows for both doctor and patient on the three principal agenda types. In this table the percentages shown are the row percentage of the total followings for either doctor ot patient.

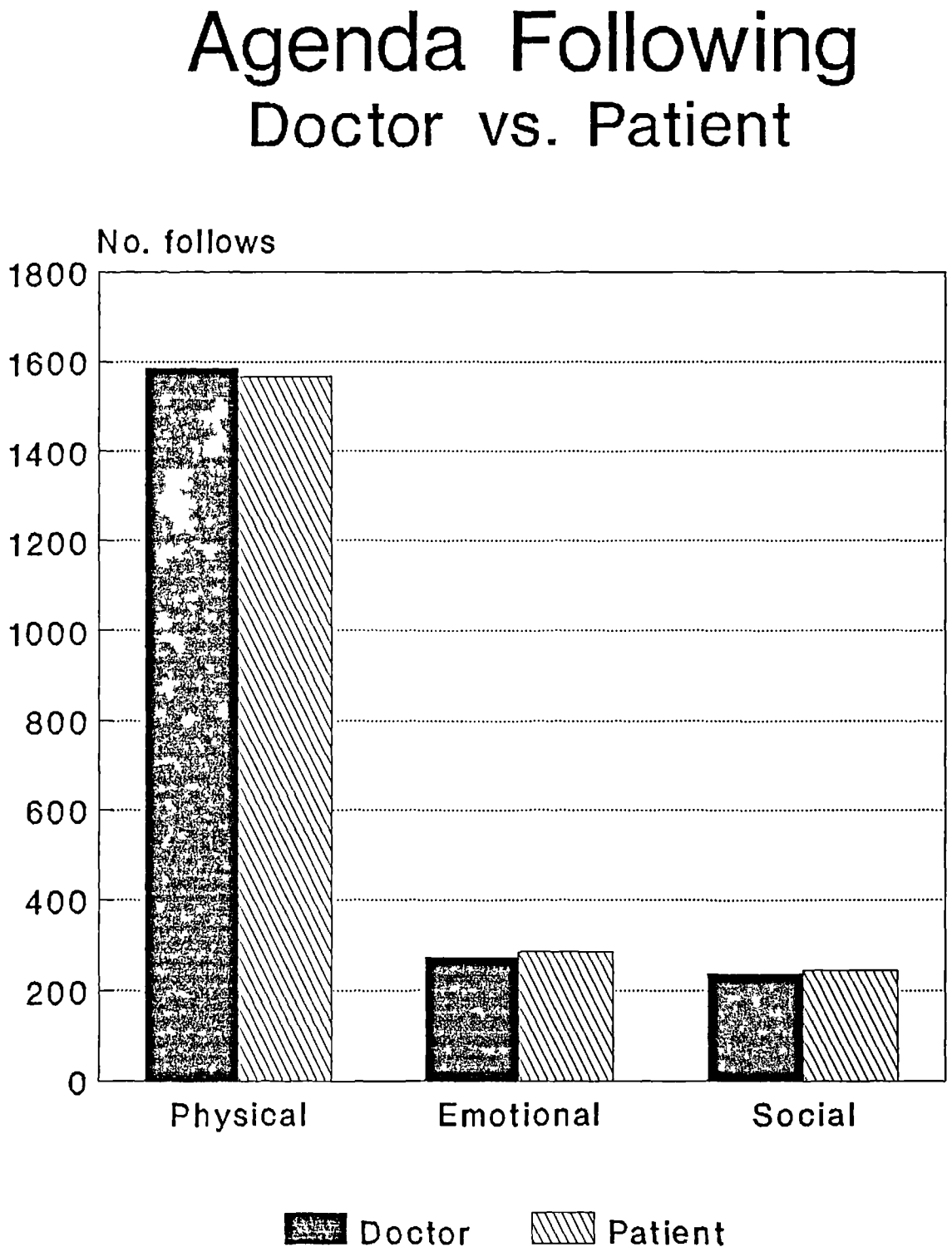
Table 4.3: Frequency and percentage of following of principal agendas distributed by doctor and patient. Figures in brackets show the percentages of total follows.

	Emotional	Physical	Social	Total	Total Follows
Doctor	272 (13%)	1585 (76%)	237 (11%)	2094	2262
Patient	284 (14%)	1565 (75%)	244 (11%)	2093	2256

Chi-square=0.5 ns

Figure 4.2 shows doctor and patient following of principal agendas derived from the above table.

Figure 4.2: Doctor and patient following of principal agendas.



E. RETURNS TO AGENDAS

Returning to an agenda previously initiated (and possibly also followed, before being non-followed) can be considered either as a delayed follow, or as a second initiation. Returns may be qualitatively different for doctors and for patients (see below). About half of doctor returns are to Emotional agendas, and nearly three quarters of patient returns were to Emotional agendas. Both doctor and patient return to Social agendas to a similar degree whereas doctors return proportionately more often to Physical agendas than patients. Of all the occasions when a patient refers to an Emotional agenda (initiations, follows or returns) 41% are returns. This contrasts with doctors for whom 26% of all Emotional references were returns. Table 4.4 shows the frequency and percentage of returns for both doctors and patients.

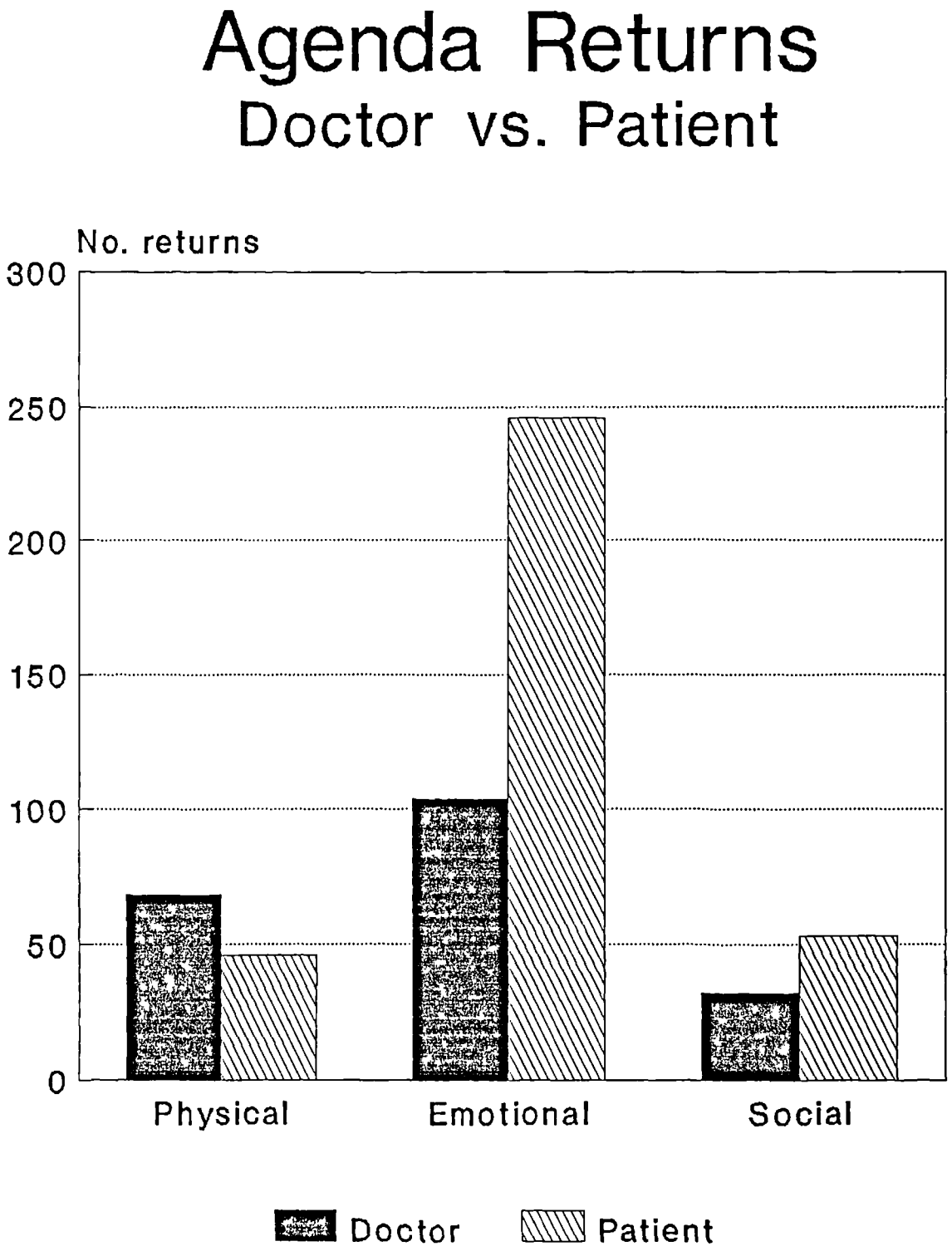
Table 4.4: Frequency and percentage of returns of principal agendas distributed by doctor and patient. Figures in brackets show percentage of total returns.

	Emotional	Physical	Social	Total	Total Returns
Doctor	104 (51%)	68 (33%)	32 (16%)	204	229
Patient	246 (71%)	46 (14%)	53 (15%)	345	379

Chi-square=33.01 $p<0.01$

Figure 4.3 shows doctor and patient returns to principal agendas derived from the above table.

Figure 4.3: Doctor and patient returns to principal agendas.



F. THE TIMING OF AGENDAS

Table 4.5 shows the frequency of occurrence for the three principal agendas during the four quarters of each interview. The interview was divided into four sections on the basis of the number of floorholdings in the interview, and the agendas occurring in each quarter of the interviews summed across all the interviews.

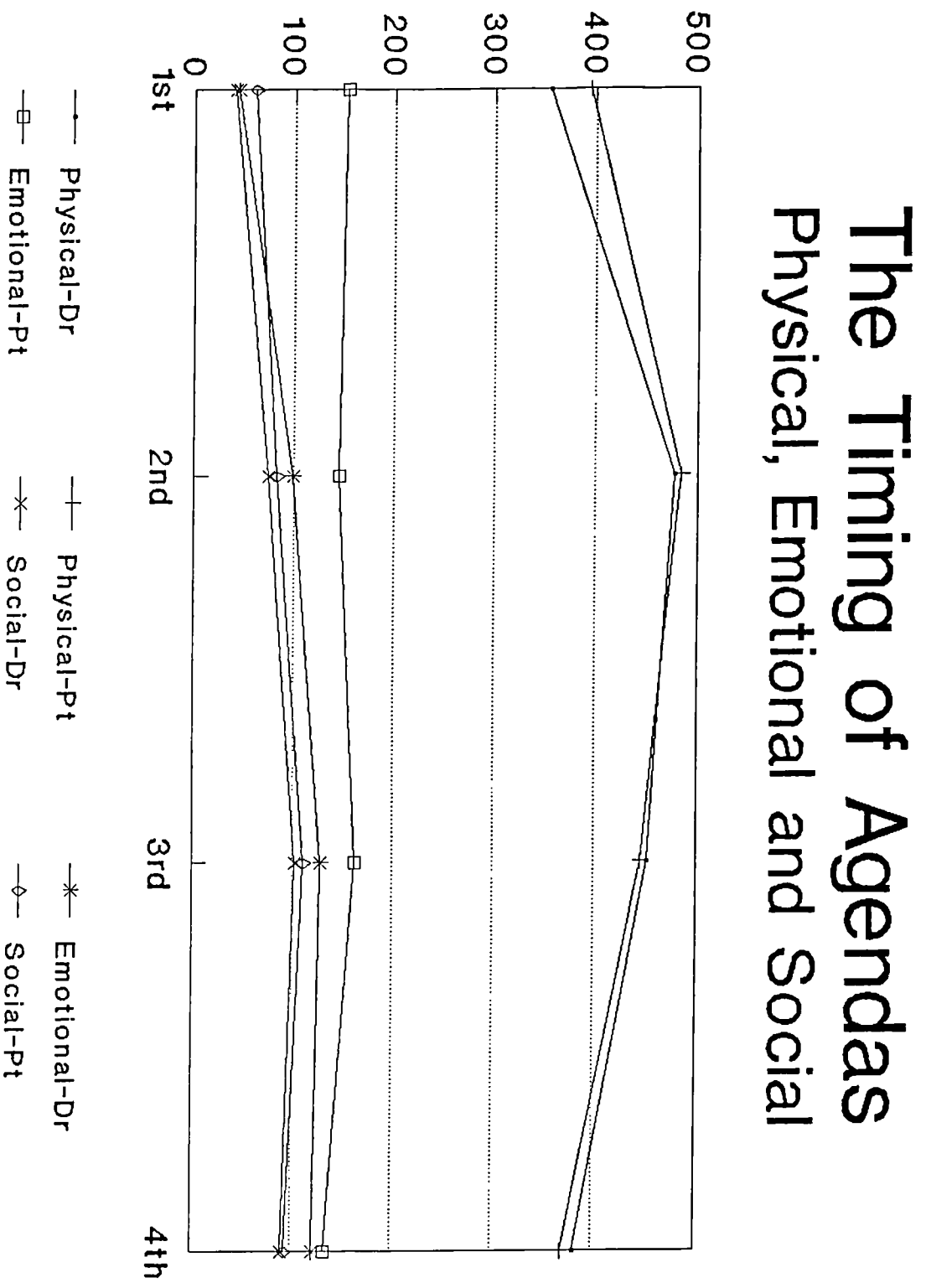
Table 4.5: Frequency of specific agendas during four quarters of the interviews.

	Quarter of Interview			
	1st	2nd	3rd	4th
PHYSICAL				
Doctor	355	478	452	381
Patient	394	484	446	370
Chi-square=2.03 ns				
EMOTIONAL				
Doctor	43	99	128	122
Patient	153	145	163	134
Chi-square=34.90 $p<0.001$				
SOCIAL				
Doctor	40	75	102	91
Patient	61	83	111	94
Chi-square=2.65 ns				

Physical agendas occur to a high degree throughout the interview for both doctor and patient: frequency is well matched. Social agendas are also reasonably matched in frequency, although patients initiate more Social agendas than doctors in the first quarter of the interview. More Social agendas occur for both parties in the second half of the consultation. Emotional agendas show an asymmetry in that patients bring a fairly constant number of Emotional agendas to the

consultation throughout the four quarters. Doctors, in contrast, tend to use fewer Emotional agendas in the first half of the interview, only approaching the patient's level of emotional engagement in the last quarter. Interestingly, doctor and patient only approach congruence when the doctor's level of emotional engagement is at its highest and the patient's level of emotional engagement is at its lowest. However, as was noted above, patients tend to initiate and sustain Emotional agendas non-verbally more often than doctors who initiate or return to Emotional agendas by asking questions. Figure 4.4 depicts the timing and occurrence of principal agendas for doctor and patient.

Figure 4.4: Timing of occurrence of principal agendas.



G. THE PAY-OFF FOR AGENDAS

When either party in the interview adopts an agenda in the interview it may be either followed or not followed by the other participant. There will always be a certain 'pay off' in terms of the likelihood of it being followed or not followed by either party in the next floorholding. The tables given below show the pay off both for doctor and for patient for initiating, following or returning to the three principal agendas. Initiations, follows and returns are shown in terms of doctor's and patient's current floorholding. Frequency and percent show what happened to initiations, follows and returns by either party in the next floorholding.

Table 4.6: Frequency of Following and Non-Following in next floorholding broken down by nature of current floorholding - Physical agendas.

DOCTOR			
		Next Floorholding	
		Followed	Non-Followed
Current	Initiation	8 (100%)	0 (0%)
Floorholding	Follow	1512 (95.5%)	72 (4.5%)
	Return	56 (84.8%)	10 (15.2%)
PATIENT			
		Next Floorholding	
		Followed	Non-Followed
Current	Initiation	75 (90.4%)	8 (9.6%)
Floorholding	Follow	1475 (94.4%)	88 (5.6%)
	Return	39 (86.7%)	6 (23.3%)

Table 4.6 shows that where Physical agendas are concerned, doctors and patients follow one another to a comparable extent regardless of whether the agenda was initiated by either party, previously followed by the other party, or returned to by either party. For example, 90 percent

of patient initiated Physical agendas were followed by the doctor, and all doctor initiated Physical agendas were followed by the patient. About 87 percent of patient returns to Physical agendas were followed by the doctor, and 85 percent of doctor returns to Physical agendas were followed by the patient.

Table 4.7: Frequency of Following and Non-Following in next floorholding broken down by nature of current floorholding - Emotional agendas.

DOCTOR			
		Next Floorholding	
		Followed	Non-Followed
Current	Initiation	8 (50%)	8 (50%)
Floorholding	Follow	211 (77.6%)	61 (22.4%)
	Return	65 (63.1%)	38 (36.9%)
PATIENT			
		Next Floorholding	
		Followed	Non-Followed
Current	Initiation	16 (25%)	48 (75%)
Floorholding	Follow	164 (71.9%)	120 (28.1%)
	Return	90 (36.6%)	156 (63.4%)

From Table 4.7 we see that only 50 percent of doctor initiated Emotional agendas are followed by the patient, and that only 25 percent of patient initiated Emotional agendas are followed by the doctor. Some 63 percent of doctor returns on Emotional agendas are followed by the patient and only 37 percent of patient returns to Emotional agendas are followed by the doctor. Furthermore, the doctor is most likely to follow the patient if the patient has previously followed the doctor. For Social agendas, too, doctors are followed more than they follow, and are more likely to follow if the patient has previously followed the doctor (see Table 4.8). In

contrast to Emotional agendas initiated by doctors, patients followed 95 percent of doctor initiated Social agendas. Although following patient initiated Social agendas more than patient initiated Emotional agendas, doctors still follow patient initiated Social agendas less than patient initiated Physical agendas. Similarly with Social returns, doctors follow patient returns to Social agendas more than they do patient returns to Emotional agendas, but follow patient returns to Social agendas less than they do patient returns to Physical agendas.

Table 4.8: Frequency of Following and Non-Following in next floorholding broken down by nature of current floorholding - Social agendas.

DOCTOR			
		Next Floorholding	
		Followed	Non-Followed
Current	Initiation	37 (94.9%)	2 (5.1%)
Floorholding	Follow	181 (76.4%)	56 (23.6%)
	Return	26 (83.9%)	5 (16.1%)
PATIENT			
		Next Floorholding	
		Followed	Non-Followed
Current	Initiation	31 (59.6%)	21 (40.4%)
Floorholding	Follow	177 (72.5%)	67 (27.5%)
	Return	30 (56.7%)	23 (43.3%)

Figures 4.5 to 4.7 show the differential pay-off for doctor and patient according to agenda type. The black bars show doctor behaviour (Initiation, Following or Returning) and also patient responding in the next floorholding. Similarly the white bars show patient behaviour and doctor responding in the next floorholding. Important to note is the way the middle white bar is lower in the differential pay-off for Emotional agendas than it is for Physical and Social

agendas. This shows visually the hesitancy that patients demonstrate in following doctors' follows in the emotional domain.

Figure 4.5: Differential pay-off for Physical agendas.

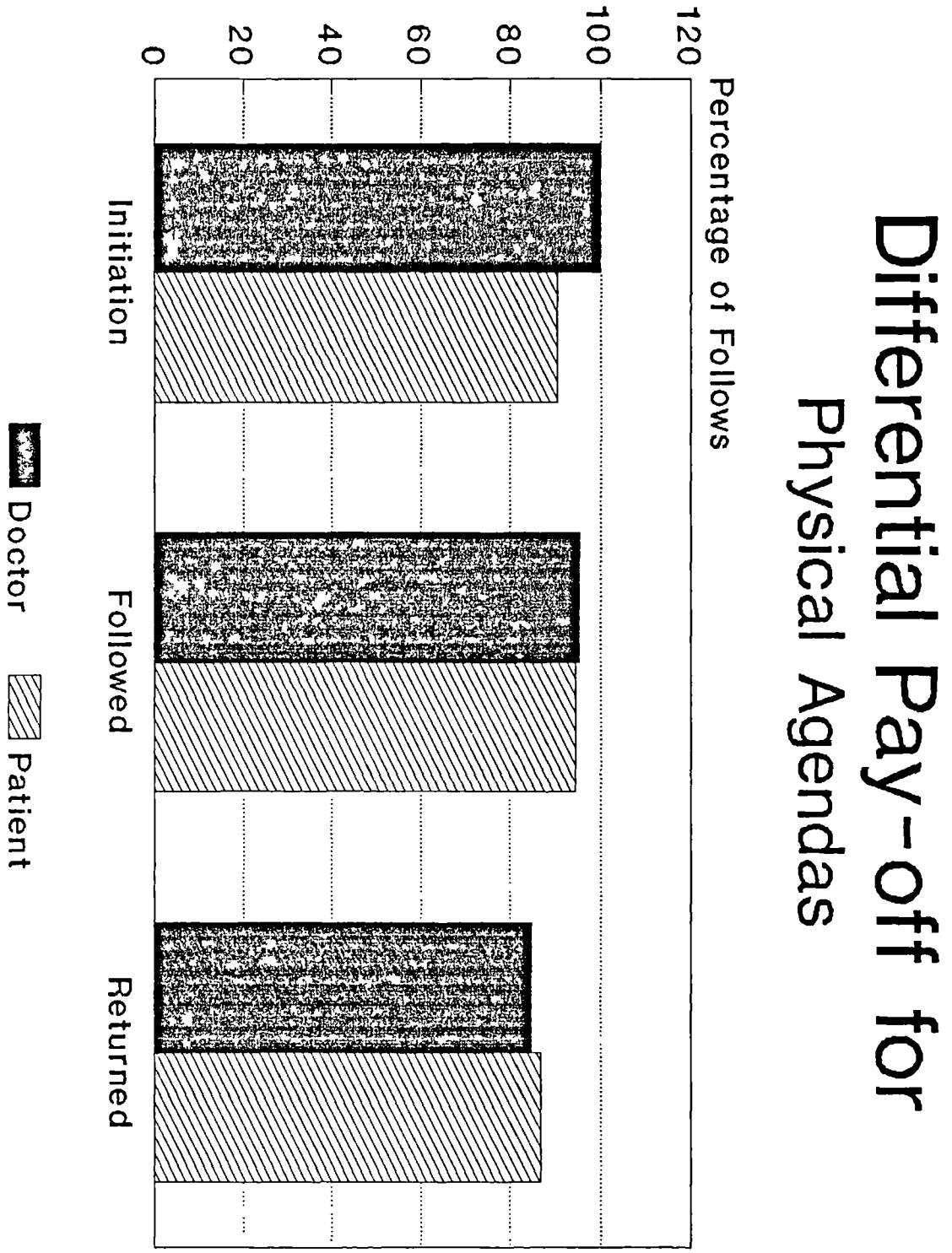
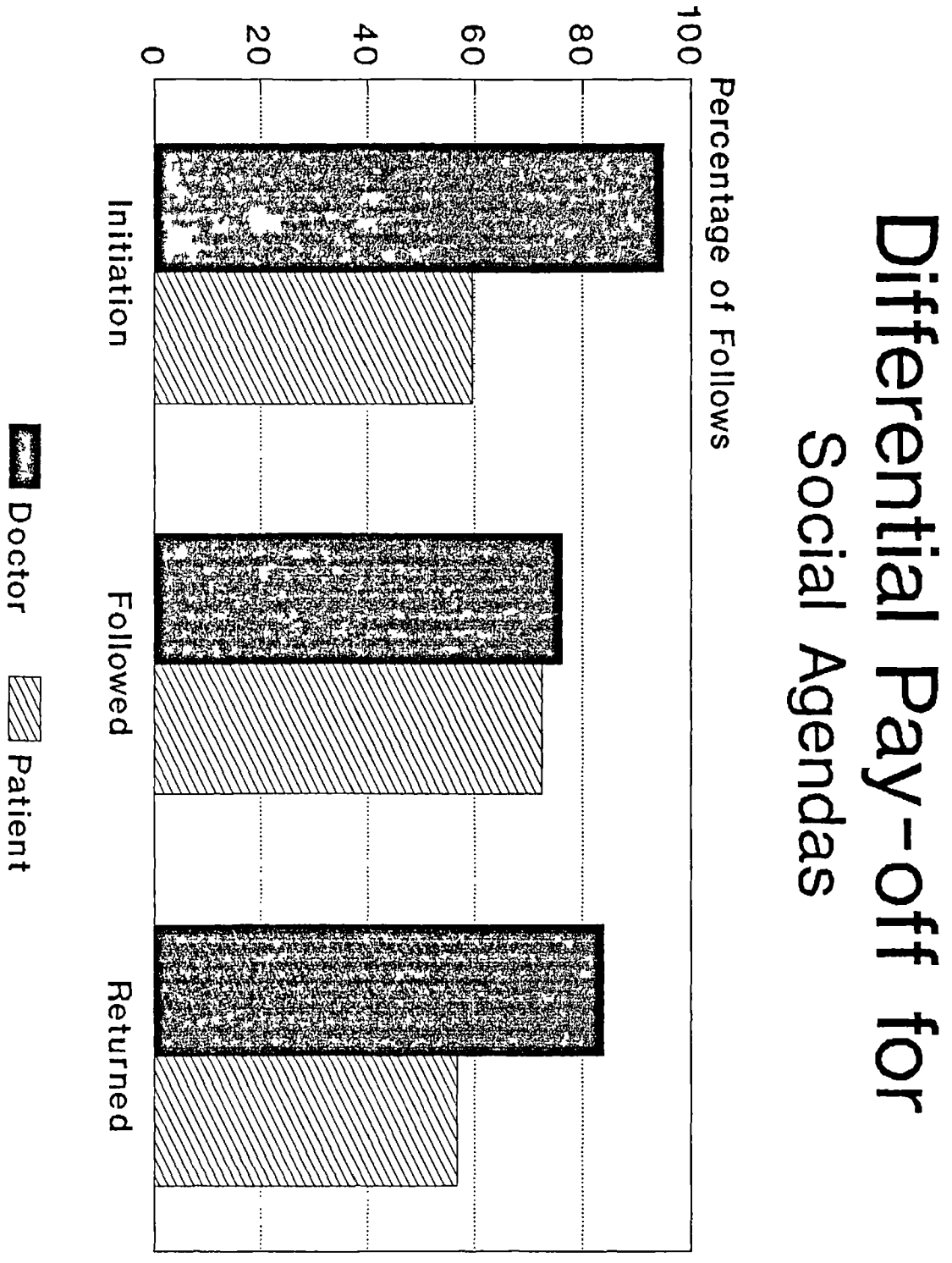


Figure 4.6: Differential pay-off for Emotional agendas.

Figure 4.7: Differential pay-off for Social agendas.



H. DISCUSSION

The system of interaction analysis described in Chapter 3 was applied to a set of 73 naturally occurring general practice interviews. Results are analysed in terms of the three principal agenda types; Physical, Emotional and Social. Physical agendas were the most prevalent occurring in approximately 80 percent of all floorholdings, Emotional agendas were the next most commonly occurring, followed by Social agendas. Patients initiated Emotional and Physical agendas more often than doctors, both parties initiated Social agendas to a similar extent. Doctors initiated Open agendas to a greater extent than patients. Physical agendas were followed to a high extent by both parties, Emotional and Social agendas were followed to a lesser extent and equally by both parties. Both doctors and patients were more likely to return to Emotional agendas than to Physical agendas, however patients returned to Emotional agendas more than doctors who more commonly returned to Physical agendas. The timing of the occurrence of the principal agendas was also explored. Physical agendas occur at a high rate throughout all four quarters of the interview. Doctors address Emotional agendas to a greater extent towards the end of the interview, in contrast patients address emotional concerns at a constant rate throughout the interview. Both doctor and patient show a similar pattern of occurrence for Social agendas where the occurrence is highest towards the second half of the interview. The pay-off (the probability of the agenda being followed) for initiating, following or returning to an agenda was examined for doctor and patient according to the three principal agenda types. Physical agendas demonstrated a high pay-off for both doctor and patient regardless of how it was addressed. For Emotional agendas the pay-off was generally lower than that for Physical agendas; patients were most likely to be followed if they had previously followed the doctor in an Emotional agenda. Patients follow doctors' Emotional agendas more than doctors follow patients' Emotional agendas, the rate of following being highest if the patient was following an Emotional agenda which had been followed by the doctor. Following of Social agendas was intermediate between that for Physical agendas and that for Emotional agendas. Patients in general followed doctors more than doctors followed patients.

The data provide evidence for several of the hypotheses outlined in Chapter 2. Physical agendas are not more frequent early in the interview (refuting hypothesis 1). The following rate for Physical agendas is greater than that for non-physical agendas (supporting hypothesis 4). Finally, rates of non-following were higher for Emotional agendas than for Social agendas, supporting hypotheses 6 and 7.

Chapter 3 described how models of the doctor-patient consultation may be described across three dimensions: the extent to which the consultation allows the perspective of either doctor or patient (or both), the extent to which the consultation acknowledges the influence of either or both parties, and the extent to which the consultation demonstrates an awareness of broader psychosocial issues.

The results presented here show that patient initiation of Physical agendas is extremely high. Doctors do not appear to initiate Physical agendas very much, but this may be because patients most often initiate Physical agendas in response to the doctor's open question at the beginning of the interview (55% of total Physical, Emotional, Social and Open agenda initiations are Open). In terms of following one another on Physical agendas, both parties seem to be in tune: doctor and patient following is comparably matched. The return rate for Physical agendas is low for both parties, indicating that each is satisfied with the way Physical agendas have been previously dealt with in the consultation. Initiating, following and returning to Physical agendas begets a very high degree of following from both parties.

Patients also appear to initiate Emotional agendas more than doctors. At least some of the time this is in response to the doctor's initial open question, and Emotional agendas quite often occur in parallel with Physical agendas at this point in the interview. Nevertheless, patient initiations of Emotional agendas account for almost 25% of Physical, Emotional, Social and Open initiations. That doctors' initiations of Emotional agendas account for 11% of doctor initiations on the same four agenda types indicates that some doctors at least do not regard emotional topics as being anathema to the consultation. Neither doctors nor patients follow the other's Emotional agendas to a high degree when compared to the other two principal agenda types. Even when doctors have followed the patients' Emotional initiation, patients are less

likely to follow the doctor in the next floorholding than they are when the doctor has followed the patient on a previously raised Physical agenda. But following the other's agenda is still more likely to prompt a following than the reverse. Patients return to Emotional agendas to an extremely high degree: 71% of patient returns on the three main agenda types are to Emotional agendas. Patients are demonstrating very clearly that they have much unfinished business in the emotional domain. Insofar as a following is more likely than not to result in a following (but to a lesser extent than is the case for Physical agendas) and insofar as patients initiate a lot of Emotional concerns, it suggests that if doctors allow patients to initiate Emotional agendas *in their own* way, patients will follow on. Doctors also return to Emotional agendas to a high degree, though when compared to patients they proportionately return more often to Physical agendas than to Emotional agendas. This suggests that some doctors are prepared to deal with Emotional agendas but perhaps in their own time - borne out by the increased frequency of Emotional agenda occurrence by doctors in the second half of the interview and by the low doctor follow rate for patient initiated Emotional agendas. It also suggests that some doctors recognise that there is unfinished business in the Emotional domain but, when compared to patients, preferentially return to Physical agendas. In terms of getting the doctor to follow an Emotional agenda, it 'pays' the patient to follow the doctor. Similarly, it pays the doctor to follow the patient, but it pays the doctor to return to an Emotional agenda rather than to initiate one in terms of obtaining a patient follow.

Both doctor and patient are more in tune when it comes to the social domain. Both initiate Social agendas to a comparable extent, both follow one another's Social agendas to the same degree, and both return to social topics similarly. Patients are much more likely to follow the doctor's initiation of a Social agenda than they are the doctor's initiation of an Emotional agenda, suggesting that patients are more comfortable with the social domain than the emotional domain. It almost always pays the doctor to engage in a Social agenda (whether it be initiating, returning or following) when it comes to patient following, whereas it most pays the patient to follow the doctor's previously raised Social agenda. However, unlike the emotional

domain, it pays the patient to initiate a Social agenda rather than to return to a Social agenda in terms of obtaining a doctor follow in the next floorholding.

The data thus show that in terms of the three dimensions described in Chapter 3, both doctor and patient are balanced in terms of perspective and influence when it comes to Physical agendas. Doctor and patient perspective is far less balanced when it comes to the emotional domain. Patients bring a lot of emotion to the interview, and are active in returning to emotional topics. Doctors do concede the salience of Emotional agendas but in a limited way. They are more in control of the consultation when it comes to emotional considerations, but not wholly in control since the patients seem to be more hesitant to follow a doctor's initiation, to follow a doctor's follow, or to follow a doctor's return, than is the case in the other two principal domains. It may be, of course, that in following the patient or in returning to a previously raised Emotional agenda doctors are satisfying the requirements of that agenda in some measure. But this can only partially be the case because, of the very high level of returns to Emotional agendas by patients, only about a third are subsequently followed by doctors. That Emotional agendas prompt much more of a mismatch in terms of doctor and patient perspective and influence within the consultation, shows that there is unease when it comes to addressing the wider issues engendered by emotional topics. Doctor and patient perspective and influence are intermediately balanced in the Social domain. Both doctor and patient seem to concede the relevance of the social perspective, and doctors seem more comfortable than patients in this domain. Doctors are nevertheless more in control of the consultation than patients, but in terms of following one another both parties seem to be a little happier with the presence of social issues in the interview than they are with the presence of emotional issues. However, the pay off for patients initiating a Social agenda in terms of obtaining a doctor following in the next floorholding is still some way below the 90 percent pay off obtained when patients initiate a Physical agenda.

To summarise: overall, doctors in the present sample have more influence within the general practice interview than do patients. This is shown by the higher level of patient following of doctor initiations, follows and returns on all principal agendas. However within

the emotional domain, although balance of power still rests with the doctor, patients appear to wield more influence. This is demonstrated by the lower level of patient following in this domain when compared to patient following in the physical and social domains. When it comes to establishing a debate (demonstrated by the establishing of sequences of follows on any given agenda) it would seem that Physical agendas respond best to direct discussion while cue following is preferable for Emotional agendas. Both doctor and patient are happy with the physical domain, but each appears less certain about the presence of emotional and social issues within the consultation. This is shown by the mismatches and non-responding which occurs between doctor and patient in the last two agenda types. Returning to an agenda may be seen as qualitatively different for patients and for doctors. For patients it represents unfinished business - a need to engage or re-engage the doctor on a topic that has not sufficiently been aired. For doctors it may represent rather the sense that they have time to discuss the agenda to which they are returning. This is borne out by our data which show that doctors return to Emotional agendas more in the latter part of the interview (64 percent of doctor returns to Emotional agendas occurred in the second half of the interview, compared to only 47 percent of patient returns to Emotional agendas). This squares with the findings of Roland et al (1986) who found that in consultations booked at 7.5 minute intervals doctors did not spend so much time explaining the patient's problem, discussing proposed management, or on health promotion as in consultations booked at 10 minute intervals. That patients return to Emotional agendas to a very high degree in our sample demonstrates that there is much emotional material they wish to discuss which has not sufficiently been addressed. For doctors to acknowledge this earlier in the interview may result in more satisfied patients and not necessarily in longer consultations.

There may also be evidence of a mutual process of somatisation of emotional problems by doctor and patient. Somatisation has been described as the way in which patients come to seek medical help for bodily symptoms misattributed by them to organic disease (Murphy, 1989). Goldberg & Bridges (1988) add two further criteria to define somatisation as it is found in British general practice attenders; psychiatric disorder shown by standardised interview, and

the likelihood that treatment of the disorder would reduce the physical symptoms. Past studies have tended to address patient characteristics and presentation of somatisation to the exclusion of the doctor. However, it is possible that the way in which the doctor is perceived and perceives himself will mediate in some measure the extent to which psychosocial distress is presented to the doctor by the patient (Dale & Middleton, 1989; Verhaak, 1986; Tuckett et al, 1985). A recent commentary suggests that to adopt a discrete diagnostic entity for somatisation disorder such as that laid out in DSM-III-R, is to obscure the doctors contribution to the process of somatisation. The theoretical shift towards viewing somatisation as a process rather than a category can be helpful both in prevention and treatment (Smith et al, 1986; Murphy, 1989). Much research has been done to claim somatisation as a disease entity. Less has been done to demonstrate the way in which it may also be perceived as a process of attribution involving both doctor and patient (Grol et al, 1988).

In the present study, patients almost always respond to the doctors open question ("What can I do for you ?") at the beginning of the consultation with a Physical agenda. This may suggest that patients perceive a Physical agenda as the most acceptable way to commence the interview, perhaps 'legitimising' their presence in the surgery. Of course for many patients attending a general practice surgery, a physical complaint may be the primary reason for attending. However, as noted below, research also demonstrates that a substantial proportion of patients present to the G.P. with underlying psychiatric disorder. The view put forward by Pickering (1989), that general practitioners should "consistently rebut rather than reinforce the notion that non-medical need is part of (their) domain", persists with a number of doctors. Indeed the data suggest that doctors are more comfortable with Physical agendas: they spend a great proportion of the interview dealing with Physical agendas, and are more likely to follow the patient's Physical agendas than their Emotional or Social agendas even where the patient has already followed the doctor in the previous floorholding. Doctors appear to be less comfortable with Emotional agendas: they initiate far fewer of them than patients, and return to Emotional agendas far less. The data suggest that Social agendas are more acceptable to doctors than Emotional agendas, in that doctors initiate Social agendas to a comparable degree to

patients. Social considerations perhaps present something more tangible and accessible to the doctor than emotional concerns. In this respect Social agendas represent an intermediary topic in the interview between the physical and emotional domains.

Somatisation is one of the most common ways for psychiatric disorder to present itself, and high levels of psychiatric morbidity have been demonstrated in primary care (Goldberg & Huxley, 1980). Goldberg & Bridges (1988) found that when applied to all new episodes of illness, the criteria for somatisation were fulfilled by approximately 20 percent of patients. Only 5 percent of patients, in contrast, consulted the general practitioner specifically for psychological complaints. Manu et al (1988) found that in two thirds of cases of patients presenting with chronic fatigue, psychological disorder seemed to be implicated. The present study shows that in fact patients bring a lot of emotion to the general practice consultation. Patients are quite active in their demonstration of emotional concerns. They initiate a lot of Emotional agendas, and return to Emotional agendas to a high degree. Goldberg & Bridges (1988) have hypothesised that somatisation allows patients who are unsympathetic to emotional disturbance nevertheless to play the sick role, and that somatisation helps the patient to avoid blame for their predicament. The author does not doubt this, but propose the possibility that for whatever reason similar mechanisms may operate within the doctor. It may be that doctors who feel inadequate to deal with the patient's psychosocial problems unwittingly contribute to the somatisation process by colluding with the patient who focuses on the physical domain. A recent study shows that G.P.s were less satisfied with the consultation than their patients, particularly in terms of their ability to assess and treat patients, communicate with them, and allow patients time to express aspects of psychological ill health (Rashid et al, 1989). Studies have also shown that medical staff may acknowledge psychiatric or emotional disturbance in only a small proportion of those patients they recognise as having them (Sensky et al, 1985; 1989). Additionally, general practitioners are not always sure how much weight they should place on stress factors, individual symptoms, or personality variables (Anonymous, 1988). Indeed the ICD-9 frustrates the doctor's attempt to address the 'whole' person by lack of more

than one axis for the diagnosis of illness in adults. Psychosocial categories are consigned to chapter 16, 'Signs, Symptoms and Ill Defined Conditions' (Sharp & King, 1989).

Several workers have discussed the most appropriate means for G.P.s to detect somatisation disorder (Goldberg et al, 1980; 1988; Wright, 1990; Nabarro, 1984). Porter & Gorman (1989) propose three alternatives: reduction in list size, attachment of appropriately trained counsellors to the primary care team, and standardised screening questionnaires. These questionnaires may address psychiatric, psychosocial, and health screening concerns. It could be argued that to give the doctor a questionnaire to identify either somatisation disorder or other psychological distress, is to provide him with a way of identifying the patient's Emotional agenda. The data in this chapter suggest the view that patients are able to express their emotional concerns, and that it is the doctor who is less able or willing to identify observable emotional considerations which are presented in the normal course of the interview. To give the doctor a questionnaire to use in the emotional domain is to provide the doctor with a technique. Questionnaires have their appropriate place as validating instruments (Davenport et al, 1987; Goldberg & Bridges, 1988; Goldberg & Huxley, 1992). The more effective way of identifying patients' Emotional agendas, however, may be to train G.P.s both in cue recognition and how to use the problem solving skills they already possess in emotional areas to enable patients to reattribute physical symptoms for which no cause can be found and which are accompanied by symptoms of an anxiety state and/or depressive illness (Gask, Boardman & Standart, 1991). This will be discussed further in Chapter 8.

To focus on the patient's Physical agenda, then, is to avoid the problem of dealing with the patients' emotional or social concerns. For example, Goldberg et al (1993) report that the dependent variable in doctor behaviour which leads to increased cue emission in patients in the patient-led consultation. Building on work which compares the activity of general practitioners to detect patients with high scores on the General Health Questionnaire (G.H.Q., Goldberg & Huxley, 1992), they rated trainees interviewing four patients with low G.H.Q. scores, and four patients with high G.H.Q. scores. They confirmed earlier findings that trainees who are able identifiers of psychological distress (high II doctors) are more likely to offer information,

advice and treatment (Millar & Goldberg, 1991), and with less urgency, than doctors less able to identify emotional distress (low II doctors). More significantly, they demonstrated that the same medical behaviour can be associated with cue release in patients with one group of doctors, but not with others. For example, asking closed questions can lead to decreased patient cue emission among low II doctors, but that high II doctors appear to be able to ask these questions without sacrificing patient cues that allow them to be good detectors of psychological distress. The usefulness of a medical behaviour will depend on the strategy that the doctor is following in displaying his behaviour. Thus, a question about events at home (a directive Social question) in the context of exploring a resent mood disorder (Emotional agenda) may lead to further disclosures, whereas the same question inserted aimlessly in an interview which appears to the observer to be leading nowhere, does not achieve the same effects. Goldberg et al (1993) point out that if questions are asked to complete gaps in the doctor's knowledge towards the end of a sequence of directive questions related to mood disorders, they are likely to be more effective than if they are included in a stereotyped routine of closed questions fired at the patient at the beginning of the consultation. These findings are consonant with the data presented in this chapter and confirm the findings of Davenport et al (1987) which show that doctors with low identification indices somehow suppress expression by patients of verbal and vocal cues.

In summary, then, seventy-three general practice consultations were analysed using the method of interaction analysis described by Butler et al (1990; 1991). Three principal agendas were described in detail; Physical, Emotional and Social. Overall the most frequently occurring agenda type was Physical. Patients initiated far more Physical agendas than doctors and both doctor and patient followed one another to a high degree when Physical agendas were raised. That patients initiated the majority of Physical agendas reflected the way in which doctors and patients behave in the G.P. setting: at the beginning of the consultation doctors tended to ask how they might help and patients would usually respond by initiating a Physical agenda. There was also a low rate of returning to Physical agendas by both parties. Patients used many more Emotional agendas than doctors and were more likely to initiate Emotional agendas. Patients

more frequently followed doctors on Emotional agendas, though doctors were most likely to follow patients if the patient had previously followed the doctor. Both doctor and patient initiated a similar number of Social agendas and patients were more likely to follow doctors than doctors to follow patients. As with Emotional agendas, although to a less marked degree, doctors were more likely to follow the patient if the patient had already followed the doctor. If the patient wishes to get the doctor to follow an Emotional or Social agenda, it appears that it 'pays' the patient to follow the doctor in the previous floorholding. These results suggest that the doctor can give validity to the patients Emotional and Social agendas by following and being responsive to them.

CHAPTER 4 APPENDIXCORRELATIONS OF DOCTOR AND PATIENT INITIATIONS, FOLLOWS, RETURNS AND NON-FOLLOWS FOR PRINCIPAL AGENDAS

Chapter 4 has been concerned with the sequential analysis of the doctor-patient consultation, and has examined the interview as a whole. Correlations of doctor and patient behaviours in respect of principal agendas, in contrast, give a feel for the climate of the interview. Generally there is a negative correlation between Initiations by either party. This is most marked for Emotional agendas (table 4.A). Thus the number of initiations of Emotional agendas correlates negatively with the number of initiations of Emotional agendas by the other party. the more Emotional agendas the patient initiates, the fewer Emotional agendas the doctor initiates, and vice versa. The same is true for Physical and Social agendas although to a lesser extent. Only the negative correlation for Emotional agendas is statistically significant at $r = -0.38$. Examination of followings shows very strong positive correlations between the number of followings and agenda type (table 4.B). The more the doctor follows Emotional agendas, therefore, the more the patient follows Emotionaal agendas and so on for both Physical and Social agendas. Following begets following as sequences build up. The strongest association is for Physical agendas but all three agenda types are highly significant.

Table 4.A: Correlations of doctor and patient initiations of the three principal agendas. The calculations have been corrected for the number of floorholdings in the interviews.

		Dr Initiations		
		Emotional	Physical	Social
Pt	Emotional	-0.38 **		
Initiations	Physical		-0.29	
	Social			-0.18

** $p < 0.01$

Table 4.B: Correlations of doctor and patient followings of the three principal agendas. The calculations have been corrected for the number of floorholdings in the interviews.

		Dr Followings		
		Emotional	Physical	Social
Pt	Emotional	0.90 **		
Followings	Physical		0.93 **	
	Social			0.89 **

** $p < 0.01$

Generally initiations are not related either to doctor or patient returns for any agenda. However, there is a positive correlation for doctor initiations and doctor returns to Emotional agendas (Table 4.C). Patient initiating is not related either to doctor or patient returning. Doctor follows of Social agendas are correlated with both doctor and patient returns to the same agenda. So for those interviews in which the doctor follows the patient's Social agendas a lot, the patient tends to return to those agendas. Similarly, in those interviews in which the doctor does not follow Social agendas very much, the patient tends not to return to Social agendas once interview length has been accounted for. Patient following of Social agendas tends to be associated with doctor and patient returns to Social agendas. Therefore, if the patient follows a Social agenda the doctor is more likely to return to a Social agenda. Once again, this does not hold for Physical and Emotional agendas.

Table 4.C: Correlations of doctor and patient returns to the three principal agendas, with doctor and patient initiations and follows of the principal agendas. The calculations have been corrected for the number of floorholdings in the interviews.

		Dr Initiations		
		Emotional	Physical	Social
Pt	Emotional	-0.21		
Returns	Physical		0.13	
	Social			-0.21
Dr	Emotional	0.34		
Returns	Physical		0.04	
	Social			-0.11

** $p < 0.01$

		Pt Initiations		
		Emotional	Physical	Social
Pt	Emotional	0.22		
Returns	Physical		-0.08	
	Social			0.24
Dr	Emotional	-0.03		
Returns	Physical		0.18	
	Social			0.28

** $p < 0.01$

Contd...

Table 4.C: Correlations of doctor and patient returns to the three principal agendas, with doctor and patient initiations and follows of the principal agendas. The calculations have been corrected for the number of floorholdings in the interviews. (Contd.)

		Dr Follows		
		Emotional	Physical	Social
Pt	Emotional	0.12		
Returns	Physical		-0.27	
	Social			0.41
Dr	Emotional	-0.03		
Returns	Physical		0.18	
	Social			0.63 **

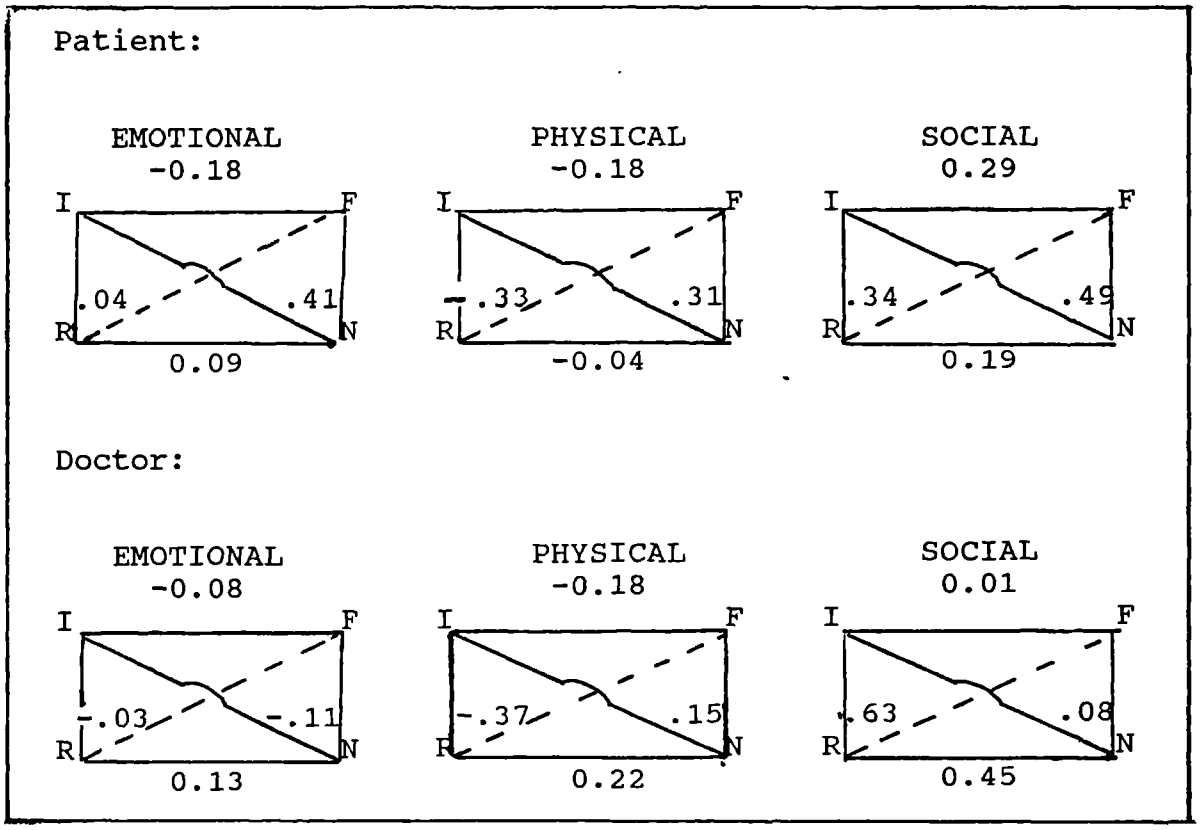
** $p < 0.01$

		Pt Follows		
		Emotional	Physical	Social
Pt	Emotional	0.04		
Returns	Physical		-0.30 *	
	Social			0.34 *
Dr	Emotional	0.13		
Returns	Physical		-0.07	
	Social			0.71 **

** $p < 0.01$

Figure 4.A shows agenda 'paths' for doctor and patient standardised by length of interview (defined as number of floorholdings). The most striking result here is that for all three principal agendas initiation of the agenda in question correlates with the subsequent non-following by the patient of the same agenda. This is not the case for doctors. Aside from the correlations between initiations and non-following, the only significant correlations for patients are between following of Social agendas and returns to Social agendas. The pattern of the correlations for doctors vary between the agenda types. For Emotional agendas the only significant correlation is between initiations and returns (Table 4.C). Physical agendas show significant negative correlations between follows and returns. In the social domain significant positive correlations are shown between returns and non-follows and between follows and returns.

Figure 4.A: Agenda 'paths' for each participant in the consultation. (Correlation coefficients are standardised according to length of interview). All correlations over 0.30 are statistically significant. For correlations of Initiations with Returns and Initiations and Follows see Table 4C.



These figures show the correlations between various doctor and patient behaviours for different agendas. For example taking Patient Emotional agendas (i), tne correlation between initiation and following is r=-0.18, that between following and returns is r=0.04, that between initiation and non-following is r=0.41, and the correlation between returns and non-follows is r=0.09. The remaining tables are interpreted in the same manner.

These correlations seem to show a lack of doctor and patient reciprocity in the emotional domain. Patient initiating of Emotional agendas does not encourage the doctor to initiate in the emotional domain. Indeed the reverse is true. Although following begets following in all domains, patient returns are not significantly associated with doctor or patient initiating or following in the emotional domain. That patient initiating of all principal agendas correlates with patient non-following of all principal agendas, indicates that patients paradoxically raise and block agendas.

Patients initiating in the physical and social domains does not inhibit doctor initiating in these domains to the same extent as with Emotional agendas. Following begets doctor following, and patient following of Social agendas seems to encourage both parties to return more often to this domain. Although there is a correlation between patient following and returning to the social domain, there continues to be the association between patients' initiating Social agendas and not following Social agendas.

Doctors, like patients, follow follows, and doctor follows of Social agendas correlate with doctor and patient returns to this domain. Later analysis will show that doctors do not problem solve to any great extent in the social domain, and this association may suggest that when doctors do follow Social agendas they do so about a social consideration they feel able to handle and therefore return to that agenda later in the interview. Once doctors have followed Social agendas, patients return to them perhaps hoping that the doctor will help them to find a solution to a social concern.

Correlations provide an indication of sensitive areas in the consultation. Greater sensitivity is shown in the emotional and social domains than the physical domain. Analysis continues to highlight the way in which these domains behave differently.

CHAPTER 5 : ACUTE VERSUS CHRONIC PRESENTATIONS OF PRINCIPAL AGENDAS

A. RATIONALE.

B. AGENDA OCCURRENCE.

C. AGENDA INITIATIONS.

D. AGENDA FOLLOWING.

E. AGENDA RETURNS.

F. TIMING OF AGENDAS.

G. ACUTE VERSUS CHRONIC CLASSIFICATION: PAY OFF FOR AGENDAS.

H. ACUTE VERSUS CHRONIC CLASSIFICATION: MEAN RATES OF DOCTOR AND PATIENT BEHAVIOUR ACCORDING TO PRINCIPAL AGENDAS.

I. ACUTE VERSUS CHRONIC CLASSIFICATION: DISCUSSION.

A. RATIONALE

There is some evidence to suggest that patients who present with more serious medical problems may meet with more problematic consultations. This is inferential to the extent that studies which have looked at doctor satisfaction have shown that doctors tend to be more satisfied with the consultation when they are dealing with patients who present with medical problems to which the solution is clear (Winefield & Murrell, 1991; Buijs et al, 1984). It could be argued that patients who present with serious or chronic illness are more likely to have psychosocial concomitants to their illness which will interfere with the doctor's perception of straightforward medical management. Doctors are also less satisfied with consultations in which psychosocial factors are predominant. Pendleton et al (1983) found that the most powerful predictors of difficulty in the doctor-patient interviews was tension in doctors and perceived tension in patients. Almost always the doctors attributed the source of difficulty externally. In two studies Pendleton et al found that approximately one in four consultations contained some communication difficulty for the doctors. It is again arguable that doctors may respond to type of patient presentation, and indeed these investigators found a significant relationship between the seriousness of a problem and the difficulty in the consultation medically. Tension in both parties makes the consultation more difficult and doctors may perceive this as emotional interference by the patient. The question therefore arose as to whether the patterns that had been found in the analysis so far presented would be sustained if the data were examined according to patient presentation.

Tuckett et al (1985) point out that as part of providing primary care, general practice consultations by their nature deal with a varied set of problems, and that patients attending the surgery are inevitably at different stages of care. They identify six broad categories to subsume patients' reasons for attending the general practitioner. A small number will be seeing a given doctor for the first time, a larger but still relatively small group will be attending with 'new' problems, a far greater proportion will be coming with a new episode of an 'old' problem, and still more will be visiting to report progress on an ongoing episode. Some patients will be presenting their problem only because they need a certificate of absence from work or other

certification, and others will be visiting the doctor in his capacity as controller of a given resource (such as contraception or vaccination).

There are a number of ways in which to categorise the nature of the presenting problem. For example, one way might have been to classify according to the International Classification of Diseases, and this was considered. The idea was rejected on the grounds that it was unlikely that doctors would show much variance between anatomical subdivisions. Another possibility was to categorise according to the unpublished work of Brown & Harris (1978). This is a system used for the classification of events and difficulties experienced by women. The difficulties section in particular classifies in a way which lends itself to the concepts underlying the present system of interactional analysis. Whereas 'events' in the Brown & Harris system are occurrences which are fixed in onset and which have a short course, 'difficulties' are problems which have a longer duration. Difficulties are subdivided into three groupings. These are health of the subject, health of other, and non- health. The first two are further subdivided to include housing, finance, role and interaction and other. There are clear similarities between these classifications and the present system's definitions of Physical, Social and Emotional agendas (see Rules for Coding, Chapter 3).

In an attempt to define the general practitioner and to describe his work, James Knox (1984) proposes the idea of a 'triage'. He notes that approximately 60 percent of patients seen by himself in an eleven month period presented with 'minor' conditions. Apparent minor conditions which may appear trivial, can be categorised according to five classifications. These include single minor complaints; the "Mary Jane" phenomena (where a patient, usually a child, is an index of a disturbed family); collateral problems (where the patient presents with a surface agenda only to reveal the 'true' agenda as a "By the way, while I'm here" question), and recidivist (patients who are characterised by the disproportionately large volume of work they generate for the doctor by repeatedly reopening issues which the doctor has attempted to close). There are also some major diseases which present as apparently minor problems.

In the present study the work of both Brown & Harris and Knox informed the decision to classify the nature of the presenting problem according to Acute versus Chronic

presentation. Each of these were initially to be subdivided according to major and minor. The worry here, however, was that Chronic may reflect the nature of the individual rather than the nature of the problem, and that general practitioners would tend not to see Acute major or Chronic minor problems. It was eventually decided, therefore, to classify according to the more parsimonious groupings of Acute and Chronic, but to categorise each according to agenda type. To classify in this way had the advantage of broadly retaining Tuckett et al's distinctions (cited above) but of incorporating the observations of Brown & Harris, and Knox.

Chronic problems were considered to be agendas of extended duration (over four weeks) which may have been present for a long time. Alternatively agendas of relatively short duration but where the prognosis is of a prolonged duration. Typically, but not necessarily, Chronic problems are of insidious onset. If a problem fulfilling these criteria gives rise to a complication or symptom which has a short duration and/or prognosis, then this last complication will be defined as an Acute agenda.

Acute problems were considered to be agendas of short duration where the prognosis is one of a rapid recovery or resolution. Where a problem is Chronic in nature but gives rise to a complication or symptom of short duration, then the complication or symptom will be defined as Acute. Acute problems will typically be of definite onset.

Further categorisation is set out in the Rules for Coding (Appendix F).

B. AGENDA OCCURRENCE

In the majority of interviews the patient presented with an Acute Physical problem, which squares with the observations of Tuckett et al (1985) referred to above (see tables 5.1 and 5.2). About a quarter of patients presented with a Chronic Physical agenda. Only six interviews began with an Acute Emotional problem and only two interviews commenced with a Social agenda. There was in fact one interview in which the presenting problem was Acute Social, and one interview in which the presenting problem was Chronic Social. For purpose of analysis Acute and Chronic Social agendas are therefore considered together and Acute Emotional presentations are referred to simply as Emotional presentations throughout. Table

5.3 shows the nature of the presenting problems for interviews in the present sample. In all cases where numbers are low caution should be used in making generalisations.

Table 5.1: Frequency of initiations (and percentage of total of all initiations) for principal agendas distributed by doctor and patient, for different presenting problems.

Acute Physical

	Emotional	Physical	Social	Open	Total initiations for all agendas
Doctor	14 (8%)	4 (2%)	28 (16%)	49 (28%)	174
Patient	41 (22%)	56 (30%)	25 (13%)	1 (1%)	186

Chi-square=102.67 $p<0.001$

Chronic Physical

	Emotional	Physical	Social	Open	Total Initiations for all Agendas
Doctor	1 (2%)	2 (4%)	9 (16%)	17 (31%)	55
Patient	16 (20%)	18 (22%)	16 (20%)	1 (1%)	82

Chi-square=39.12 $p<0.001$

Acute Emotional

	Emotional	Physical	Social	Open	Total Initiations for all Agendas
Doctor	1 (6%)	2 (12%)	1 (6%)	8 (47%)	17
Patient	5 (13%)	5 (13%)	8 (20%)	0 (0%)	40

Chi-square=16.87 $p<0.001$

Social

	Emotional	Physical	Social	Open	Total Initiations for all Agendas
Doctor	0 (0%)	0 (0%)	1 (17%)	3 (50%)	6
Patient	2 (9%)	4 (18%)	3 (14%)	0 (0%)	22

Chi-square=9.48 $p<0.05$

Table 5.2: Initiations of principal agendas by Doctor and Patient by chronic versus acute classification.

(Figures in brackets are number of initiations per interview, that is frequency divided by number of interviews).

	PHYSICAL			EMOTIONAL	
	Dr	Pt		Dr	Pt
Acute Physical	4 (0.08)	56 (1.17)		14 (0.29)	41 (0.85)
Chronic Physical	2 (0.11)	18 (1.06)		1 (0.06)	16 (0.94)
Acute Emotional	2 (0.33)	5 (0.83)		1 (0.17)	5 (0.83)
Social	0 (0.00)	4 (2.00)		0 (0.00)	2 (1.00)
	Chi^2= 4.18 ns			Chi^2 = 3.68 ns	

	SOCIAL	
	Dr	Pt
Acute Physical	28 (0.58)	25 (0.52)
Chronic Physical	9 (0.53)	16 (0.94)
Acute Emotional	1 (0.17)	8 (1.33)
Social	1 (0.50)	3 (1.50)
	Chi^2 = 6.86 ns	

Table 5.3: Nature of presenting problems for interviews.

Nature of presenting problem	Number of Interviews
Acute Physical	48 (65.8%)
Chronic Physical	17 (23.3%)
Acute Emotional	6 (8.2%)
Social (Acute & Chronic)	2 (2.7%)
Total	73 (100%)

The nature of the presenting problems broken down by G.P. is shown in table 5.4. Six doctors saw patients who presented with problems other than Acute or Chronic Physical. These doctors all contributed more consultations to the sample than their colleagues who saw patients presenting with only Acute or Chronic Physical agendas. This demonstrates the need for longer and controlled numbers of consultations per doctor in order for the sample to be more representative. It is not possible, in a sample of this size to determine whether the differences in the nature of the presenting problem between doctors is a result of patients seeking out a particular doctor style.

Table 5.4: Nature of presenting problem broken down by G.P.

G.P. Code	1	2	3	4	5	6	7	8	9	10
Acute Physical	3	4	3	4	3	7	5	3	8	8
Chronic Physical	0	1	3	0	3	2	2	3	2	1
Acute Emotional	0	1	0	0	0	0	2	2	0	1
Social	0	0	0	0	0	1	0	0	1	0
Total	3	6	6	4	6	10	9	8	11	10

The frequency and percentage of floorholdings containing principal agendas, distributed by doctor and patient, for different presenting problems, is shown in table 5.5. The pattern differs from the main analysis in that there, although both parties spent most time in the physical domain, patients spent slightly less time than doctors. Both parties were well matched in the social domain and patients spent about twenty-five percent more time in the emotional domain than doctors. When the data are examined according to the nature of the presenting problem it can be seen that patients spend almost twice as much time as doctors in the emotional domain when the presentation is Chronic Physical. They also spend approximately a third more time than doctors in the emotional domain when the presentation is Acute Emotional. Patients spend more time than doctors in the physical domain when the presentation is either Acute Emotional

or Social, representing a reversal of the main pattern of analysis, and spend about a third more time than doctors in the social domain when the presentation is social.

Table 5.5: Frequency and percentage of floorholdings (row percentages) containing principal agendas distributed by doctor and patient, for different presenting problems. (N.B. percentages may total over 100%, since a floorholding may have more than one agenda).

Acute Physical

	Emotional	Physical	Social	Total No. of Floorholdings
Doctor	260 (20%)	1053 (80%)	170 (13%)	1323
Patient	383 (29%)	1073 (81%)	186 (14%)	1319

Chi-square=16.39 $p<0.01$

Chronic Physical

	Emotional	Physical	Social	Total No. of Floorholdings
Doctor	64 (12%)	459 (88%)	81 (16%)	521
Patient	118 (23%)	460 (89%)	87 (17%)	516

Chi-square=13.34 $p<0.01$

Acute Emotional

	Emotional	Physical	Social	Total No. of Floorholdings
Doctor	62 (36%)	115 (66%)	38 (22%)	173
Patient	85 (50%)	120 (71%)	47 (28%)	169

Chi-square=1.74 ns

Social

	Emotional	Physical	Social	Total No. of Floorholdings
Doctor	8 (14%)	34 (60%)	19 (33%)	57
Patient	8 (15%)	41 (77%)	29 (55%)	53

Chi-square=0.67 ns

C. AGENDA INITIATIONS

Table 5.1 shows that for Physical presentation the patterns of doctor and patient initiation throughout the interviews are broadly similar to the main analysis. Patients subsequently initiate significantly more than doctors irrespective of presenting problem. However, on closer inspection some differences become apparent. In the Acute Emotional presentation, patients initiate proportionately twice as many Emotional agendas as doctors, but Physical initiation is well matched by both parties (12% doctors: 13% patients). This contrasts with other presentations where the patient always initiates more than the doctor in the physical domain. Where the presentation is Chronic Physical, patients initiate about ten times more than doctors in the emotional domain but when the presentation is Acute Physical, patients initiate only about three times more than doctors in the emotional area. In the social domain, patients initiate slightly more than doctors when the presentation is Chronic Physical, but this pattern is reversed when the presentation is Acute Physical. Table 5.2 shows that when a comparison is made between the different presenting problems and how doctor and patient handle the principal agendas, there is no statistically significant difference between them.

D. AGENDA FOLLOWING

The frequency of following of principal agendas distributed by doctor and patient for differing presenting problems can be seen in table 5.6. The pattern here is more or less the same as in the main analysis: following the other party's agenda seems to beget following. The slight (but non significant) differences lie in the Acute Emotional and Social presentations where doctors follow patients slightly more in the social domain, and in the Social presentation where patients follow doctors slightly more. Doctors also follow patients more in the emotional domain when the presentation is Social.

Table 5.6: Frequency of following (and percentages of total follows for principal agendas) of principal agendas distributed by doctor and patient, for different presenting problems.

Acute Physical

	Emotional	Physical	Social	Total	Total Follows for all Agendas
Doctor	172 (13%)	1001 (77%)	124 (10%)	1297	1413
	*(12%)	*(71%)	*(9%)	*(92%)	
Patient	183 (14%)	988 (76%)	137 (10%)	1308	1424
	*(13%)	*(69%)	*(10%)	*(92%)	

Chi-square=1.02 ns

Chronic Physical

	Emotional	Physical	Social	Total	Total Follows for all Agendas
Doctor	43 (8%)	447 (81%)	64 (12%)	554	587
	*(7%)	*(76%)	*(11%)	*(94%)	
Patient	42 (8%)	437 (81%)	61 (11%)	540	573
	*(7%)	*(76%)	*(11%)	*(94%)	

Chi-square=0.02 ns

Acute Emotional

	Emotional	Physical	Social	Total	Total Follows for all Agendas
Doctor	53 (28%)	106 (55%)	32 (17%)	191	205
	*(26%)	*(52%)	*(16%)	*(93%)	
Patient	57 (29%)	110 (56%)	28 (14%)	195	206
	*(28%)	*(53%)	*(14%)	*(93%)	

Chi-square=0.44 ns

Contd ...

Table 5.6: Frequency of following (and percentages of total follows for principal agendas) of principal agendas distributed by doctor and patient, for different presenting problems. (Contd.)

Social

	Emotional	Physical	Social	Total	Total Follows for all Agendas
Doctor	4 (8%)	31 (60%)	17 (33%)	52	57
	*(7%)	*(54%)	*(30%)	*(91%)	
Patient	2 (4%)	30 (60%)	18 (36%)	50	53
	*(4%)	*(57%)	*(34%)	*(94%)	

Chi-square=0.67 ns

* Percentage of Total follows for all agendas

Table 5.7 shows that there are no significant differences between doctor and patient follows when a comparison is made between the different presenting problems.

Table 5.7: Follows of principal agendas by Doctor and Patient by Chronic versus Acute classification. (Figures in brackets are number of follows per interview, that is frequency divided by number of interviews).

	PHYSICAL		EMOTIONAL	
	Dr	Pt	Dr	Pt
Acute Physical	1001 (20.8)	988 (20.6)	172 (3.58)	183 (3.81)
Chronic Physical	447 (26.3)	437 (25.7)	43 (2.53)	42 (2.47)
Acute Emotional	106 (17.7)	110 (18.4)	53 (8.83)	57 (9.50)
Social	31 (15.5)	30 (15.0)	4 (2.00)	2 (1.00)
	$Chi^2 = 0.16$ ns		$Chi^2 = 0.91$ ns	

	SOCIAL	
	Dr	Pt
Acute Physical	124 (2.55)	137 (2.85)
Chronic Physical	64 (3.76)	61 (3.59)
Acute Emotional	32 (5.35)	28 (4.67)
Social	17 (8.50)	18 (9.00)
	$Chi^2 = 0.91$ ns	

E. AGENDA RETURNS

Table 5.8 shows the frequency of returns for principal agendas distributed by doctor and patient for different presenting problems. In the main analysis patients returned to Emotional agendas more than doctors whereas doctors returned more to Physical agendas. Both parties were matched in their returns to Social agendas. When the frequency of return for principal agendas is examined according to presenting problem, some differences emerge. Patients

continue to return to the emotional domain a lot more than doctors (more than twice as much as doctors when the presentation is Acute Physical, and three times as much as doctors when the presentation is Chronic Physical), but doctors and patients return to the emotional domain comparably (to the extent that the comparison is not statistically significant) when the presentation is emotional. When the presentation is Social doctors return to the emotional domain twice as much as patients. Patients, conversely, return more than twice as much as doctors in the social domain. When there is a Chronic Physical presentation the doctor returns to the physical domain four times more than the patient. When the presentation is social, the pattern differs from the main analysis in that patients return both to Emotional agendas and to Social agendas twice as much as doctors.

Table 5.8: Frequency of returns (and percentage of total of returns for principal agendas) for principal agendas distributed by doctor and patient, for different presenting problems.

Acute Physical

	Emotional	Physical	Social	Total	Total Returns for all Agendas
Doctor	74 (53%)	48 (34%)	18 (13%)	140	159
	*(47%)	*(30%)	*(11%)	*(88%)	
Patient	159 (75%)	29 (14%)	24 (11%)	212	235
	*(68%)	*(12%)	*(10%)	*(90%)	

Chi-square=17.79 p<0.001

Chronic Physical

	Emotional	Physical	Social	Total	Total Returns for all Agendas
Doctor	20 (53%)	10 (26%)	8 (21%)	38	42
	*(48%)	*(24%)	*(19%)	*(90%)	
Patient	60 (80%)	5 (7%)	10 (13%)	75	82
	*(73%)	*(6%)	*(12%)	*(91%)	

Chi-square=10.95 p<0.01

Acute Emotional

	Emotional	Physical	Social	Total	Total Returns for all Agendas
Doctor	8 (40%)	7 (35%)	5 (25%)	20	22
	*(36%)	*(32%)	*(23%)	*(91%)	
Patient	23 (59%)	5 (13%)	11 (28%)	39	40
	*(58%)	*(13%)	*(28%)	*(98%)	

Chi-square=2.06 ns

Social

	Emotional	Physical	Social	Total	Total Returns for all Agendas
Doctor	2 (33%)	3 (50%)	1 (17%)	6	6
	*(33%)	*(50%)	*(17%)	*(100%)	
Patient	4 (25%)	7 (35%)	8 (40%)	19	22
	*(18%)	*(32%)	*(36%)	*(86%)	

Chi-square=3.35 ns

* Percentage of Total returns for all agendas

When a comparison is made between doctor and patient handling of principal agendas according to Acute and Chronic classification and according to returns to agendas there is once again no statistically significant difference (Table 5.9).

Table 5.9: Returns to principal agendas by Doctor and Patient by Chronic versus Acute classification. (Figures in brackets are number of returns per interview, that is frequency divided by number of interviews).

	PHYSICAL		EMOTIONAL	
	Dr	Pt	Dr	Pt
Acute P	48 (1.00)	29 (0.60)	74 (1.54)	159 (3.31)
Chronic P	10 (0.59)	5 (0.47)	20 (1.18)	60 (3.53)
Acute E	7 (1.17)	5 (0.83)	8 (1.33)	23 (3.83)
Social	3 (1.50)	7 (3.50)	2 (1.00)	4 (2.00)
	$Chi^2 = 4.20$ ns		$Chi^2 = 1.58$ ns	

	SOCIAL	
	Dr	Pt
Acute P	18 (0.38)	24 (0.50)
Chronic P	8 (0.47)	10 (0.59)
Acute E	5 (0.83)	11 (1.33)
Social	1 (0.50)	8 (4.00)
	$Chi^2 = 3.82$ ns	

F. TIMING OF AGENDAS

Table 5.10 shows that the number of floorholdings containing the principal agendas by half of interview for differing presenting problems does vary. There are a lot more patient floorholdings containing an Emotional agenda than doctor floorholdings containing an Emotional agenda in the first half of the interview when the presentation is Acute Physical. Both doctor and patient increase the amount of time spent in floorholdings containing a Social agenda in the second half of the interview when there is an Acute Physical presentation. These patterns are more or less repeated for the Chronic Physical presentation. When the presentation is Acute Emotional both parties are more evenly distributed between the two halves of the

consultation in the emotional domain. The patients still spend more floorholdings than the doctor in the emotional domain, but the discrepancy between doctor and patient time in emotional floorholdings seen in the main analysis is not sustained. When the presentation is social, patients spend a lot more time than doctors in the physical domain in the second half of the interview.

Table 5.10: Number of floorholdings containing the principal agendas in each half of the interviews, for different presenting problems.

Acute Physical

	Half of Interview					
	1st	2nd	1st	2nd	1st	2nd
	PHYSICAL		**EMOTIONAL**		**SOCIAL**	
Doctor	527	526	86	174	66	104
Patient	555	518	180	204	75	113
	Chi^2=0.53 ns		Chi^2=11.61 p<0.001		Chi^2=0.03 ns	

Chronic Physical

	Half of Interview					
	1st	2nd	1st	2nd	1st	2nd
	PHYSICAL		**EMOTIONAL**		**SOCIAL**	
Doctor	226	233	25	39	27	54
Patient	238	222	70	48	35	52
	Chi^2=0.48 ns		Chi^2=6.04 p<0.05		Chi^2=0.59 ns	

Acute Emotional

	Half of Interview					
	1st	2nd	1st	2nd	1st	2nd
	PHYSICAL		**EMOTIONAL**		**SOCIAL**	
Doctor	56	59	29	33	16	22
Patient	60	60	45	40	24	23
	Chi2=0.01 ns		Chi2=0.33 ns		Chi2=0.37 ns	

Contd ...

Table 5.10: Number of floorholdings containing the principal agendas in each half of the interviews, for different presenting problems. (Contd.).

Social

	Half of Interview					
	1st	2nd	1st	2nd	1st	2nd
	PHYSICAL		**EMOTIONAL**		**SOCIAL**	
Doctor	19	15	2	4	6	13
Patient	25	65	3	5	10	19
	Chi^2=7.33 p<0.01		Chi^2=0.03 ns		Chi^2=0.04 ns	

G. PAY OFF FOR AGENDAS

When the 'pay-off' for the three principal agenda types is examined according to the nature of the presenting problem, it can be seen that both doctor and patient handle the principal agendas differently when a comparison is made with the main analysis. The 'pay-off', it will be remembered, is the likelihood of either party obtaining a follow in the next floorholding by the other party. This is assessed according to whether either party has initiated a principal agenda.

When Physical agendas are examined, it can be seen that they are handled by either party in much the same way as in the main analysis (Table 5.11). Both doctor and patient obtain a high proportion of follows irrespective of the presenting problem. There is one exception to this when the patient presents with a social problem. In this case the doctor follows the patient's Physical agenda rather less than in the main analysis. However, in spite of this reduction, doctor following of patient Physical agendas is still high.

Table 5.11: Frequency of Following and Non-Following in next floorholding broken down by nature of presenting problem - PHYSICAL agendas.

Each table shows a different presenting problem.

Acute Physical

		DOCTOR		**PATIENT**	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	4 (100%)	0 (0%)	50 (90.9%)	5 (9.1%)
Floorholding	Follow	934 (94.6%)	53 (5.4%)	919 (94.6%)	52 (5.4%)
	Return	37 (82.2%)	8 (17.8%)	25 (92.6%)	2 (7.4%)

Chronic Physical

		DOCTOR		**PATIENT**	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	2 (100%)	0 (0%)	17 (94.4%)	1 (5.6%)
Floorholding	Follow	435 (97.3%)	12 (2.7%)	424 (97.0%)	13 (3.0%)
	Return	8 (80%)	2 (20%)	5 (100.0%)	0 (0%)

Contd ...

Table 5.11: Frequency of Following and Non-Following in next floorholding broken down by nature of presenting problem - PHYSICAL agendas.
Each table shows a different presenting problem. (Contd.).

Acute Emotional

		DOCTOR		**PATIENT**	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	2 (100%)	0 (0%)	4 (80.0%)	1 (20.0%)
Floorholding	Follow	101 (95.5%)	5 (4.5%)	98 (89.0%)	12 (11.0%)
	Return	7 (100%)	0 (0%)	4 (80.0%)	1 (20.0%)

Social

		DOCTOR		**PATIENT**	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	0	0	2 (66.7%)	1 (33.3%)
Floorholding	Follow	29 (93.5%)	2 (6.5%)	21 (70.0%)	9 (30.0%)
	Return	3 (100%)	0 (0%)	6 (75.0%)	2 (25.0%)

Table 5.12 shows that Emotional agendas are handled by both doctor and patient in a very similar way to the main analysis when the presenting problem is Acute Physical. That is, doctors are followed less than for Physical agendas by patients, and doctors follow patients Emotional agendas far less than they follow their Physical agendas. In particular patient initiations of and returns to Emotional agendas are followed far less by doctors.

Table 5.12: Frequency of Following and Non-Following in next floorholding broken down by nature of presenting problem - EMOTIONAL agendas.
Each table shows a different presenting problem.

Acute Physical

		DOCTOR		**PATIENT**	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	6 (42.9%)	8 (57.1%)	9 (22.0%)	32 (68.0%)
Floorholding	Follow	132 (76.7%)	40 (23.3%)	103 (56.3%)	80 (43.7%)
	Return	45 (61.6%)	28 (38.4%)	57 (35.8%)	102 (64.2%)

Chronic Physical

		DOCTOR		**PATIENT**	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	1 (100%)	0 (0%)	4 (25.0%)	12 (75.0%)
Floorholding	Follow	29 (67.4%)	14 (32.6%)	18 (42.9%)	24 (57.1%)
	Return	12 (80%)	8 (20%)	25 (41.7%)	35 (58.3%)

Contd ...

Table 5.12: Frequency of Following and Non-Following in next floorholding broken down by nature of presenting problem - EMOTIONAL agendas.
Each table shows a different presenting problem. (Contd.).

Acute Emotional

		DOCTOR		**PATIENT**	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	1 (100%)	0 (0%)	4 (80.0%)	1 (20.0%)
Floorholding	Follow	49 (92.4%)	4 (7.6%)	98 (89.0%)	12 (11.0%)
	Return	7 (87.5%)	1 (12.5%)	4 (80.0%)	1 (20.0%)

Social

		DOCTOR		**PATIENT**	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	0	0	2 (66.7%)	1 (33.3%)
Floorholding	Follow	4 (57.1%)	3 (42.9%)	0 (0%)	2 (100%)
	Return	1 (50.0%)	1 (50.0%)	5 (83.3%)	1 (16.7%)

When the presenting problem is Chronic Physical it can be seen that patient follows of doctor follows of Emotional agendas are followed by doctors more in the main analysis. Doctors initiations are followed by patients 100 percent, but there is only one in the cell. Doctor returns to Emotional agendas are followed by patients more when the presenting problem is Chronic Physical than in the main analysis.

Doctor initiations, follows and returns to Emotional agendas are all followed more by patients when the presenting problem is Acute Emotional than is the case in the main analysis. Similarly patient initiations, follows and returns to Emotional agendas are all followed more by doctors. The doctors initiation of emotion is again followed 100 percent by the patient but again there is only one in the cell.

When the presentation is social, doctor follows of and returns to Emotional agendas are followed less by patients. However, patients' initiations of Emotional agendas are followed by doctors more, as are patient returns to Emotional agendas. There is no doctor following of patient following the doctors' Emotional agenda.

The 'pay-off' of obtaining a follow in the next floorholding by either party for Social agendas broken down by the nature of the presenting problem is shown in table 5.13. When the presentation is Acute Physical, the pay-off for both doctor and patient is broadly similar to the main analysis. The pay-off is likewise similar for the doctor when the presenting problem is Chronic Physical. Although the pattern is fairly similar for the patient, there is a slight difference in that doctors follow patient returns to Social agendas more when the presenting problem is Chronic Physical. (However there is a small number of observations, $n \approx 7$).

Table 5.13: Frequency of Following and Non-Following in next floorholding broken down by nature of presenting problem - SOCIAL agendas.

Each table shows a different presenting problem.

Acute Physical

		DOCTOR		**PATIENT**	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	27 (85.7%)	1 (14.6%)	12 (48.0%)	13 (52.0%)
Floorholding	Follow	94 (75.8%)	30 (24.2%)	101 (73.7%)	36 (26.3%)
	Return	15 (83.3%)	3 (16.7%)	12 (50.0%)	12 (50.0%)

Chronic Physical

		DOCTOR		**PATIENT**	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	8 (88.8%)	1 (11.2%)	10 (62.5%)	6 (37.5%)
Floorholding	Follow	47 (73.4%)	17 (26.6%)	47 (77.0%)	14 (23.0%)
	Return	7 (87.5%)	1 (12.5%)	7 (70.0%)	3 (10.0%)

Contd ...

Table 5.13: Frequency of Following and Non-Following in next floorholding broken down by nature of presenting problem - SOCIAL agendas.
Each table shows a different presenting problem. (Contd.).

Acute Emotional

		DOCTOR		**PATIENT**	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	1 (100%)	0 (0%)	6 (75.0%)	2 (25.0%)
Floorholding	Follow	24 (75.0%)	8 (25.0%)	17 (60.7%)	11 (39.3%)
	Return	3 (75.0%)	1 (25.0%)	9 (81.8%)	2 (18.2%)

Social

		DOCTOR		**PATIENT**	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	1 (100%)	0 (0%)	3 (100%)	0 (0%)
Floorholding	Follow	19 (95.0%)	1 (5.0%)	12 (66.7%)	6 (33.3%)
	Return	1 (100%)	0 (0%)	2 (25.0%)	6 (75.0%)

When the presenting problem is Acute Emotional, patient's following of doctors' Social agendas is roughly akin to the main analysis. However, patients' initiations of, and returns to, Social agendas are followed more by doctors when the presenting problem is social, but their following of the doctors' previous agenda is followed by the doctor less.

Patients handle Social agendas very much as they did in the main analysis when the presenting problem is also social. Doctors, in contrast, follow patient initiations of Social agendas much more than they did in the main analysis, but follow patients returns to Social agendas about 50 percent less than in the main analysis.

H. MEAN RATES OF DOCTOR AND PATIENT BEHAVIOURS

Table 5.14 shows the mean rates of doctor and patient behaviours in the three principal domains, broken down by the nature of the presenting problem.

The mean following rates of doctors and patients endure one another in a fairly balanced way. This is as would be expected both from the main analysis and from the follow rates of doctors and patients according to the nature of the presenting problem. In general following begets following. However, the standard deviation for patients' following of Physical agendas when the presenting problem is Acute Physical stands out as showing more variance than doctor or patient behaviour in any other domain or presenting problem.

Doctors' and patients' mean return rates show that patients return more in the emotional domain when the presentation is Acute Physical, whereas in the same presentation doctors tend to return slightly more in the physical domain. Also in the same presentation patients show a slightly enhanced standard deviation in the emotional domain. Patients again show a higher mean return rate to Emotional agendas when presentation is Chronic Physical, although their standard deviation in this domain and with this presenting problem is not as wide as it is with the Acute Physical presentation. When the presentation is emotional, patients demonstrate a higher mean return rate than doctors in the emotional domain, and also more variance in the standard deviation. Patients also show a wider standard deviation in the social domain, when the presentation is emotional, than doctors. With social presentations, patients have a higher

mean return rate in the emotional and social domain than doctors, and show a wider standard deviation than doctors in all three domains.

Doctor and patient initiations are difficult to compare because of the lower number of doctor initiations overall. However, there is a higher mean initiation rate for patients in the emotional domain when the presentation is Emotional, and a higher mean rate of patient initiating in all three domains when the presentation is Social. The latter are statistically significant. There higher rates are in comparison to other patient initiation across domain and presentation.

Doctors stand out as having a high mean rate of non- following in the emotional domain in Acute Physical, Chronic Physical and Emotional presentations. Given that doctors follow patients more in the emotional domain when the presentation is emotional in nature, their mean rate of non-following in this area is very high. Doctors additionally show a high mean non-following rate of Emotional and Social agendas when the presentation is Social, and patients show a very high mean number of non- follows in the emotional area when the presentation is social. These doctor and patient differences summed, according to principal agendas and following and non- following, are shown in Table 5.15. Significant results are demonstrated for doctor and patient following in the emotional domain, and for doctor and patient non-following in the physical domain.

Table 5.14: Mean rates of Doctor and Patient Initiations, Returns, Follows and Non-Follows, shown broken down by nature of presenting problem.
The rates are corrected for number of floorholdings:
e.g. No. of Dr Follows of E / No. of Dr Floorholdings
or No. of Pt Follows of E / No. of Pt Floorholdings

	Acute Physical		Chronic Physical		Emotional		Social	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
FOLLOWING								
Doctor Emotional	.087	.115	.081	.081	.310	.310	.180	.221
Doctor Physical	.774	.014	.858	.113	.591	.236	.549	.010
Doctor Social	.083	.116	.134	.114	.199	.125	.403	.216
Patient Emotional	.091	.125	.078	.083	.357	.308	.022	.031
Patient Physical	.787	.227	.844	.098	.628	.231	.590	.049
Patient Social .	.094	.130	.108	.093	.183	.133	.457	.238
RETURNS								
Doctor Emotional	.056	.062	.039	.042	.045	.039	.021	.030
Doctor Physical	.033	.036	.017	.022	.041	.028	.077	.050
Doctor Social	.012	.027	.015	.020	.027	.021	.056	.079
Patient Emotional	.103	.091	.119	.054	.141	.132	.147	.145
Patient Physical	.018	.027	.008	.016	.029	.029	.078	.110
Patient Social	.014	.026	.018	.025	.067	.054	.089	.130
INITIATIONS								
Doctor Emotional	.012	.026	.003	.012	.006	.015	0 0	-
Doctor Physical	.003	.010	.005	.015	.013	.021	0 0	-
Doctor Social	.022	.031	.017	.026	.007	.018	.010	.015
Patient Emotional	.036	.030	.032	.011	.030	.016	.074	.073
Patient Physical	.051	.028	.037	.015	.030	.016	.096	.041
Patient Social	.020	.032	.033	.026	.049	.024	.085	.057
NON-FOLLOWS								
Doctor Emotional	.145	.098	.138	.078	.209	.154	.042	.059
Doctor Physical	.041	.051	.027	.030	.083	.040	.170	.084
Doctor Social	.044	.050	.048	.045	.089	.041	.170	.084
Patient Emotional	.063	.076	.043	.037	.027	.037	.200	.250
Patient Physical	.047	.038	.027	.029	.029	.038	.074	.073
Patient Social	.025	.034	.036	.040	.053	.036	.063	.088

Table 5.15: Number of (a) Follows and (b) Non-Follows of Initiations, Follows and Returns (Summed) for different presenting problems.

(A) Number of Follows:

PHYSICAL	Acute Physical	Chronic Physical	Emotional	Social
Doctor	973	445	110	32
Patient	994	446	106	29
	Chi-square=0.35 ns			
EMOTIONAL				
Doctor	183	42	57	5
Patient	169	47	106	7
	Chi-square=13.08 $p<0.005$			
SOCIAL	Acute Physical	Chronic Physical	Emotional	Social
Doctor	136	62	28	21
Patient	125	64	32	32
	Chi-square=1.02 ns			

(B) Number of Non-Follows:

PHYSICAL	Acute Physical	Chronic Physical	Emotional	Social
Doctor	61	14	5	2
Patient	59	14	14	12
	Chi-square=9.93 $p<0.05$			
EMOTIONAL	Acute Physical	Chronic Physical	Emotional	Social
Doctor	76	22	5	4
Patient	214	71	14	4
	Chi-square=2.66 ns			
SOCIAL	Acute Physical	Chronic Physical	Emotional	Social
Doctor	34	19	9	1
Patient	61	23	15	12
	Chi-square=6.08 ns			

H. DISCUSSION

This chapter has examined the effect of the nature of the presenting problem on the interactional pattern in general practice interviews. The interviews described in previous chapters were classified according to the nature of the patient's presenting problem into one of four categories; Acute Physical, Chronic Physical, Emotional, Social. The interviews in these categories were then compared using variables taken from the system of interactional analysis described in chapter 3. The hypothesis under test was that the pattern of interaction would be, in part, a function of the presenting problem and thus differences would emerge in the findings between interviews with different types of presenting problem (chapter 2, hypothesis 7). This was clearly the case.The number of floorholdings containing an Emotional agenda differed markedly across different presenting problem types; subjects spent twice as much time, compared to the overall analysis, in Emotional agendas when the presentation was Chronic Physical but only one third as much time if the presentation was Acute Physical. The pattern of initiations and follows was largely similar to that found in the overall analysis. The pattern of returns to agendas was different when the presenting problem was Emotional. The timing of agendas was similar regardless of the presenting problem. The 'pay-off' for agendas differed greatly according to the nature of the presenting problem, and the agenda under study. These differences are summarised above. The analysis of the mean rates of doctor and patient behaviours in the interview according to presenting problem demonstrate that when the presentation is Emotional patients show increased rates of return to and initiation of Emotional agendas. When the presentation is Social, patients have higher rates of return to both Emotional and Social agendas; and initiate more Emotional, Social and Physical agendas.

In terms of the three dimensions described in chapter 3, some differences between doctors and patients do emerge when the nature of the presenting problem is taken into account. It will be recalled that the three dimensions of the interview are: mutual influence; recognition of the others perspective, and an awareness of broader psychosocial issues. To initiate an agenda is to bring your own perspective to the consultation. To follow the other person's agenda is to accede to their perspective. Not to follow the other party's agenda is to

disallow that perspective, and to return to a previously raised agenda may indicate unfinished business in the given domain. A return may also represent an attempt to distract from one agenda to another or may represent a willingness to acknowledge the other person's previously raised agenda.

The most notable difference between doctors and patients' handling of the principal agendas when examined according to the nature of the presenting problem emerges in the Emotional domain.

In terms of doctor and patient influence demonstrated by the following rate by either party of the others initiated, followed or returned agenda, doctors continue to have more influence than patients overall. That is to say that doctors are always followed by patients more than patients are followed by doctors. This is broadly the same pattern as is found in the main analysis. In the physical domain, when Physical agendas are examined, doctors have slightly more influence when the presenting problem is social. This is demonstrated by the lower following rate of the patients' Physical agenda in the next floorholding by the doctor. The doctor's influence is always primary in the social domain: doctors are followed to a fairly high degree by patients (although less than is the case for Physical agendas) irrespective of the presenting problem. Doctors are less likely to follow the patient's Social agenda when the presenting problem is Acute Physical than is the case with other presenting problems, suggesting that the doctor is more in control.

In the emotional domain, the doctor's influence, although foremost, is less than in the other two domains. The exception to this is when the presenting problem is social. In this case patients seem to wield more power than doctors, manifest in their following less of the doctors' Emotional agendas than doctors follow the patients' Emotional agendas. It is interesting that doctors have least control of the consultation with respect to Emotional agendas in terms of patient following of these agendas when the presenting problem is Acute Physical. However, when the presenting problem is Chronic Physical, doctors have far more influence: patients follow doctors to a fairly high degree. Doctors follow patients' Emotional agendas least when the presenting problem is either Acute Physical or Chronic Physical. Doctors have a very high

follow rate of their Emotional agendas by patients when the presenting problem is Acute Emotional. Doctors also follow patients' Emotional agendas remarkably often when Acute Emotional is the presenting problem. Both doctors and patients thus seem to show reticence towards emotional agendas when the presenting problem is Acute Physical in nature, demonstrated by their being least in tune, but seem to be happier with Emotional agendas when the presenting problem is Emotional demonstrated by their being far more in tune. However, it is also the case that doctors' mean rate of non-following in the emotional domain, when the presentation is also emotional, is very high. Thus although doctors are more in tune with patients in the latter presentation, they continue to demonstrate considerable non-following behaviour towards Emotional agendas when compared to their non-following behaviour of Physical agendas. The greatest mismatch between doctor and patient behaviour in the emotional domain is found when the presenting problem is Chronic Physical. When doctors do initiate, follow, or return to Emotional agendas patients follow doctors to a fairly high degree. This contrasts with doctors' low follow rate of patient Emotional agendas (doctors follow patients' Emotional agendas less still when the presenting problem is Acute Physical, but the difference between doctor and patient behaviour is less marked, shown by the lower following rate by patients of doctors' Emotional agendas).

Patients continue to initiate more than doctors in general, but doctors initiate more than patients in the social domain when the presenting problem is Acute Physical. They also initiate more than patients in the social domain when the presenting problem is social. Doctors initiate almost as much as patients in the physical domain when the presenting problem is Acute Emotional. Here they initiate proportionately twice as many Physical agendas as they do Emotional agendas whereas patients proportionately initiate to the same degree in both the emotional and physical domains.

Patients return to Emotional agendas a lot when the presenting problem is Acute Physical, Chronic Physical or Acute Emotional. Doctors return to Physical agendas around twice as much as patients when the presenting problem is Acute Physical, and return to Physical agendas about three times as much as patients when the presenting problem is Chronic

Physical. However, doctors return to Emotional agendas as much as patients return to Emotional agendas when the presenting problem is emotional.

Both doctor and patient seem to be uneasy about Emotional agendas when the presenting problem is Acute Physical patients do not readily follow doctors Emotional agendas, and doctors are even less likely to follow patients Emotional agendas. Doctors continue to be wary of patients' Emotional agendas when the presenting problem is Chronic Physical, whereas patients seem readily to follow doctors' Emotional agendas. Doctors are acknowledging the patients' perspective and are demonstrating an awareness of broader psychosocial issues when the presenting problem is Acute Emotional. That they initiate Physical agendas comparably to patients when the presenting problem is Acute Emotional, may suggest either that doctors are appropriately checking the physical domain, or may demonstrate an attempt by doctors to deflect patients' Emotional agenda. For example, Shapiro & Schiemer (1990) found that while residents' performance was adequate in basic interpersonal and medical skills, the general practitioners performed less well in areas of greater psychosocial complexity, and especially in addressing the meaning of illness for the patient.

As in the main analysis, patients are bringing a lot of emotion to the consultation. Proportionately this is most obvious when the presenting problem is Chronic Physical and doctors are not showing very much awareness of emotional issues or the patients' perspective in this respect. It is perhaps difficult to square these findings with those of Hjortdahl (1992). Although his study was longitudinal and therefore methodologically very different from the present investigation, he found that the doctors' sense of responsibility to the patient increased more rapidly and to a higher degree with density of visits than with duration of relationships. Four to five visits in the previous year could account for the equivalent of up to five years for doctors to acquire a comparable knowledge of their patients. It could be argued on such a basis that chronic presentations might have enhanced doctors' sensitivity to emotional concerns. However, doctors seem to be more alert to social issues than in the main analysis, demonstrated by their initiating more social issues than patients when the presenting problem is Acute Physical or Social. Proportionately they are here more willing to acknowledge the social

implications of Chronic Physical presentations than they are the emotional concomitants. In summary, some differences do emerge between doctor and patient handling of the three principal agendas when they are examined according to the nature of the presenting problem. Both doctor and patient appear to be unhappy with the presence of emotion in the interview when the presenting problem is Acute Physical. Doctors continue to be unhappy with emotion when the presentation is Chronic Physical but patients here seem willing to engage with doctors. Doctors are far more ready to discuss emotional issues with the patient when the presenting problem is Emotional in nature, and they appear to be alert to the social implications of both Chronic Physical and Social presentations. Pendleton et al (1983) found that approximately one in four consultations contained some communication difficulty for the doctors. They also found that the most powerful predictors of difficulty in the doctor-patient interview was tension in doctors and perceived tension in patients. In the present sample approximately one in four of the consultations is of a Chronic Physical presentation. In these, patients seem willing to discuss Emotional agendas, and indeed bring a lot of emotion to the interview. Doctors, in contrast, seem to be hesitant to follow patients' Emotional agendas and there is considerable mismatch in terms of doctor and patient following of Emotional agendas in this presentation. It is not inconceivable that the emotional aspects of physical problems may create a sense of disjuncture for the doctor in terms of management and that these consultations may be the source of greater tension for doctors. It is also possible that doctors will be sensitive to the patients' readiness to follow and discuss the doctors' reference to emotional concerns and will interpret this readiness as tension in the patient. Chronic presentations are also more likely than Acute presentations to be serious and to have more complications. Doctors are therefore less likely to be able to recognise the clear medical solution associated with greater doctor satisfaction (Winefield & Murrell, 1991; Buijs et al, 1984). Aborelius et al (1991), in a detailed study of 14 consultations where it was obvious that the general practitioner felt uncertain, found that one important contributory factor was that the doctor did not allow himself to use his feelings of uncertainty as useful information about the situation. They propose that doctors' frustration at being unable to improve the situation, accompanied by

a desire to prevent cracks in the doctors' image from showing, may be important mediators in consultations characterised by uncertainty. Although doctors have been shown to be less satisfied with consultations in which psychosocial factors are predominant, it is probable that when the patient clearly presents with an emotional problem, the doctor experiences less tension and more readily engages with the patient in the emotional domain. However, it is also the case that when the presenting problem is Acute Emotional, doctors initiate Physical agendas comparably to patients. With a few exceptions in the social domain, this is unusual in that doctors generally initiate fewer agendas than patients. This may represent either the doctors' appropriate checking of the physical domain, or the doctors' attempt to deflect the Emotional agenda. It is noteworthy, however, that doctors also return to Emotional agendas to the same extent as patients when the presenting problem is Acute Emotional. In terms of the process of somatisation spoken about in Chapter 4, it is more probable that doctors contribute to this process when the presenting problem is physical in nature, demonstrated by their low following rate of emotion in both the Acute Physical and Chronic Physical presentations. Patients with an underlying psychological problem will be unlikely to discuss such a problem with doctors, even if they are aware of it, when doctors do not follow their cues (see also chapter 8). This is particularly the case when the presentation is Acute Physical since patients seem to share the doctors hesitancy to discuss emotional concerns. Patients with Chronic Physical problems, on the other hand, readily engage with doctors when they are followed in the emotional domain. Further research is required to demonstrate any causal links between doctor style and the process of somatisation and to assess doctor satisfaction with consultations with different presenting problems.

CHAPTER 6 : AGENDA VARIATION BETWEEN DOCTORS IN PRINCIPAL AGENDAS

A. THEORETICAL CONSIDERATIONS CONCERNING BETWEEN DOCTOR VARIATION.

B. AGENDA INITIATIONS ACCORDING TO G.P.

C. AGENDA FOLLOWING ACCORDING TO G.P.

D. AGENDA RETURNS ACCORDING TO G.P.

E. PAY-OFF FOR PRINCIPAL AGENDAS ACCORDING TO G.P.

F. DURATION OF INTERVIEWS ACCORDING TO G.P.

G. DOCTOR 'STYLE' ACCORDING TO INTERVIEW DURATION.

H. MEAN RATES FOR DOCTOR AND PATIENT BEHAVIOUR ACCORDING TO INTERVIEW DURATION AND PRINCIPAL AGENDAS.

I. VARIATION BETWEEN DOCTOR GENDER ON PRINCIPAL AGENDAS.

J. DISCUSSION.

A. THEORETICAL CONSIDERATIONS CONCERNING BETWEEN DOCTOR VARIATION

A number of studies have suggested that physician self- awareness is an important factor in the doctor-patient relationship. For example, Longhurst (1989) has described the way in which people become patients: being from the Latin patior (to suffer), a person seeks out someone who professes to help when they pass some point of tolerance for a symptom or a debility (Pellengrino, 1979). To become a healer requires an individual to become conscious of the impact of the internal subjective world; it requires a person to discover the source of emotional responses which develop at a personal rather than at a professional level (Keen, 1970). To become a physician in the fullest sense of the word asks the would-be doctor to create for the patient an 'empty space' where the guest, or the patient, can find his soul and where his loneliness will be understood (Nouwren, 1979). It further requires the would-be doctor to be willing to recognise himself in the patient (Stein, 1985). If the doctor cannot afford to see his own defence in the patient, the interaction between doctor and patient will suffer. An empirical study which looked at determinants of difficult doctor-patient relationships found that two factors underlay physicians' perceptions of difficult patients: medical uncertainty, characterised by particularly vague, difficult to describe, undifferentiated medical problems; and interpersonal difficulty, reflected in a perceived abrasive behavioural style (Schwenk et al, 1989). It was noted in the previous chapter that Pendleton et al (1983), in a replicated study, found that doctors perceive the difficulty that occurs in approximately one in four consultations to be external to themselves. This last is reflected in a study by Ort et al as long ago as 1964. These researchers show doctor dissatisfaction stems from feeling out of control and that such feeling was mainly attributed to the patient. Schwent et al propose a model whereby physician motivation to practice medicine interacts to develop difficult doctor-patient relationships when they occur. It is conceivable that the stable doctor traits rated by Dale & Middleton (1990) as contributing to a positive attitude by doctors to patient's psychosocial problems may be informed by self-awareness. Two of

these traits were older age and postgraduate training in psychiatry. It may be argued that both require the individual to be more aware of the source of emotional responses. It may also be argued that self-awareness cannot be 'taught'. However speculative any of these observations may be, there is some evidence to suggest that doctor style, which may include a preference for long or short consultations, tends to be consistent over time; that longer general practitioner consultations are associated with greater attention being paid by the doctor to the patient's psychosocial concerns, and that such attention is linked to patient satisfaction. If future research is able to address the concept of doctor self awareness empirically, it is possible that doctor traits now thought to be stable may in fact be more fluid and open to training. In reporting their method for measuring patient centredness in the consultation, Henbest & Stewart (1989) describe the finding that the score for the first two minutes of the consultation correlated highly with the score for the entire consultation. Dale & Middleton (1990) found that a positive attitude towards psychosocial problems by general practitioners was associated with postgraduate training in psychiatry and with older age. They also found that male general practitioners rated their ability to manage cases more highly than female general practitioners, and suggest that personal traits and qualities remain a stronger determinant of G.P.'s reaction to patient's problems than formal training and qualifications. Positive personal traits included interest, enthusiasm, concern and flexibility. In a study which assessed doctor style on the practitioner's mean consultation time, Howie et al (1991) found that patients reported greater satisfaction with longer consultations. Although the ratio of long to short consultations fell by as much as 50% when surgeries were heavily booked or were running late, it seems that doctors in this study nevertheless maintained a consistent tendency either towards long or short interview styles. In an experimental study Roland et al (1986) demonstrated that when consultation time was deliberately manipulated, general practitioners whose surgeries were booked at 10 minute intervals spent more time explaining patients problems, explaining proposed management of problems, and in discussing both health education and prevention than general practitioners whose

surgeries were booked at five minute intervals. This is consistent with the findings of Verby et al (1979) who showed that a substantial improvement in interviewing techniques in a group of doctors who had undergone specified training sessions occurred at the expense of a 40% increase in interview duration. However, doctor style may mediate against the argument for an increase in consultation length. It will be remembered that Dale & Middleton (1990) suggest that personal traits and qualities may remain stronger determinants of general practitioners' reactions to patients' problems than formal teaching or training. Moreover, Lassen (1990) found that patient compliance (which is arguably a measure of patient satisfaction with the consultation) and length of interview showed no correlation, and Ridsdale et al (1992) demonstrated that increasing consultation time tended only to increase those communication behaviours doctors already possess rather than to effect to change in the way they approach the consultation. If doctor style is indeed stable over time, variance in interaction analysis measures (as well as outcome measures) is likely to be due to differences between doctors within a given study rather than to within doctor variation. Any general assessment of doctors' technique, and in particular patient centredness, needs to be aware of these variables. The following analysis represents an attempt to tease out, insofar as possible in a naturalistic study, measures of doctor stability according to the system of interaction analysis presented. While general observations may be made about doctors' sensitivity to patient's initiations, follows or returns, between doctor analysis demonstrates how doctor variation influences previous measures obtained.

B. AGENDA INITIATIONS ACCORDING TO G.P.

Table 6.1 shows the frequency of principal agendas distributed by doctor and patient between the ten general practitioners who participated in the present study. The data seem to suggest that there is an inverse relationship between initiations by either party within each of the three main agenda groups. For example, although the rate at which the patient initiates Physical agendas is far higher than the doctor, their proportionate rate of initiating Physical agendas declines as the doctor's initiation rate goes up. In general the

range of initiation rates for doctors are far wider than they are for patients. This is the case for all three agendas.

Table 6.1: Frequency of initiations of principal agendas distributed by doctor and patient, shown for ten different G.P.s. (Percentages are calculated as proportion of total initiations of Physical, Emotional and Social).

G.P. 1				
	Emotional	Physical	Social	Total
Doctor	2 (29%)	0 (0%)	5 (71%)	7
Patient	3 (50%)	3 (50%)	0 (0%)	10
	Chi-square= 8.17 $p<0.05$			
G.P. 2				
	Emotional	Physical	Social	Total
Doctor	3 (75%)	0 (0%)	1 (25%)	4
Patient	5 (36%)	6 (43%)	3 (21%)	14
	Chi-square= 2.81 ns			
G.P. 3				
	Emotional	Physical	Social	Total
Doctor	1 (50%)	0 (0%)	1 (50%)	2
Patient	6 (43%)	6 (43%)	3 (14%)	14
	Chi-square= 2.06 ns			
G.P. 4				
	Emotional	Physical	Social	Total
Doctor	1 (25%)	0 (0%)	3 (75%)	4
Patient	4 (33%)	5 (42%)	3 (25%)	12
	Chi-square= 3.73 ns			
G.P. 5				
	Emotional	Physical	Social	Total
Doctor	1 (14%)	1 (14%)	5 (72%)	7
Patient	5 (28%)	7 (39%)	6 (33%)	18
	Chi-square= 3.00 ns			

Contd ...

Table 6.1: Frequency of initiations of principal agendas distributed by doctor and patient, shown for ten different G.P.s. (Percentages are calculated as proportion of total initiations of Physical, Emotional and Social). Contd.

G.P. 6				
	Emotional	Physical	Social	Total
Doctor	0 (0%)	0 (0%)	11 (100%)	11
Patient	11 (38%)	13 (45%)	5 (17%)	29
	Chi-square= 22.70 p<0.001			
G P. 7				
	Emotional	Physical	Social	Total
Doctor	0 (0%)	2 (67%)	1 (33%)	3
Patient	7 (29%)	8 (33%)	9 (38%)	24
	Chi-square= 1.69 ns			
G.P. 8				
	Emotional	Physical	Social	Total
Doctor	2 (20%)	3 (30%)	5 (50%)	10
Patient	6 (26%)	9 (39%)	8 (35%)	23
	Chi-square= 0.68 ns			
G.P. 9				
	Emotional	Physical	Social	Total
Doctor	5 (42%)	1 (8%)	6 (50%)	12
Patient	9 (24%)	17 (45%)	12 (31%)	38
	Chi-square= 5.27 ns			
G.P. 10				
	Emotional	Physical	Social	Total
Doctor	1 (33%)	1 (33%)	1 (33%)	3
Patient	8 (38%)	9 (43%)	4 (19%)	21
	Chi-square= 0.33 ns			

In general the patients' initiations rates reasonably balanced between the three agendas between doctors, although it is usually the Emotional and/or Social that may be initiated somewhat less. Given the relatively even rate of initiation by patients, an inverse relationship between the initiation rates of the two parties within the three main agenda types is suggested. There also appears to be considerable variability among doctors in the extent to which patients initiate in these areas. However, it should be noted that the number of interviews per doctor in this sample is quite small (see table 6.4 below), this may account for the variability within doctors.

C. AGENDA FOLLOWING ACCORDING TO G.P.

As in the main analysis reported in chapter 3, and in the analysis according to Acute versus Chronic patient presentation, there seems to be a remarkable match between doctor and patient following of one another's agendas independent of general practitioner. This confirms a very strong tendency for either party within the consultation to follow one another. Once again the axiom 'following begets following' holds true. This is shown in Table 6.2.

Table 6.2: Frequency of follows of principal agendas distributed by doctor and patient, shown for ten different G.P.s. (Percentages are calculated as proportion of total follows of Physical, Emotional and Social).

G.P. 1				
	Emotional	Physical	Social	Total
Doctor	64 (38%)	97 (57%)	8 (5%)	169
Patient	68 (39%)	99 (56%)	9 (5%)	176
	Chi-square= 0.06 ns			
G P. 2				
	Emotional	Physical	Social	Total
Doctor	28 (15%)	151 (79%)	12 (6%)	191
Patient	36 (18%)	149 (76%)	11 (6%)	196
	Chi-square= 0.99 ns			
G.P. 3				
	Emotional	Physical	Social	Total
Doctor	24 (12%)	162 (81%)	13 (7%)	199
Patient	21 (11%)	158 (83%)	12 (6%)	191
	Chi-square= 0.13 ns			
G.P. 4				
	Emotional	Physical	Social	Total
Doctor	3 (5%)	57 (85%)	7 (10%)	67
Patient	3 (5%)	55 (83%)	7 (12%)	66
	Chi-square= 0.09 ns			
G.P. 5				
	Emotional	Physical	Social	Total
Doctor	16 (9%)	137 (77%)	24 (14%)	177
Patient	12 (7%)	136 (80%)	23 (13%)	171
	Chi-square= 0.49 ns			

Contd ...

Table 6.2: Frequency of follows of principal agendas distributed by doctor and patient, shown for ten different G.P.s. (Percentages are calculated as proportion of total follows of Physical, Emotional and Social).Contd.

G.P. 6				
	Emotional	Physical	Social	Total
Doctor	44 (10%)	318 (72%)	80 (18%)	442
Patient	51 (11%)	314 (69%)	90 (20%)	445
	Chi-square= 0.94 ns			
G.P. 7				
	Emotional	Physical	Social	Total
Doctor	32 (12%)	190 (74%)	35 (14%)	257
Patient	31 (22%)	190 (75%)	32 (13%)	253
	Chi-square= 0.12 ns			
G.P. 8				
	Emotional	Physical	Social	Total
Doctor	24 (13%)	131 (69%)	34 (18%)	189
Patient	31 (16%)	131 (66%)	37 (18%)	199
	Chi-square= 0.76 ns			
G.P. 9				
	Emotional	Physical	Social	Total
Doctor	27 (11%)	203 (82%)	18 (7%)	248
Patient	21 (9%)	191 (83%)	17 (7%)	229
	Chi-square= 0.39 ns			
G.P. 10				
	Emotional	Physical	Social	Total
Doctor	10 (6%)	139 (90%)	6 (4%)	155
Patient	10 (6%)	140 (90%)	6 (4%)	156
	Chi-square= 0.01 ns			

D. AGENDA RETURNS ACCORDING TO G.P.

In Table 6.3 the frequency of returns to the three principal agendas is shown according to G.P. The table shows that the G.P. always has a greater proportionate return to Physical agendas than the patient. The patient, in contrast, always has a greater proportionate return to Emotional agendas than the doctor. Whereas patients always have the highest proportionate return to the emotional domain, doctors vary their highest return rates between emotional and physical concerns.

Table 6.3: Frequency of returns to principal agendas distributed by doctor and patient, shown for ten different G.P.s. (Percentages are calculated as proportion of total returns to Physical, Emotional and Social).

G.P. 1				
	Emotional	Physical	Social	Total
Doctor	7 (41%)	8 (47%)	2 (12%)	17
Patient	21 (75%)	3 (11%)	4 (14%)	28
	Chi-square= 7.71 $p<0.05$			
G.P. 2				
	Emotional	Physical	Social	Total
Doctor	22 (76%)	3 (10%)	4 (14%)	29
Patient	28 (78%)	2 (6%)	6 (16%)	36
	Chi-square= 0.57 ns			
G.P. 3				
	Emotional	Physical	Social	Total
Doctor	7 (50%)	5 (36%)	2 (14%)	14
Patient	28 (78%)	6 (17%)	2 (5%)	36
	Chi-square= 3.73 ns			
G.P. 4				
	Emotional	Physical	Social	Total
Doctor	5 (50%)	5 (50%)	0 (0%)	10
Patient	11 (61%)	5 (28%)	2 (11%)	18
	Chi-square= 2.14 ns			
G.P. 5				
	Emotional	Physical	Social	Total
Doctor	5 (33%)	7 (47%)	3 (20%)	15
Patient	21 (72%)	6 (21%)	2 (8%)	29
	Chi-square= 6.31 $p<0.05$			

Contd ...

Table 6.3: Frequency of returns to principal agendas distributed by doctor and patient, shown for ten different G.P.s. (Percentages are calculated as proportion of total returns to Physical, Emotional and Social).Contd.

G P. 6				
	Emotional	Physical	Social	Total
Doctor	17 (44%)	16 (41%)	7 (15%)	39
Patient	48 (66%)	9 (12%)	16 (22%)	73
	Chi-square= 12.10 p<0.01			
G.P. 7				
	Emotional	Physical	Social	Total
Doctor	6 (35%)	6 (35%)	5 (30%)	17
Patient	24 (65%)	5 (13%)	8 (22%)	37
	Chi-square= 4.84 ns			
G.P. 8				
	Emotional	Physical	Social	Total
Doctor	8 (44%)	5 (28%)	5 (28%)	18
Patient	20 (67%)	3 (10%)	7 (23%)	30
	Chi-square= 3.17 ns			
G.P. 9				
	Emotional	Physical	Social	Total
Doctor	13 (62%)	6 (29%)	2 (9%)	21
Patient	32 (74%)	6 (14%)	5 (12%)	43
	Chi-square= 1.98 ns			
G.P. 10				
	Emotional	Physical	Social	Total
Doctor	13 (69%)	5 (26%)	1 (5%)	19
Patient	13 (87%)	1 (7%)	1 (6%)	15
	Chi-square= 2.23 ns			

The data suggest that G.P.s cannot be categorised according to the balance of, and the extent to which they return to, the emotional and physical domains. For example, some G.P.s (Drs 2,3,8,9 and 10) return to the emotional area at a far higher rate than they return to the physical; some return at roughly similar rates for both emotional and physical (Drs 1,4,6 and 7) and Dr 5 returns more to physical than emotional agendas. The extent to which a doctor returns to a given domain does not appear to go along with the nature of the presenting problem. Thus, although there is some tendency for doctors to return more to Emotional agendas where there have been Chronic Physical presentations by the patient, this is by no means always the case (compare Table 6.4 which shows the nature of the presenting problem broken down by G.P.). Those G.P.s with a balanced rate of returns to both the emotional and physical domains do include some who have Chronic Physical and Acute Emotional patient presentations in their group of interviews. The proportionate returns by G.P.s to Social agendas is always less than to other principal domains.

Table 6.4: Nature of presenting problem broken down by G.P.

G.P. No.	1	2	3	4	5	6	7	8	9	10
Acute Physical	3	4	3	4	3	7	5	3	8	8
Chronic Physical	0	1	3	0	3	2	2	3	2	1
Acute Emotional	0	1	0	0	0	0	2	2	0	1
Social	0	0	0	0	0	1	0	0	1	0
Total	3	6	6	4	6	10	9	8	11	10

E. PAY-OFF FOR PRINCIPAL AGENDAS ACCORDING TO G.P.

Table 6.5 shows the pay-off for doctors and patients initiating, following and returning to Physical agendas according to G.P. There appears to be a very high pay-off for both patient and doctor in the physical domain, and very little variation between G.P.s

Table 6.5: Pay-off for Physical agendas by G.P. PHYSICAL

G.P. 1					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	0	0	3 (100%)	0 (0%)
Floorholding	Follow	91 (93.8%)	6 (6.2%)	84 (85.0%)	15 (15.0%)
	Return	6 (75.0%)	2 (25.0%)	9 (100%)	0 (0%)
G.P. 2					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	0	0	6 (100%)	0 (0%)
Floorholding	Follow	144 (95.3%)	7 (4.7%)	145 (95.3%)	4 (2.3%)
	Return	3 (100%)	0 (0%)	2 (100%)	0 (0%)
G.P. 3					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	0	0	6 (100%)	0 (0%)
Floorholding	Follow	159 (98.1%)	3 (1.9%)	154 (97.5%)	4 (2.5%)
	Return	3 (60.0%)	2 (40.0%)	1 (100%)	0 (0%)
G.P. 4					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	0	0	5 (100%)	0 (0%)
Floorholding	Follow	52 (91.2%)	5 (8.8%)	50 (90.9%)	5 (9.1%)
	Return	4 (80.0%)	1 (20.0%)	3 (100%)	0 (0%)
G.P. 5					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	1 (100%)	0 (0%)	6 (85.7%)	1 (14.6%)
Floorholding	Follow	131 (95.6%)	6 (4.4%)	124 (91.2%)	12 (8.8%)
	Return	7 (100%)	0 (0%)	5 (83.3%)	1 (16.7%)

Contd ...

Table 6.5: Pay-off for Physical agendas by G.P. PHYSICAL

G.P. 6					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	0	0	12 (92.3%)	1 (7.7%)
Floorholding	Follow	305 (95.9%)	13 (4.1%)	294 (93.6%)	20 (6.4%)
	Return	15 (93.8%)	1 (6.2%)	7 (77.7%)	2 (22.3%)
G.P. 7					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	2 (100%)	0 (0%)	3 (100%)	0 (0%)
Floorholding	Follow	183 (96.3%)	7 (3.7%)	124 (94.6%)	7 (5.4%)
	Return	4 (66.7%)	2 (33.3%)	4 (80.0%)	1 (20.0%)
G.P. 8					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	3 (100%)	0 (0%)	8 (88.9%)	1 (11.1%)
Floorholding	Follow	124 (94.6%)	7 (5.4%)	122 (93.1%)	9 (6.9%)
	Return	4 (80.0%)	1 (20.0%)	2 (66.7%)	1 (33.3%)
G.P. 9					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	1 (100%)	0 (0%)	15 (88.2%)	2 (11.8%)
Floorholding	Follow	190 (93.5%)	13 (6.5%)	183 (95.8%)	8 (4.4%)
	Return	6 (100%)	0 (0%)	5 (83.3%)	1 (16.7%)
G.P. 10					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	1 (100%)	0 (0%)	8 (88.9%)	1 (11.1%)
Floorholding	Follow	134 (96.4%)	5 (3.6%)	137 (99.3%)	1 (0.7%)
	Return	4 (80.0%)	1 (20.0%)	1 (100%)	0 (0%)

The pay-off rate for either doctor or patient in the Emotional domain shows far greater variation (Table 6.6). This is particularly the case in the extent to which the doctor follows the patient. When patient following doctor following, and doctor following patient following is considered, there is a good deal of variability. Because of the low

cell frequencies for the measures of initiating and returning, the 'pay-off' for doctor and patient following one another's following is the most appropriate measure of the extent to which doctor and patient are 'in tune'. Although the rates are roughly equal for doctors 4,7,9 & 10 for most G.P.s the patient following the doctor following of Emotional agendas is greater than the doctor following the patient's following of Emotional considerations.

Table 6.6: Pay-off for Emotional agendas by G.P. EMOTIONAL

G.P. 1					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	1 (50%)	1 (50%)	3 (100%)	0 (0%)
Floorholding	Follow	58 (90.6%)	6 (9.4%)	50 (73.5%)	18 (26.4%)
	Return	6 (85.7%)	1 (14.3%)	12 (57.1%)	9 (42.9%)
G.P. 2					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	1 (33.3%)	2 (66.7%)	1 (20.0%)	4 (80.0%)
Floorholding	Follow	20 (71.4%)	8 (28.6%)	18 (50.0%)	18 (50.0%)
	Return	16 (72.7%)	6 (27.3%)	8 (28.6%)	20 (71.4%)
G.P. 3					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	0 (0%)	1 (100%)	1 (16.7%)	5 (83.3%)
Floorholding	Follow	18 (75.0%)	6 (25.0%)	11 (52.4%)	10 (47.6%)
	Return	4 (57.1%)	3 (42.9%)	12 (42.9%)	16 (57.1%)
G.P. 4					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	1 (100%)	0 (0%)	0 (0%)	4 (100%)
Floorholding	Follow	1 (33.3%)	2 (66.7%)	1 (33.3%)	2 (66.7%)
	Return	2 (40.0%)	3 (60.0%)	2 (18.2%)	9 (80.8%)
G.P. 5					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	1 (100%)	0 (0%)	0 (0%)	5 (100%)
Floorholding	Follow	8 (50.0%)	8 (50.0%)	5 (41.7%)	7 (58.3%)
	Return	3 (60.0%)	2 (40.0%)	11 (52.4%)	10 (47.6%)

Contd ...

Table 6.6: Pay-off for Emotional agendas by G.P. EMOTIONAL (Contd.)

G.P. 6					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	0	0	0 (0%)	11 (100%)
Floorholding	Follow	41 (93.2%)	3 (6.8%)	28 (54.9%)	23 (45.1%)
	Return	11 (64.7%)	6 (30.5%)	14 (29.2%)	34 (70.8%)
G.P. 7					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	0	0	3 (42.9%)	4 (57.1%)
Floorholding	Follow	25 (78.1%)	7 (21.9%)	25 (80.6%)	6 (19.4%)
	Return	5 (83.3%)	1 (16.7%)	5 (20.8%)	19 (79.2%)
G.P. 8					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	2 (100%)	0 (0%)	2 (33.3%)	4 (66.7%)
Floorholding	Follow	23 (95.8%)	1 (4.2%)	13 (41.9%)	18 (58.1%)
	Return	5 (62.5%)	3 (37.5%)	6 (30.0%)	14 (70.0%)
G.P. 9					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	2 (40.0%)	3 (60.0%)	4 (44.4%)	5 (55.6%)
Floorholding	Follow	14 (51.9%)	13 (48.1%)	10 (47.6%)	11 (52.4%)
	Return	6 (46.2%)	7 (53.8%)	14 (43.8%)	18 (56.2%)
G.P. 10					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	0 (0%)	1 (100%)	2 (25.0%)	6 (75.0%)
Floorholding	Follow	3 (30.0%)	7 (70.0%)	3 (30.0%)	7 (70.0%)
	Return	7 (53.8%)	6 (46.2%)	6 (46.2%)	7 (53.8%)

The data suggest that the nature of the presenting problem may have influenced the doctor and patient 'pay-off' figures in the emotional domain (compare Tables 6.4 and 6.6). For example, doctors 4 and 1 both had three Acute Physical presentations, but doctor 4 had three Chronic Physical presentations additionally. Doctor 4's following of patient following of the doctor's Emotional agendas is balanced with the patient's following of the doctor's following of the patient's Emotional agendas but at a low level. This is not the case for doctor 1 and his patients. Although doctor 4's pattern is not repeated for doctor 8, who, like doctor 4 had three Acute and three Chronic Physical presentations, the trend is supported. As was noted in chapter 3, doctors tend to be more in tune with patients in the emotional domain when the patients presenting problem has been Acute Emotional, and less in tune with patient's emotional concerns when the presenting problem has been Chronic Physical. It was also observed in Chapter 4, that the extent to which a doctor is in tune with the patient in the emotional domain generally (demonstrated by the doctors following of the patient), seems to effect the extent to which patients will follow the doctor in this area. That doctor 8 had two Acute Emotional presentations in addition to the three Acute Physical and three Chronic Physical presentations already referred to, and obtains from his patients a 96% follow rate for his Emotional agendas, shows that the balance of patient following has altered in favour of the doctor. This is also the case for doctor 1, who has neither Chronic Physical nor Acute Emotional presenting problems. But for doctor 1, the pay-off for the patient following the doctor is greater than for doctor 8 suggesting that it is emotional concerns in the Chronic Physical perspective which may particularly influence the extent to which doctor and patient are in tune in the emotional area. However, G.P. 7 also had a relatively high proportion of Chronic Physical presentations, but the follow rates differ. Whereas doctor 8 follows the patient follows less than 50% of the time, doctor 7 achieves a balanced following with her patients at a fairly high level (around 80%).

There is much less variation between doctors in the pay-off for Social agendas for both parties (Table 6.7). In general, doctor initiating and returning produce high

patient follow rates whereas patient initiating and returning does a little less well. In all cases of between doctor analysis, except perhaps for the following measures in the 'pay-off' tables, it is important to note the low cell frequencies and the effect this may have on any generalisations.

Table 6.7: Pay-off for Social agendas by G.P. SOCIAL

G.P. 1					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	5 (100%)	0 (0%)	0	0
Floorholding	Follow	2 (25.0%)	6 (75.0%)	6 (66.7%) 3	(33.3%)
	Return	2 (100%)	0 (0%)	3 (75.0%)	1 (25.0%)
G.P. 2					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	1 (100%)	0 (0%)	2 (66.7%)	1 (33.3%)
Floorholding	Follow	7 (58.3%)	5 (41.7%)	7 (63.6%)	4 (36.4%)
	Return	2 (50.0%)	2 (50.0%)	3 (50.0%)	3 (50.0%)
G.P. 3					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	1 (100%)	0 (0%)	1 (50.0%)	1 (50.0%)
Floorholding	Follow	9 (69.2%)	3 (30.8%)	10 (83.3%)	2 (16.7%)
	Return	2 (100%)	0 (0%)	2 (100%)	0 (0%)
G.P. 4					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	3 (100%)	0 (0%)	2 (66.7%)	1 (33.3%)
Floorholding	Follow	4 (57.1%)	3 (42.9%)	4 (57.1%)	3 (42.9%)
	Return	0	0	1 (50.0%)	1 (50.0%)
G.P. 5					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	4 (80.0%)	1 (20.0%)	4 (66.7%)	2 (33.3%)
Floorholding	Follow	17 (70.8%)	7 (29.2%)	18 (78.3%)	5 (21.7%)
	Return	3 (100%)	0 (0%)	2 (100%)	0 (0%)

Contd ...

Table 6.7: Pay-off for Social agendas by G.P. SOCIAL (Contd.)

G.P. 6					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	11 (100%)	0 (0%)	4 (80.0%)	1 (20.0%)
Floorholding	Follow	74 (92.5%)	6 (7.5%)	71 (78.9%)	20 (21.1%)
	Return	6 (85.7%)	1 (14.3%)	5 (31.3%)	11 (68.7%)
G.P. 7					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	1 (100%)	0 (0%)	8 (88.9%)	1 (11.1%)
Floorholding	Follow	26 (74.3%)	9 (25.7%)	22 (68.8%)	10 (31.2%)
	Return	4 (80.0%)	1 (20.0%)	6 (75.0%)	2 (25.0%)
G.P. 8					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	4 (80.0%)	1 (20.0%)	4 (50.0%)	4 (50.0%)
Floorholding	Follow	29 (85.3%)	5 (14.7%)	25 (67.6%)	12 (32.4%)
	Return	4 (80.0%)	1 (20.0%)	5 (71.4%)	2 (28.6%)
G.P. 9					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	6 (100%)	0 (0%)	5 (41.7%)	7 (58.3%)
Floorholding	Follow	9 (50.0%)	9 (50.0%)	11 (64.7%)	6 (35.3%)
	Return	2 (100%)	0 (0%)	2 (40.0%)	3 (60.0%)
G.P. 10					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	1 (100%)	0 (0%)	1 (25.0%)	3 (75.0%)
Floorholding	Follow	4 (66.7%)	2 (33.3%)	3 (50.0%)	3 (50.0%)
	Return	1 (100%)	0 (0%)	1 (100%)	0 (0%)

F. DURATION OF INTERVIEWS ACCORDING TO G.P.

Table 6.8 shows the mean, standard deviation, minimum and maximum duration of interviews in the present sample broken down by G.P. The number of floorholdings according to G.P., overall figures and number of interviews per doctor are also shown. The average consultation was 7.72 minutes and the mean number of floorholdings per interview was 56.6. Doctors 1 and 10 stood out as having exceptionally long and short consultations (mean duration of 15.10 and 4.50 minutes respectively). Doctor 1 was also extremely variable in both interview duration and number of floorholdings.

Table 6.8: Mean, standard deviation, minimum and maximum duration of interview, and number of floorholdings per interview, broken down by G.P.
N=No. of interviews per G.P.

	Duration of interview (mins)				Number of Floorholdings				N
	Mean	S.D.	Min.	Max.	Mean	S.D.	Min	Max.	
G.P. 1	15.10	9.90	7.51	26.30	111.7	68.9	67	191	3
G.P. 2	8.08	2.90	4.22	12.50	58.8	17.9	29	77	6
G.P. 3	9.27	3.12	6.40	15.30	64.0	12.9	49	79	6
G.P. 4	6.25	3.42	3.45	11.10	46.8	16.3	28	67	4
G.P. 5	8.59	2.00	5.36	11.30	60.3	13.1	46	81	6
G.P. 6	9.86	3.55	4.53	16.20	80.8	20.0	39	115	10
G.P. 7	6.62	3.30	2.00	12.10	54.8	24.8	19	106	9
G.P. 8	8.09	2.99	4.10	12.30	44.6	5.4	36	53	8
G.P. 9	6.38	3.23	3.16	12.30	46.3	23.7	17	93	11
G.P. 10	4.50	2.00	2.34	8.31	34.2	14.0	18	62	10
Overall	7.72	3.95	2.00	26.30	56.6	16.8	17	191	73

G. DOCTOR 'STYLE' ACCORDING TO INTERVIEW DURATION

To test Howie et al's hypothesis that longer interviews contain more doctor attention to psychosocial concerns, and that the ratio of long to short consultations may be used as a proxy measure of quality of care, the present sample of G.P.s were divided according to their definitions of long, medium and short consultations, and comparisons made between the principal agendas on the measures for each. For the purpose of this analysis doctors' mean consultation length is referred to as 'doctor style'.

Short consultations were defined as those with a mean of less than 7 minutes duration (Doctors 4,7,9 & 10); medium consultations defined as those with a mean between 7 and 9 minutes (doctors 2,5 & 8), and long consultations were those with a

mean of 9 or more minutes (doctors 1,3 & 6). It should be noted that while some G.P.'s interviews may be short and other G.P.'s interviews long, what is shown in tables 6.11 to 6.16 (excluding 6.12) represents the overall time. Thus, overall G.P. 2 has a medium consultation style, but in detail has one short consultation, one medium consultation and one long consultation. What is presented thus reflects a general *tendency* by the G.P. towards a given style.

The average length of G.P. interviews according to the above definitions is shown in Table 6.9. The largest number of interviews fell into the short doctor style. This was followed by the medium and long styles respectively. The sum of medium and long styles was not much more than the total of short interviews (39:34).

Table 6.9: Number of short, medium and long interviews classified according to the definitions of Howie et al (1991). Figures in brackets show percentage of all interviews.

Interview Classification	Number of interviews (%)
SHORT	34 (46.6%)
MEDIUM	20 (27.4%)
LONG	19 (26.0%)

Table 6.10: Table showing number of short, medium and long interviews (classified according to Howie et al, 1991) grouped according to the nature of the presenting problem.

	Nature of Interview Length		
Presenting problem	Short	Medium	Long
Acute Physical	25	10	13
Chronic Physical	5	7	5
Acute Emotional	3	3	0
Social	1	1	1
	Chi-square= 7.11 ns		

There were no statistically significant differences between short, medium and long consultations when the nature of the presenting problem was taken into account (Table 6.10). However, when comparisons were made between interview style and the handling of principal agendas, differences did emerge (Table 6.11). One way analysis of variance showed a significant difference in the number of Social agendas initiated by doctors in longer consultations; and in the number of Physical agendas not followed by doctors in longer consultations. The latter were significant at $p=0.001$. When this is compared with patients' handling of principal agendas according to doctor style, analysis of variance shows that on the measures of 'initiating' their own agendas and 'not following' doctor agendas, patients do not significantly differ according to doctor style. For both doctors and patients, analysis of variance demonstrates that the longer the consultation the more either party follows the other's agenda. This is always statistically significant and is what would be expected. Doctors return more to Physical agendas when their interview style is longer whereas patients return significantly more often to the emotional domain.

Table 6.11: Mean number of doctor and patient initiations, follows, returns and non-followings per interview for the three principal agendas by duration of interview. One way analysis of variances comparing the three interview lengths.

	Interview Length					
DOCTOR		SHORT	MEDIUM	LONG	F	p
Initiations	Physical	0.12	0.20	0.001	2.05	ns
	Emotional	0.21	0.30	0.16	0.33	ns
	Social	0.32	0.55	0.89	3.65	0.03
Follow	Physical	17.32	21.05	30.37	13.78	0.001
	Emotional	2.02	3.45	6.95	2.88	0.06
	Social	1.94	3.95	5.32	4.04	0.02
Returns	Physical	0.68	0.80	1.53	3.99	0.02
	Emotional	1.15	1.75	1.63	1.02	ns
	Social	0.26	0.60	0.58	1.53	ns
Non-Follows	Physical	0.91	1.45	2.21	2.97	0.06
	Emotional	2.88	5.00	6.63	7.98	0.001
	Social	1.18	1.65	2.00	1.44	ns
PATIENT		SHORT	MEDIUM	LONG	F	p
Initiations	Physical	1.15	1.10	1.16	0.05	ns
	Emotional	0.82	0.80	1.05	1.64	ns
	Social	0.82	0.85	0.37	2.43	ns
Follows	Physical	17.00	22.30	30.05	12.26	0.001
	Emotional	1.91	3.95	7.37	3.01	0.06
	Social	1.82	3.55	5.84	5.09	0.01
Returns	Physical	0.47	0.55	1.00	1.02	ns
	Emotional	2.35	3.50	4.79	4.64	0.01
	Social	0.47	0.70	1.16	1.75	ns
Non-Follows	Physical	1.00	1.05	1.42	1.00	ns
	Emotional	1.47	1.50	1.42	0.01	ns
	Social	0.71	1.10	0.89	0.93	ns

Correlations support the association between longer doctor interview style and greater doctor and patient following of the three principal agendas (Table 6.12). A positive association is also demonstrated between consultation length and doctor initiations of Social agendas and patient returns to Social agendas, and doctor and patient non-following of all three principal agendas. Whereas doctors and patients return to Physical agendas comparably when the interview is longer, the correlation for patients returning to Emotional agendas is slightly more positive. As interview duration increases both doctors and patients tend not to follow Physical agendas, and this is the case for Emotional and Social agendas also. However, the correlation for doctors non-following of Emotional agendas when compared to the patients' non-following of Emotional agendas is stronger for doctors.

Table 6.12: Correlations between interview duration (not classified into groups) and the number of doctor and patient initiations, follows, returns and non-follows.

		Correlation with Interview Duration	
		DOCTOR	PATIENT
Initiations	Physical	0.04	0.23
	Emotional	0.25	0.15
	Social	0.37 *	0.15
Follows	Physical	0.64 **	0.61 **
	Emotional	0.69 **	0.70 **
	Social	0.41 **	0.42 **
Returns	Physical	0.61 **	0.59 **
	Emotional	0.44 **	0.55 **
	Social	0.25	0.52 **
Non-Follows	Physical	0.61 **	0.48 **
	Emotional	0.63 **	0.35 *
	Social	0.47 **	0.34 *

Two tailed significance * $p<0.01$ ** $p<0.001$

Tables 6.13 and 6.14 demonstrates the overall ratio of long-short interviews, calculated according to Howie et al (1991). There were 21 short doctor consultations to 5 long consultations for doctors with a short doctor style (ratio 0.24:1). For doctors with a medium doctor style there were 6 short interviews to 8 long interviews (ratio 1.33:1), and for doctors with a long consultation style there were 2 short interviews to 8 long interviews (ratio 4:1). When the ratio is examined according to G.P. it can be seen that doctors 1 and 10, who had a long and short interview style respectively, were consistent in this style (G.P. 1 had only 3 interviews in the sample, however). In general, doctors with a short interview style had a similar ratio to the doctors sampled by Howie et al (0.24:1 to Howie et al's 0.28:1). Doctors with a medium style had a ratio of 0.71:1. This is compared to 1.33:1 in the present sample. Howie et al's long G.P.s had a long to short ratio style of 2.3:1 compared to a ratio of 4:1 in the sample presented here. Overall, then, the data suggest that doctors in the present study tended to have longer consultations than Howie et al's doctors but that those doctors with a short interview style in the former were comparable to the latter.

Table 6.13: The number of short interviews, the number of long interviews, and the ratio of long to short interviews shown broken down into the classification of doctor style into short or long (according to the criteria of Howie et al, 1991).

Doctor style	No. of Short interviews	No. of Long interviews	Ratio long:short	Total
Short	21 (62%)	5 (15%)	0.24:1	34
Medium	6 (30%)	8 (40%)	1.33:1	20
Long	2 (11%)	8 (53%)	4:1	19

Table 6.14: The number of short interviews, the number of long interviews, and the ratio of long to short interviews shown broken down by G.P. (The classification into short or long is made according to the criteria of Howie et al, 1991). Wording in brackets indicate the overall classification of the individual G.P.'s style.

	No. of Short interviews	No. of Long interviews	Ratio long:short	Total
G.P. 1 (Long)	0 (0%)	2 (67%)	-	3
G.P. 2 (Medium)	1 (17%)	2 (33%)	2:1	6
G.P. 3 (Long)	1 (17%)	2 (33%)	2:1	6
G.P. 4 (Short)	3 (75%)	1 (25%)	0.33:1	4
G.P. 5 (Medium)	1 (17%)	3 (50%)	3:1	6
G.P. 6 (Long)	1 (10%)	6 (60%)	6:1 1	0
G.P. 7 (Short)	4 (44%)	2 (22%)	0.5:1	9
G.P. 8 (Medium)	4 (50%)	3 (38%)	0.75:1	8
G.P. 9 (Short)	7 (64%)	2 (18%)	0.28:1	11
G.P. 10 (Short)	9 (90%)	0 (0%)	-	10

When general comparisons are made between doctors with long and short interview styles and proportionate attention to Emotional and Social agendas (Table 6.15), it does not seem that doctors with a short consultation style devote less attention to Emotional and Social concerns than doctors with a long consultation style, when 'attention' is defined as the doctor initiating or returning to these agendas. Neither do doctors with a short consultation style appear to follow patients' initiated Emotional agendas, or patients' returns to Emotional agendas less than doctors with a long consultation style (Table 6.16). However, doctors with a long style do seem to follow patient initiated Social agendas, and patients' returns to Social agendas, more frequently than doctors with a short style follow these concerns (significant at $p<0.005$).

Table 6.15: Number of doctor initiations and returns to Emotional and Social agendas for short and long interviews.

DOCTOR		
	No. of Initiations Emotional	No. of Returns Emotional
Short interviews	7	37
Long interviews	3	31
	Chi-square=0.86 ns	
	No. of Initiations Social	No. of Returns Social
Short interviews	11	8
Long interviews	17	11
	Chi-square=0.04 ns	

The data do not therefore support the hypothesis that longer consultations are necessarily more concerned with Emotional considerations than shorter interviews. But doctors with a long interview style did seem to follow their patients more frequently when the latter either raised or returned to Social issues. It should be remembered that the cell frequencies in this sample are vastly inferior to Howie et al's, and that the analysis was conducted post hoc.

H. MEAN RATES FOR DOCTOR AND PATIENT BEHAVIOUR ACCORDING TO INTERVIEW DURATION AND PRINCIPAL AGENDAS

Table 6.16 shows the mean rate of doctor and patient behaviours broken down by interview length and principal domain. Of eight significant results, five were in the emotional domain. In general doctor and patient following were well matched. Patients of doctors with a medium interview style, however, showed considerably more variance

in their standard deviation in the physical domain either than doctors, or doctors and patients of other interview lengths.

Patients' mean return rate in the emotional domain consistently stood out as being very much higher than doctors' irrespective of interview length. However, patients' mean return rate was highest in medium consultations. Long consultations showed an intermediate patient return rate in the emotional domain suggesting the possibility of a falling off of emotional concern beyond a certain point. This trend was significant at the 0.005 level.

Doctor initiations are difficult to assess because of the low number of doctor initiations overall. However, comparing patients' initiation rates across interview length in the emotional domain, it can be seen that mean initiations decline as interview length increases. A longer doctor interview style thus provides a lower number of mean initiations. This trend is slightly present in the social domain, but does not seem to be present in the physical domain.

Patient rate of non-following shows that non-following tends to decrease as interview length increases in the emotional domain. The trend is reversed with respect to doctor non-following in the emotional domain. Here doctors' non-following of the emotional domain increases as interview time increases. This trend is also found for doctors in the social domain, but to a far less marked degree. Patients' mean rate of non-following in the social domain shows a very slight increase of non-following behaviours as interview style increases, and a slight decrease in medium and long interviews, when compared to short interviews, in the physical domain.

Table 6.16: Rates of Doctor and Patient Initiation, Following, Returns and Non-Follows broken down by interview length.

		Short		Medium		Long		One-way ANOVA	
		Mean	S.D.	Mean	S.D.	Mean	S.D.	F	p
FOLLOWING									
Doctor	Emotional	.057	.079	.124	.192	.160	.159	3.62	0.03
	Physical	.759	.129	.812	.190	.767	.170	0.80	ns
	Social	.085	.121	.141	.130	.128	.141	1.33	ns
Patient	Emotional	.043	.059	.134	.195	.174	.179	5.76	0.005
	Physical	.748	.123	.861	.335	.761	.149	1.95	ns
	Social	.094	.143	.118	.112	.140	.150	0.74	ns
RETURNS									
Doctor	Emotional	.050	.064	.047	.060	.054	.041	0.08	ns
	Physical	.035	.041	.014	.019	.041	.028	3.89	0.025
	Social	.011	.028	.019	.023	.016	.029	0.63	ns
Patient	Emotional	.074	.080	.149	.095	.130	.076	5.70	0.005
	Physical	.015	.028	.016	.020	.025	.038	0.80	ns
	Social	.009	.029	.032	.039	.028	.042	2.91	ns
INITIATIONS									
Doctor	Emotional	.013	.028	.004	.018	.008	.018	0.88	ns
	Physical	.005	.014	.003	.010	.004	.012	0.06	ns
	Social	.023	.035	.011	.022	.022	.022	1.25	ns
Patient	Emotional	.044	.038	.036	.012	.024	.014	3.72	0.03
	Physical	.062	.029	.038	.016	.035	.022	10.30	0.001
	Social	.030	.041	.029	.027	.024	.027	0.17	ns

Contd ...

Table 6.16: Rates of Doctor and Patient Initiation, Following, Returns and Non-Follows broken down by interview length. (Contd.)

NON-FOLLOWS									
Doctor	Emotional	.099	.082	.178	.114	.181	.086	6.72	0.002
	Physical	.040	.056	.034	.037	.060	.056	1.49	ns
	Social	.045	.061	.054	.041	.059	.052	0.51	ns
Patient	Emotional	.073	.098	.047	.062	.049	.045	0.96	ns
	Physical	.053	.045	.025	.028	.040	.028	3.64	0.03
	Social	.028	.040	.040	.034	.028	.037	0.71	ns

I. VARIATION BETWEEN DOCTOR GENDER ON PRINCIPAL AGENDAS

Table 6.17 shows the differences between male and female doctors on the three principal agendas in terms of initiating, following and returning. The frequency of male versus female floorholdings containing the principal agendas is also shown.

Table 6.17: Frequency of floorholdings containing the principal agendas, number of initiations, follows and returns by the doctor shown broken down according to the gender of the G.P. (Figures in brackets indicate percentage of row totals).

i. Frequency of floorholdings containing the principal agendas

Doctor	Emotional	Physical	Social	Total
Female	140 (11%)	791 (64%)	155 (13%)	1237
Male	252 (17%)	870 (58%)	153 (10%)	1509
	Chi-square= 20.77 $p<0.001$			

ii. Frequency of initiations of the principal agendas

Doctor	Emotional	Physical	Social	Open	Total
Female	3 (3%)	2 (2%)	18 (31%)	33 (31%)	1237
Male	252 (17%)	870 (58%)	153 (10%)	44 (30%)	1509
	Chi-square= 4.63 ns				

iii. Frequency of follows of the principal agendas

Doctor	Emotional	Physical	Social	Total
Female	94 (9%)	756 (73%)	123 (12%)	1034
Male	178 (14%)	829 (68%)	114 (9%)	1228
	Chi-square= 19.28 $p<0.001$			

iv. Frequency of returns to the principal agendas

Doctor	Emotional	Physical	Social	Total
Female	43 (45%)	33 (35%)	14 (15%)	95
Male	61 (46%)	35 (26%)	18 (13%)	134
	Chi-square= 0.86 ns			

There were 6 male and 4 female general practitioners in the present sample. Chi^2 differences between the genders emerge for frequency of floorholdings, for 'doctor follows' and for 'doctor returns' to the three principal agendas. The frequency of initiations between male and female doctors was not statistically significant.

Proportionately, female general practitioners appear to initiate fewer Emotional agendas than their male colleagues; to follow fewer Emotional agendas, and to return to slightly fewer Emotional agendas. This pattern is reversed in the social domain with female doctors initiating slightly more Social agendas, following more of the patients' Social agendas, and returning to Social concerns more frequently than male doctors. Female general practitioners initiate fewer Physical agendas than male G.P.s, but follow more Physical agendas and return to substantially more Physical agendas than males. When doctor gender differences are compared on their ratio with 'patients initiating, following and returning' (Table 6.18) it can be seen that female doctors' patients initiate proportionately more Emotional agendas than male doctors' patients, and that female doctors' patients follow Emotional agendas to the same degree as their doctors. The rate of female doctor and patient returning to Emotional agendas is slightly less than for male general practitioners. That is, female general practitioners' patients return to Emotional considerations slightly more than male general practitioners' patients. The rate of female doctors' patients initiating Social agendas is comparable whereas male doctors' patients initiate Social agendas more. The ratio of doctor to patient returning in the social domain is comparable.

Table 6.18: Frequency of floorholdings containing the principal agendas, number of initiations, follows and returns by doctor and patient, shown broken down according to the gender of the G.P. (Figures in brackets indicate percentage of column totals).

i. Frequency of floorholdings containing the principal agendas

		Emotional	Physical	Social	Total
FEMALE G.P.s	Doctor	140 (37%)	791 (50%)	155 (48%)	1237
	Patient	235 (63%)	803 (50%)	169 (52%)	1326
	Chi-square= 18.43 p<0.01				
MALE G.P.s	Doctor	252 (41%)	870 (49%)	153 (46%)	1509
	Patient	360 (59%)	891 (51%)	180 (54%)	1607
	Chi-square= 12.55 p<0.01				

ii. Frequency of initiations of the principal agendas

		Emotional	Physical	Social	Open	Total
FEMALE G.P.s	Doctor	3 (9%)	2 (5%)	18 (51%)	33 (97%)	1237
	Patient	30 (91%)	35 (95%)	17 (49%)	1 (3%)	1326
	Chi-square= 79.42 p<0.001					
		Emotional	Physical	Social	Open	Total
MALE G.P.s	Doctor	13 (28%)	6 (11%)	21 (37%)	44 (98%)	147
	Patient	34 (72%)	48 (89%)	35 (63%)	1 (2%)	165
	Chi-square= 83.28 p<0.001					

Contd ...

Table 6.18: Frequency of floorholdings containing the principal agendas, number of initiations, follows and returns by doctor and patient, shown broken down according to the gender of the G.P. (Figures in brackets indicate percentage of column totals). Contd.

iii. Frequency of follows of the principal agendas					
		Emotional	Physical	Social	Total
FEMALE G.P.s	Doctor	94 (50%)	756 (50%)	123 (48%)	1034
	Patient	94 (50%)	750 (50%)	131 (52%)	1032
	Chi-square= 0.27 ns				
		Emotional	Physical	Social	Total
MALE G.P.s	Doctor	178 (48%)	829 (50%)	114 (50%)	1228
	Patient	190 (52%)	815 (50%)	113 (50%)	1224
	Chi-square= 0.51 ns				

iv. Frequency of returns to the principal agendas					
		Emotional	Physical	Social	Total
FEMALE G.P.s	Doctor	43 (28%)	33 (65%)	14 (40%)	95
	Patient	110 (72%)	18 (35%)	21 (60%)	163
	Chi-square= 21.93 $p<0.001$				
		Emotional	Physical	Social	Total
MALE G.P.s	Doctor	61 (31%)	35 (56%)	18 (36%)	134
	Patient	136 (69%)	28 (44%)	32 (64%)	1224
	Chi-square= 12.43 $p<0.001$				

The pay-off tables (Table 6.19) indicate that when female doctors initiate Emotional agendas they are followed by the patient in the next floorholding considerably less often than is the case when male general practitioners initiate in the emotional domain (33% followed by patients compared to 54% followed by patients). There is less gender difference between doctors when they return to emotional concerns. Female doctor returns to Emotional agendas are followed 60% of the time in the next floorholding by patients. There is little difference for male doctors whose patients follow their doctors 66% of the time in the emotional domain. The pay-off for male and female doctors initiating in the social domain, in terms of obtaining a patient follow in the next floorholding, is comparable (95% versus 94%). However, when female doctors return to Social agendas, patients follow the return by 92%. This contrasts with a patient following of 78% of male doctors returns to Social agendas. When doctor following is examined in terms of obtaining a patient following subsequently, there is a slight tendency for male doctors to obtain a patient follow more often than female doctors in the emotional domain (79% to 74%). Female doctors, in contrast,, obtain a patient follow much more often than do male general practitioners in the social arena. Both sexes have a high pay-off for initiating, returning to, or following, Physical agendas.

Table 6.19: Pay-off for the principal agendas shown broken down by gender of G.P.

i. Physical agendas					
FEMALE G.P.s					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	2 (100%)	0 (0%)	32 (91%)	3 (9%)
Floorholding	Follow	729 (96%)	27 (4%)	709 (95%)	39 (5%)
	Return	29 (88%)	4 (12%)	14 (82%)	3 (8%)
		Chi-square=6.22 p<0.05		Chi-square=5.44 p<0.06	
MALE G.P.s					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	6 (100%)	0 (0%)	43 (90%)	5 (10%)
Floorholding	Follow	784 (95%)	45 (5%)	766 (94%)	49 (6%)
	Return	27 (82%)	6 (8%)	25 (89%)	3 (11%)
		Chi-square=9.71 p<0.01		Chi-square=2.37 ns	

Contd ...

Table 6.19: Pay-off for the principal agendas shown broken down by gender of G.P. (Contd.)

ii. Emotional agendas					
FEMALE G.P.s					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	1 (33%)	2 (67%)	3 (10%)	27 (90%)
Floorholding	Follow	30 (74%)	24 (26%)	47 (50%)	47 (50%)
	Return	25 (60%)	17 (40%)	43 (39%)	67 (61%)
		Chi-square=4.87 ns		Chi-square=15.23 p<0.01	
MALE G.P.s					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	7 (54%)	6 (46%)	13 (62%)	21 (38%)
Floorholding	Follow	141 (79%)	37 (21%)	117 (62%)	73 (38%)
	Return	40 (66%)	21 (34%)	47 (35%)	89 (65%)
		Chi-square=7.58 p<0.05		Chi-square=24.95 p<0.001	

Contd ...

Table 6.19: Pay-off for the principal agendas shown broken down by gender of G.P. (Contd.)

iii. Social agendas					
FEMALE G.P.s					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	17 (94%)	1 (6%)	10 (59%)	7 (41%)
Floorholding	Follow	104 (85%)	19 (15%)	102 (78%)	29 (22%)
	Return	12 (92%)	1 (8%)	10 (48%)	11 (52%)
		Chi-square=1.73 ns		Chi-square=9.93 $p<0.01$	
MALE G.P.s					
		DOCTOR		PATIENT	
		Next Floorholding		Next Floorholding	
		Followed	Non-Followed	Followed	Non-Followed
Current	Initiation	20 (95%)	1 (5%)	21 (60%)	14 (40%)
Floorholding	Follow	77 (68%)	37 (32%)	75 (66%)	38 (34%)
	Return	14 (78%)	4 (22%)	20 (63%)	12 (37%)
		Chi-square=7.11 $p<0.05$		Chi-square=0.54 ns	

J. DISCUSSION

This chapter has examined the pattern of interactional analysis in a series of general practice consultations, noting in particular how the pattern of interaction varies according to the characteristics of the general practitioner. The findings clearly support the hypothesis that the pattern of interaction within general practice consultations varies according to the characteristics of the general practitioner (Chapter 2, hypothesis 11). Differences between individual doctors were greatest in the analysis of the pay-off for initiating, returning to and following the principal agendas. The variation was greatest for Emotional agendas; less for Social agendas; and there was very little difference in the pay-off between doctors for Physical agendas. Doctors were also found to differ in the length of time they took to complete consultations. Doctors with a long consultation style were more likely to follow and return to Social agendas. There was no evidence that longer interviews resulted in more initiation and following of Emotional agendas. Interview length per se was related to differences in interactional measures. Longer interviews were associated with greater doctor initiations of Social agendas; differences in doctor non-following of Physical agendas; more follows by both parties on all three principal agenda types; more returns to Physical agendas by the doctor, and more returns to Emotional agendas by the patient. These findings support to a degree the hypotheses laid out in chapter 2. It was suggested that longer interviews may be associated with greater processing of non-physical agendas by both patient (hypothesis 2) and doctor (hypothesis 3). Longer interviews are associated with more following of, and returning to, Emotional agendas by patients; there is no effect of interview length on patients' handling of Social agendas other than an increase in following. For doctors increasing interview length means an increase in initiation and following of Social agendas, but only an increase in following of Emotional agendas. Finally, differences were found between male and female general practitioners in their handling of the three principal agenda types. Female doctors had a higher rate of occurrence of Physical agendas than male doctors who had a greater rate of occurrence of Emotional agendas. Female doctors

initiating Emotional agendas were less likely to be followed by their patients, however they were more successful than their male counterparts when they returned to Social agendas.

Several important issues arise out of the analysis of principal agendas between G.P.s The first concerns the generalisability of the main analysis, since considerable doctor differences emerged. Kraan et al (1990), in a paper presented at the International Conference on Communication in Health Care, Oxford, propose that more than 30 medical interviews from any one doctor are required for a reliable evaluation of the physician's interviewing skills. For an evaluation of process skills, 15 cases are needed, and for content related skills 25 consultations are required. This assessment is based on generalisability analysis.

In the present sample it appears that physicians may provisionally be categorised according to the extent to which they return to emotional and social concerns. Nor does doctor returning to these agendas seem to be associated with the nature of the patients presenting problem. In general, however, doctors tend to return to Physical agendas more than they do to Emotional or Social agendas. Patient initiation of all three principal agendas is fairly balanced between doctors whereas doctors demonstrate considerable variability in the extent to which they initiate agendas, especially in the social and emotional domains. As in the main analysis and in the analysis according to the nature of patients' presenting problems, following seems always to beget following. The 'pay-off' data show that there is a high pay-off for doctors and patients on all measures in the physical domain, but that there is considerable variation between doctors in the emotional domain. The nature of the presenting problem may influence the extent to which doctors follow patients on the pay-off measures of initiating, following and returning in the next floorholding, but low cell frequencies make it difficult for interpretation to be anything more than suggestive.

In terms of the three dimensions referred to in earlier chapters there again appears to be considerable variation between doctors. For example, Doctor 1 proportionately

initiates a lot of emotional and social issues whereas doctor 6 initiates frequently in the social domain. Doctors 3,7 & 10 initiate very little at all. G.P. 7 returns in a balanced way to all three agendas whereas most other doctors vary in the extent to which they return to each domain. The balance of power between doctor and patient thus reflects similar variability with respect to each party being in tune with one another the message is the same: in the physical arena both doctor and patient tend to be in tune irrespective of G.P. However, in the emotional and social domains some doctors are more in tune with their patients than others. The extent to which doctors demonstrate an awareness of broader psychosocial issues reflects these differences.

Since there is without question considerable between doctor variation, the analysis moved on to consider what stable 'between doctor' relationships might emerge in the light of Dale & Middleton's (1990) conjecture that stable doctor traits may contribute more to doctors' consideration of patients psychosocial problems than formal training. Length of interview and gender were considered.

The consultations were divided, according to the criteria of Howie et al (1991), into long, medium and short interviews defined by doctors mean interview duration. Howie et al found that longer interviews were associated with greater doctor attention to psychosocial issues, a finding consistent with other investigators (Verby et al, 1979; Roland, 1986). Howie et al also calculated the ratio of long to short doctor consultations with a view to assessing the extent to which this fell as a result of various logistical pressures such as the surgery running late. The idea informing this study was that if longer consultations were associated with more doctor attention being paid to considerations like health promotion and psychosocial issues, the ratio of long to short interview could provide an index of the quality of care being provided to patients.

Analysis showed that doctors in the present sample did seem to show a bias towards long, medium or short interviews. Any doctor preference for a particular length of consultation was referred to as doctor 'style'. The ratio of long to short interviews was very similar to the ratio found by Howie et al for doctors with a short consultation

style. However, the ratio of long to short interviews increased in the present sample as doctor interview style increased. Howie et al's sample did not show an increase to the same extent, suggesting that doctors in this study had longer interviews.

Unlike other research, it did not seem that length of interview in the present investigation contributed significantly to the extent to which doctors paid attention to emotional issues. This echoes to some extent the findings of Risdale et al (1992). These investigators looked at general practitioners' use of asking questions, facilitation and problem explanation in consultations booked at 5 minute and 10 minute intervals. They found that all doctors asked more questions in longer interviews, but only some doctors used facilitation more frequently. Doctors who used these skills least with patients booked at 5 minutes did not necessarily change their practice with patients booked at 10 minute intervals. Thus time available did not seem to be the main determinant of consultation style. Rather than remedying any defect, doctors tended to increase what they did already. In the present study however, doctors with a longer consultation style did seem to follow patients Social agendas more often than doctors with a shorter interview style. As interview time increased, however, there was significantly more doctor non-following of all patient agendas and particularly Physical and Emotional agendas. This may suggest that when they feel the pressure of time doctors are reluctant to pursue patients' agendas further, and that they are particularly reluctant to follow Physical and Emotional agendas which they perceive may require more time to process. It can be said, therefore, that doctors are less in tune with patients the longer doctor and patient are in consultation; and that doctors with a short interview style do not seem to be less in tune with their patients in the emotional domain than doctors with a long consultation style. Moreover, consultation length seems only to contribute to greater attention being paid to the social domain, demonstrated by a slightly less positive (but still significant) relationship between interview duration and doctor non-following of Social agendas than is the case with doctor non-following in the other principal domains, and a significant relationship between consultation length and doctor following of

patients social concerns. Doctors with all three styles pay considerably less attention to Emotional and Social agendas than they do to Physical agendas, and in this respect they echo the main analysis.

Given that significant differences emerged between male and female general practitioners On the face of it, it seemed that female doctors were less in tune with the emotional domain than male doctors, which was demonstrated by their lower initiating and following of Emotional agendas. This result must be balanced with the finding that female G.P.'s patients initiated proportionately more emotion than male doctor's patients (although this was not statistically significant) suggesting that female doctors' patients are more prepared to volunteer emotional information than male doctors' patients and that female doctors do not therefore need to initiate as much emotion. A similar finding by Shapiro & Schiemer (1990) supports this trend. In an examination of residents' performance in conducting clinical interviews they found that although sex differences between general practitioners were generally non significant, female residents tended to perform somewhat better in terms of empathy, use of open ended questions and reassurance. In the context of Dale & Middleton's (1990) study showing that male general practitioners rated their ability to manage consultations more highly than female general practitioners, it is possible to conceive that male doctors will step in and 'manage' a consultation by asking about emotion directly, whereas female doctors will more often wait for patients' emotional cues. The pattern is reversed for Social agendas with female doctors initiating more social concerns than their male colleagues and with male physicians' patients initiating proportionately more in the social domain. However the pay-off for a female doctors' patient initiating an Emotional agenda was less than for a male doctors' patient (33% and 54% respectively). For causal relationships, for example, the extent to which patients initiate more of a given agenda as a result of doctors initiating less (or vice versa) cannot be inferred from these results. Irrespective of direction, it did seem that stable characteristics emerged according to doctor gender. As

numbers are low for the between doctor analysis, further research will be required to test the hypotheses further.

CHAPTER 7 : PROCEDURES AND PROCESSES

A. RATIONALE.

B. PROCESSES: INFORMATION PROCESSING ACCORDING TO PRINCIPAL AGENDAS.

C. PROCESSES: DISTRIBUTION OF INFORMATION GIVING AND INFORMATION SEEKING ACCORDING TO HALF INTERVIEW AND PRINCIPAL AGENDAS.

D. PROCESSES: DISTRIBUTION OF INFORMATION GIVING AND INFORMATION SEEKING ACCORDING TO HALF INTERVIEW, PRINCIPAL AGENDA AND PRESENTATION.

E. PROCEDURES: DISTRIBUTION OF DOCTOR AND PATIENT PROCEDURES BY QUARTER OF INTERVIEW.

F. PROCEDURES: AGENDA OCCURRENCE IN FLOORHOLDINGS FOLLOWING PHYSICAL EXAMINATION.

G. PROCEDURES: PROCEDURES ASSOCIATED WITH PRINCIPAL AGENDAS FOR DOCTORS AND PATIENTS.

H. PROCEDURES AND PROCESSES: ASSOCIATION BETWEEN PROCEDURES AND PROCESSES FOR DOCTORS AND PATIENTS.

I. PROCEDURES AND PROCESSES: PROCEDURES AND PROCESSES USED BY INDIVIDUAL GENERAL PRACTITIONERS.

J. PROCEDURES AND PROCESSES: DISTRIBUTION OF PROCEDURES AND PROCESSES FOR DOCTOR AND PATIENT.

K. DISCUSSION.

A. RATIONALE

The medical interview, and indeed any formal interview is characterised by the procedures by which it is informed. Procedures are the structural components which map an interview and very often, although not always, a procedure will follow a particular sequence. Thus, to give an extreme example, it would be unusual for parties to behave in the manner of a farewell when an interview had just begun, or in the doctor-patient consultation it would be unlikely to find a doctor prescribing treatment before he has heard the patient's history and made a diagnosis. When procedures occur in unexpected places, or do not follow a familiar pattern, it is possible to infer that there is something strange (although not necessarily wrong) about the interview in question. Procedures are also informed by the context of the interview. A common procedure may have a different meaning depending on the interview situation. For example, a physical examination in police custody would imply something rather different to the physical examination which occurs in the doctor's surgery. Both are aiding what amounts to a diagnosis, but in each case the diagnosis points to an alternative reference. In a sense, procedures enable the interview to happen. They are the quantitative stages which inform qualitative changes as they occur. The more formal the interview, the more strictly the procedures will adhere to a preconceived pattern. Procedures occur through the exchange of information. Cherry (1978) has said that communication may be defined as the exchange of information and argues cogently for this view. Because they facilitate information exchange by processing interview content, procedures therefore are integral to the communication process in many situations. Procedures can be likened to the rituals that characterise a ceremony. Information exchange may occur without procedures, but procedures give form to meaning. At a syntactic level a sentence will have meaning without punctuation, but punctuation may provide additional information about the way in which the sentence signifies or 'means'. The doctor-patient consultation seeks to diagnose a problem and to provide relief for that problem in some way: vicariously by referring or provisionally by prescribing. However this was not always the case. The term diagnosis derives from the

Greek verb to distinguish, and physicians have not always felt the need to identify disease (Clyne, 1983). The books of the Hippocratic corpus, for example, while they make clear the doctor's monopoly of relevant experience, do no more than give an account of vague and ill-defined terms such as 'crisis', 'fever', 'apoplexy' (Freidson, 1970). Diagnosis as we understand it today was born out of the finely tuned observations of the early pathographers, in conjunction with the flourishing of the natural sciences. Its development is fundamental to the historical process through which the practitioners of medicine came to claim credibility as a profession. Although modern medicine has on the one hand increased the need for accurate and precise diagnoses, it has on the other hand diminished the need. Many therapeutic measures today are so embracing that they will cure irrespective of diagnosis. Making a diagnosis is not merely an intellectual exercise for the doctor, but is a process which has social and emotional connotations for doctor and patient alike. Clyne (1985) illustrates this by giving the example of a mother who brought her six year old son to the surgery with complications in his chest. The doctor made a diagnosis of bronchitis, to him a relatively harmless acute inflammatory affliction of the bronchi readily cured by antibiotics. Upon the diagnosis the mother burst into tears. To her the diagnosis implied a terrifying disease which years ago had strangled a relative to death. In the doctor-patient consultation diagnosis is thus the overall structure which provides information on two levels. At an intellectual level it is an assessment of the patient's disease, or disorder, to indicate its etiology and possible effects. On an emotional level it may enhance meaning for both doctor and patient, in that a diagnosis may enable the patient to provide additional and perhaps important information (as in the case above), or it may structure emotion. The structuring of emotion may be malevolent or benevolent. If it enables the doctor to locate the disease and join with the patient in managing the disease it will be the former. If, alternatively, the diagnosis renders the patient further alone in his distress, it will be the latter. The way in which the diagnosis is made can therefore have important implications for the consultation, and still more important considerations for the doctor-patient relationship.

Outcome measures of the doctor-patient consultation have suggested that patients respond favourably to receiving more information from their doctor in the interview (Stiles et al, 1979; Smith et al, 1981; Inui et al, 1976). However, Kinderlan & Kent (1987) have shown that while doctors think patients want more information about treatment, patients themselves prefer more information about the diagnosis and prognosis of their condition. It could be said that information about treatment is more pragmatic, more technical, more about medical certainty and therefore more about a doctor centred approach to the consultation. To provide information about diagnosis and prognosis, on the other hand, is perhaps a little less clear cut. Patients show considerable individual difference in their response to disease, and to predict outcome may be to render the doctor more violate. Moreover, to discuss diagnosis potentially is to touch on the patient's feelings, and in touching the patient's feelings any medical solution is likely to seem less clear. It has been demonstrated that doctors are less satisfied with consultations in which the medical solution is clear cut (Winefield & Murrell, 1991; Buijs et al, 1984), so doctors may have a disincentive to provide more information about prognosis and diagnosis. Any such disinclination would additionally point to a doctor centred approach to the consultation. The dependent variable most often used to assess the doctor's provision of information is patient satisfaction. In a meta-analysis of physician and patient behaviour categories Roter (1989) found that for the doctor to seek information (question asking) correlated negatively with patient compliance and recall, and was unrelated to patient satisfaction. Giving patients information, in contrast, was quite strongly related to satisfaction, compliance and recall. However, as has been suggested above, giving information in itself may not be beneficial to the patient. This is demonstrated in the contrasting work of Ley (1979;; Ley et al, 1973, 1976) and Tuckett et al (1985). Ley's work has been used to support two propositions. Firstly, that patients are unlikely to remember very much information, and secondly that whatever information is communicated to the patient should be kept simple, should be clearly organised, and should be free from medical jargon. Unfortunately these have been used to caution

doctors to restrict their communication process and to encourage patients to write down what is said (Royal College of General Practitioners, 1981; Walton et al, 1980). Ley's thesis was in fact that communication from doctor to patient was poor because patients were dissatisfied with how little information they received. That they received little was not because information had been withheld but because patients had been unable to comprehend what they had been told and had therefore forgotten it (see below). Ley's solution was to improve doctor's communication skills by making it better organised so that patients would remember it, comprehend it, and feel satisfied that they had been informed. However, as Tuckett et al (1985) point out, Ley is known and widely quoted in medical circles and clinical psychology more because his ideas are consonant with a doctor oriented perception of the patient than because he believed that doctors should use more appropriate skills. Tuckett et al continue to elucidate the problems with Ley's conception of the consultation. This started from the premise that the problem was to determine how one person who knew communicated with another who did not. Since a questionnaire had demonstrated that many patients did not possess adequate medical knowledge, patients in effect, were being asked to learn nonsense. It was thought that patients were in this predicament because they had no set of associations to encode information and as a consequence were attempting to remember individual items of doctor information. The implication of these assumptions is twofold. First, it implies that if whatever knowledge the patient does possess is biologically unsound, it is tantamount to no knowledge at all and therefore irrelevant. Second, it assumes a doctor centred approach since the possibility of mutual influence and a shared perspective is not possible in what amounts to a 'one-way dialogue'. Sadly, Ley's recommendations are assimilated all too readily within a framework which states: "A lot of valuable time would be saved if our patients could be taught that all we want to hear from them is an account of their symptoms as concise as possible and chronological ! What we do not want to know are the very things they are bursting to tell us ..." (Cassidy, 1938). Doctor centredness may not be so explicit nowadays, but, as was drawn out in chapter 4 its

influence can still be felt and indeed continues to be claimed. Moreover, Ley's views continue to be forwarded both at undergraduate and postgraduate psychology level (cf. Ley, 1977) with the result that his model continues to hold sway with students who, as professionals, are likely to have input to medical communication skills training. To give information to patients simply, to put the most important advice first and to encourage patients to write things down, may be to give patients information and may even be to enhance patients' recall of what has been said, but it is not necessarily giving patients information that is meaningful to them. Tuckett et al examined patients' recall from an alternative perspective, paying particular attention to the characteristics of the information the patient was given; the ambiguous and contradictory cues doctors provided, and the inclination of the doctor to inhibit and evade patients' ideas. They found that these, together with the divergence of some patients' detailed understanding, seemed to explain to a high degree which patients remembered and correctly made sense of what their doctors said and which did not. Tuckett et al argue that the crucial determinant of patients' understanding and recall is the explanatory model with which they enter the consultation. Those patients who remembered did so because the doctor confirmed the ideas they had already, or provided them with treatment or advice they anticipated. Although doctors and patients did not explicitly exchange their ideas, (Tuckett et al found that both parties restricted such dialogue) this did not influence the understanding of the majority of the patients for the worse. The authors propose that the mechanisms for such an exchange are twofold. Firstly, societies in Britain and the U.S.A. lean heavily upon a health care system in which lay health knowledge and explanatory models are developed side by side. Secondly, because general practitioners tend to deal with self-limiting problems symptomatically rather than in association with the underlying disease process, their operational modes are often closer to the lay models of their patients than to the text book models of disease (Christman, 1977; Helman, 1978). Thus the patient's lay knowledge 'fills in' and draws upon the doctor's comments in making sense of the consultation, and it is this 'anecdotal' sharing of ideas that enables the patient to

remember what information he has been given. When the patient's initial view differs from that of the doctor, brief or vague comments from either party leave things implicit and do not convey an alternative perspective. In this case, patients incorrectly assumed that doctors are confirming their own views. Measuring patients' satisfaction in relation to general practitioners correctly identifying psychiatric illness as defined by the General Health Questionnaire, May (1992) found that patients only felt more helped if their problem had been identified. They did not feel more satisfied on other measures addressing issues such as patients' perception of doctor understanding or the doctors' ability to give information. May draws attention both to the problems which attend measuring something so global as satisfaction, and the distinction to be made between a doctor's silent recognition of psychiatric disorder and his sharing of this insight with the patient. This silent recognition of problems may be a counterpart in doctors to patients' 'filling in' of knowledge. There is perhaps more of a case for doctors to ascertain what has been understood by patients than to check what patients can remember. A recognition of different views is an important first step towards exploring these views and hence towards a shared explanatory model of the consultation. This is discussed further in chapter 8. The notion of the doctor dealing with a problem systematically and with an operational model closer to lay health knowledge is complementary, at a conceptual level, to the delineation of the general practitioner as an anecdotalist. This idea is explored in some depth in the Introduction and section D of the Conclusion. The provision of information from doctor to patient, then, appears either to be coded in the traditional medical model, or based upon a provisional and haphazard conjoining of doctor and patient ideas about the nature of the problem in hand. It is apparent from this that information may be transferred on many levels. Many of these levels are described by Wasserman & Inui (1983), and elucidated in chapters 1 and 3. The procedures that effect the transfer, and the processes through which the transference takes place, are the structural components of the doctor-patient consultation. In the system of interaction analysis already described, procedures are conceived of as the techniques which are

brought to bear on doctors' and patients' problems - their agendas. Thus a doctor can prescribe treatment for a problem to another speciality, may conduct a physical examination, or may carry out or order an investigation about the problem. These procedures are categorised as: Treatment, Referral, Physical Examination and Investigation. There are two further procedures and these describe the beginning and the ending of the consultation - Introduction and Conclusion. Both doctors and patients have access to all procedures. Although it is less likely, for example, a patient may suggest that a particular treatment is appropriate for his condition, may ask for referral to another speciality or may conduct Physical Examination by pointing to, or touching, a particular bodily part. If procedures are conceived of as the techniques which are brought to bear upon them in some way, Information processing, itself a procedure, provides the link to be made between agendas and procedures. Procedures enable the interview to happen: information processing takes many forms, but those most salient to the general practice consultation and which are described by the system of interaction analysis in hand, are: Giving Information, Seeking Information, Discussing Information, Accepting Information, Recording Information and Prescribing. Accepting Information includes Active Listening, and Seeking Information includes Consulting Notes. These last were rated separately but were coded overall within the main category of concern. Active Listening and Consulting Notes therefore form subcategories of Information Processing and their effects may be assessed either independently or as part of the category under which they are subsumed. Definitions for all categories are to be found in the Rules for Coding, chapter 3. Because Recording Information is primarily a doctor activity (although theoretically available to the patient) and because the hypotheses are concerned with doctor and patient interaction, analysis of this category is limited. For the same reason analysis of Prescribing is limited to the last section.

B. INFORMATION PROCESSING ACCORDING TO PRINCIPAL AGENDAS

Table 7.1 compares doctor and patient Giving Information for the three principal agendas. In all three domains patients proportionately give far more information than doctors. They give the least information about Physical agendas and the most information about Social , and give twice as much information as doctors in the emotional domain. Doctors, in comparison, seek information proportionately far more than patients, and seek comparatively more information than patients give information, Table 7.2. Patients seek most information in the physical domain and seek least information in the social domain. They seek information intermediately in the emotional domain. Correspondingly, doctors seek proportionately most information with respect to Social agendas and least information with respect to Physical agendas. Table 7.3 shows that in all three domains doctors Discuss Information more than patients, and discuss information roughly to the same extent in each principal agenda. Discussing information is relatively less frequent than either Seeking Information or Giving Information, supporting the hypothesis that Discussing Information would have a low rate of occurrence (hypothesis 17, chapter 2). Doctors and patients Accept Information to a greater or lesser extent according to domain. Patients accept information proportionately more often in the physical domain and doctors accept more information in the Social domain. However, both doctor and patient accept information equally in the emotional domain.

Table 7.1: Comparison of Doctor and Patient Giving Information for the three principal agenda types. (Figures in brackets give row percentages).

	Dr	Pt
Physical	753 (38%)	1244 (62%)
Emotional	204 (28%)	513 (72%)
Social	82 (22%)	298 (78%)
	Chi-square=48.23 $p<0.001$	

Table 7.2: Comparison of Doctor and Patient Seeking Information for the three principal agenda types. (Figures in brackets give row percentages).

	Dr	Pt
Physical	739 (77%)	218 (23%)
Emotional	123 (83%)	25 (17%)
Social	157 (87%)	24 (13%)
	Chi-square= 9.91 $p<0.01$	

Table 7.3: Comparison of Doctor and Patient Discussing Information for the three principal agenda types. (Figures in brackets give row percentages).

	Dr	Pt
Physical	155 (63%)	90 (37%)
Emotional	32 (63%)	19 (37%)
Social	27 (64%)	15 (36%)
	Chi-square= 0.02 ns	

Table 7.4: Comparison of Doctor and Patient Accepting Information for the three principal agenda types. (Figures in brackets give row percentages).

	Dr	Pt
Physical	123 (34%)	234 (66%)
Emotional	48 (50%)	48 (50%)
Social	45 (71%)	18 (29%)
	Chi-square=33.29 p<0.001	

Table 7.5: Distribution of Doctor and Patient Giving Information and Seeking Information by half of interview. (Figures in brackets give row percentages).

	Giving Information		Seeking Information	
	Interview Half		Interview Half	
	1	2	1	2
DR	323 (30%)	740 (70%)	721 (63%)	415 (37%)
PT	1184 (56%)	923 (44%)	97 (33%)	194 (67%)
	Chi-square= 188.69 p<0.001		Chi-square= 85.99 p<0.001	

C. DISTRIBUTION OF INFORMATION GIVING AND INFORMATION SEEKING ACCORDING TO HALF INTERVIEW AND PRINCIPAL AGENDAS

Overall examination of processes according to half of interview shows that patients' information giving is fairly balanced by half interview but that doctors proportionately give more than twice as much information in the second half of the interview (Table 7.5). Doctors proportionately seek more information in the first half of the consultation whereas patients seek proportionately more information in the second half of the

interview. Doctors seek information in the second half of the interview to roughly the same extent that patients seek information in the first half of the interview (Table 7.5). Distribution of doctor and patient Giving Information and Seeking Information by half of interview, broken down by the three principal agendas, shows more variance than the overall analysis. Tables 7.6, 7.7 and 7.8 demonstrate that patients give nearly twice as much information as doctors in the first half of the consultation when the agenda is Physical; more than twice as much information as doctors when the agenda is Emotional, and more than three times as much information as doctors when the agenda is Social. This bias is always towards the first half of the consultation. Doctors, in contrast, give increasingly less information in the first half of the interview according to domain. They give most information in the physical domain, least information in the social domain, and give information intermediately in the emotional domain. Although doctors seek almost twice as much information as patients in the physical domain in the first half of the consultation, patients seek information about twice as often as doctors in the second half of the interview (Table 7.7). Doctors seek only slightly more information in the first half of the interview in the emotional domain whereas patients seek information more frequently in the second half of the consultation in this domain. Doctors' information seeking in respect of Social agendas is even more balanced than their information seeking for Emotional agendas, being almost exactly balanced between half interview. Patients, in contrast, seek information about Social agendas three times as often in the second as in the first half of the consultation (Table 7.8). Proportionately patients seek increasingly more information than doctors in the second half of the interview according to Physical, Emotional and Social agendas respectively. Patients' information seeking shows a bias towards the second half of the interview in all domains. Doctors' information seeking occurs more in the first half of the consultation in the physical and emotional domains, but is more balanced according to interview half in the social domain.

Table 7.6: Distribution of Doctor and Patient Giving Information and Seeking Information by half of interview, broken down by the three principal agenda types. (Figures in brackets give row percentages).
EMOTIONAL agendas.

	Giving Information		Seeking Information	
	Interview Half		Interview Half	
	1	2	1	2
DR	44 (22%)	160 (78%)	70 (57%)	53 (43%)
PT	282 (55%)	231 (45%)	8 (32%)	17 (68%)
	Chi-square= 65.68 $p<0.001$		Chi-square= 5.17 $p<0.05$	

Table 7.7: Distribution of Doctor and Patient Giving Information and Seeking Information by half of interview, broken down by the three principal agenda types. (Figures in brackets give row percentages).
PHYSICAL agendas.

	Giving Information		Seeking Information	
	Interview Half		Interview Half	
	1	2	1	2
DR	260 (35%)	493 (65%)	471 (64%)	268 (36%)
PT	735 (59%)	509 (41%)	72 (33%)	146 (67%)
	Chi-square= 113.13 $p<0.001$		Chi-square= 64.67 $p<0.001$	

Table 7.8: Distribution of Doctor and Patient Giving Information and Seeking Information by half of interview, broken down by the three principal agenda types. (Figures in brackets give row percentages).
SOCIAL agendas.

	Giving Information		Seeking Information	
	Interview Half		Interview Half	
	1	2	1	2
DR	10 (12%)	72 (88%)	77 (49%)	80 (51%)
PT	133 (45%)	165 (55%)	6 (25%)	18 (75%)
	Chi-square= 28.83 $p<0.001$		Chi-square= 4.85 $p<0.05$	

D. DISTRIBUTION OF INFORMATION GIVING AND INFORMATION SEEKING ACCORDING TO HALF INTERVIEW, PRINCIPAL AGENDA AND PRESENTING PROBLEM

In the Acute Physical presentation both doctors and patients overall give information almost to exactly the same extent as they did in the overall analysis of Giving Information by half of interview (table 7.9, compare with table 7.5). They also Seek Information in the same proportions. However, when this is broken down by agenda type, differences emerge in the emotional and social domains. Generally, the proportions are the same as for the analysis not broken down by presenting problem, but in the emotional domain patients seek rather more information in the second half of the consultation, and in the social domain patients and doctors are almost exactly balanced in the extent to which they seek information (tables 7.10, 7.11 and 7.12). In the Chronic Physical presentation, the overall analysis within presentation again differs very little from the overall analysis shown in Table 7.5. The breakdown of Giving and Seeking Information according to agenda continues to show little difference in the physical domain. Doctors give information about twice as much in the second half as in the first half of the interview;

patients continue to give slightly more information in the first half of the interview; doctors still seek almost twice as much information in the second half of the interview, and patients seek more information in the second half of the interview (table 7.15) Patients do, however, seek very slightly more information in the first half of the interview than in the overall analysis (table 7.5). There is more of a difference in the emotional domain when compared to the overall analysis when the presentation is Chronic Physical. While 77 percent of information giving by doctors is still in the second half of the interview, proportionately patients give slightly less information in a second half of the consultation and therefore give more information in the first half of the interview (table 7.14). Patient giving of information goes up slightly from 57 percent in the first half of the interview in the overall analysis (table 7.5), to 60 percent in this domain. Patient seeking of information, however, is exactly balanced between the two halves (table 7.14). This contrasts with patients' Seeking Information 32 percent and 68 percent in the two halves of the consultation respectively in the overall analysis. Doctor and patient Giving Information in the social domain is comparable to the latter, as is doctor Seeking Information, but patients only seek information in the second half of the interview when the presentation is Chronic Physical (table 7.16).

Table 7.9: Distribution of Doctor and Patient Giving Information and Seeking Information by half of interview, broken down by the three principal agenda types. ACUTE PHYSICAL presenting problem. (Figures in bracket give row percentages). OVERALL figures

	Giving Information		Seeking Information	
	Interview Half		Interview Half	
	1	2	1	2
DR	206 (31%)	457 (69%)	473 (64%)	264 (36%)
PT	719 (56%)	573 (44%)	60 (34%)	115 (66%)
	Chi-square= 106.19 p<0.001		Chi-square= 52.03 p<0.001	

Table 7.10: Distribution of Doctor and Patient Giving Information and Seeking Information by half of interview, broken down by the three principal agenda types. ACUTE PHYSICAL presenting problem. (Figures in bracket give row percentages).

Emotional agendas				
	Giving Information		Seeking Information	
	Interview Half		Interview Half	
	1	2	1	2
DR	29 (21%)	108 (79%)	44 (55%)	36 (45%)
PT	171 (52%)	155 (48%)	3 (23%)	10 (77%)
	Chi-square= 38.48 p<0.001		Chi-square= 4.56 p<0.05	

Table 7.11: Distribution of Doctor and Patient Giving Information and Seeking Information by half of interview, broken down by the three principal agenda types. ACUTE PHYSICAL presenting problem. (Figures in bracket give row percentages).

Physical agendas				
	Giving Information		Seeking Information	
	Interview Half		Interview Half	
	1	2	1	2
DR	164 (35%)	305 (65%)	311 (65%)	169 (35%)
PT	460 (59%)	316 (41%)	42 (31%)	93 (69%)
	Chi-square= 69.11 p<0.001		Chi-square= 48.88 p<0.001	

Table 7.12: Distribution of Doctor and Patient Giving Information and Seeking Information by half of interview, broken down by the three principal agenda types. ACUTE PHYSICAL presenting problem. (Figures in bracket give row percentages).

Social agendas				
	Giving Information		Seeking Information	
	Interview Half		Interview Half	
	1	2	1	2
DR	6 (15%)	35 (85%)	45 (47%)	50 (53%)
PT	66 (43%)	89 (57%)	6 (46%)	7 (54%)
	Chi-square= 10.90 p<0.001		Chi-square= 0.007 ns	

Table 7.13: Distribution of Doctor and Patient Giving Information and Seeking Information by half of interview, broken down by the three principal agenda types. CHRONIC PHYSICAL presenting problem. (Figures in brackets give row percentages). OVERALL figures.

	Giving Information		Seeking Information	
	Interview Half		Interview Half	
	1	2	1	2
DR	87 (29%)	212 (71%)	159 (65%)	85 (35%)
PT	301 (57%)	224 (43%)	31 (34%)	61 (66%)
	Chi-square= 60.96 p<0.001		Chi-square= 26.93 p<0.001	

Table 7.14: Distribution of Doctor and Patient Giving Information and Seeking Information by half of interview, broken down by the three principal agenda types. CHRONIC PHYSICAL presenting problem. (Figures in brackets give row percentages).

Emotional agendas				
	Giving Information		Seeking Information	
	Interview Half		Interview Half	
	1	2	1	2
DR	9 (23%)	30 (77%)	8 (73%)	3 (27%)
PT	64 (60%)	42 (40%)	2 (50%)	2 (50%)
	Chi-square= 15.87 p<0.001		Chi-square= 0.68 ns	

Table 7.15: Distribution of Doctor and Patient Giving Information and Seeking Information by half of interview, broken down by the three principal agenda types. CHRONIC PHYSICAL presenting problem. (Figures in brackets give row percentages).

Physical agendas				
	Giving Information		Seeking Information	
	Interview Half		Interview Half	
	1	2	1	2
DR	73 (33%)	151 (67%)	119 (65%)	64 (35%)
PT	198 (59%)	138 (41%)	28 (39%)	43 (61%)
	Chi-square= 37.34 p<0.001		Chi-square= 13.74 p<0.001	

Table 7.16: Distribution of Doctor and Patient Giving Information and Seeking Information by half of interview, broken down by the three principal agenda types. CHRONIC PHYSICAL presenting problem. (Figures in brackets give row percentages).

Social agendas				
	Giving Information		Seeking Information	
	Interview Half		Interview Half	
	1	2	1	2
DR	3 (10%)	27 (90%)	16 (53%)	14 (47%)
PT	33 (46%)	39 (54%)	0 (0%)	10 (100%)
	Chi-square= 8.89 p<0.01		Chi-square= 11.91 p<0.001	

When doctor and patient Giving and Seeking Information is considered according to Emotional presentations overall, and compared with the main analysis of Giving and Seeking Information (table 7.5), differences are apparent. Doctors give proportionately less information in the first half of the interview in the former, and correlatively more in the second half of the interview, while patients give information in roughly the same proportions (57 percent and 43 percent according to half interview respectively). Table 7.17 doctors seek information only slightly less in the first half of the interview in comparison with the overall analysis (57 percent and 43 percent according to half interview respectively), and patients seek slightly more information in the second half of the interview. In the emotional domain doctors give more information in the first half of the interview than in the second (33 percent as opposed to 22 percent) and patients give slightly more information in the first half of the interview (59 percent compared with 55 percent in the main analysis, table 7.18). The social domain shows the most substantial difference, with the doctor Giving Information only in the second half of the consultation and the patient Seeking Information only in the second half of the interview. Patients are fairly balanced in the extent to which they give information according to interview half, and do so in the same proportions as in the overall analysis, and doctors also seek information in almost identical proportions according to half interview as in the main analysis (table 7.20). Overall distribution of doctor and patient Giving and Seeking Information according to Social presentation (tables 7.21, 7.22, 7.23 and 7.24) shows that both doctor and patient give information in roughly equal proportions, and that doctors seek information according to half interview very much according to the main analysis: 59 percent: 41 percent and 63 percent: 37 percent respectively. Patients' Seeking Information by half interview is also very similar to the main analysis. The substantial difference between the overall distribution according to Social presentation and the overall analysis of Giving and Seeking Information is therefore in doctors' and patients' Giving Information. The analysis according to domain within Social presentation show frequencies which are too low to be meaningfully interpreted.

Table 7.17: Distribution of Doctor and Patient Giving Information and Seeking Information by half of interview, broken down by the three principal agenda types. EMOTIONAL presenting problem. (Figures in brackets give row percentages). OVERALL figures.

	Giving Information		Seeking Information	
	Interview Half		Interview Half	
	1	2	1	2
DR	16 (23%)	53 (77%)	76 (57%)	57 (43%)
PT	131 (57%)	97 (43%)	5 (24%)	16 (76%)
	Chi-square= 24.88 $p<0.001$		Chi-square= 8.08 $p<0.001$	

Table 7.18: Distribution of Doctor and Patient Giving Information and Seeking Information by half of interview, broken down by the three principal agenda types. EMOTIONAL presenting problem. (Figures in brackets give row percentages).

Emotional agendas				
	Giving Information		Seeking Information	
	Interview Half		Interview Half	
	1	2	1	2
DR	5 (33%)	10 (67%)	17 (55%)	14 (45%)
PT	44 (59%)	31 (41%)	3 (27%)	5 (73%)
	Chi-square= 3.23 ns		Chi-square= 0.77 ns	

Table 7.19: Distribution of Doctor and Patient Giving Information and Seeking Information by half of interview, broken down by the three principal agenda types. EMOTIONAL presenting problem. (Figures in brackets give row percentages).

Physical agendas				
	Giving Information		Seeking Information	
	Interview Half		Interview Half	
	1	2	1	2
DR	11 (29%)	27 (71%)	37 (54%)	32 (46%)
PT	58 (56%)	46 (44%)	1 (11%)	8 (89%)
	Chi-square= 8.01 p<0.01		Chi-square= 5.76 p<0.05	

Table 7.20: Distribution of Doctor and Patient Giving Information and Seeking Information by half of interview, broken down by the three principal agenda types. EMOTIONAL presenting problem. (Figures in brackets give row percentages).

Physical agendas				
	Giving Information		Seeking Information	
	Interview Half		Interview Half	
	1	2	1	2
DR	0 (0%)	6 (100%)	11 (50%)	11 (50%)
PT	24 (55%)	20 (45%)	0 (0%)	1 (100%)
	Chi-square= 6.29 p<0.05		Chi-square= 0.96 ns	

Table 7.21: Distribution of Doctor and Patient Giving Information and Seeking Information by half of interview, broken down by the three principal agenda types. SOCIAL presenting problem. (Figures in brackets give row percentages). OVERALL figures.

	Giving Information		Seeking Information	
	Interview Half		Interview Half	
	1	2	1	2
DR	14 (44%)	18 (56%)	13 (59%)	9 (41%)
PT	33 (53%)	29 (47%)	1 (33%)	2 (67%)
	Chi-square= 0.76 ns		Chi-square= 0.71 ns	

Table 7.22: Distribution of Doctor and Patient Giving Information and Seeking Information by half of interview, broken down by the three principal agenda types. SOCIAL presenting problem. (Figures in brackets give row percentages).

Emotional agendas.				
	Giving Information		Seeking Information	
	Interview Half		Interview Half	
	1	2	1	2
DR	1 (20%)	4 (80%)	1 (100%)	0 (0%)
PT	3 (50%)	3 (50%)	0	0
	Chi-square= 1.06 ns		Chi-square=not calculable	

Table 7.23: Distribution of Doctor and Patient Giving Information and Seeking Information by half of interview, broken down by the three principal agenda types. SOCIAL presenting problem. (Figures in brackets give row percentages).

Physical agendas.				
	Giving Information		Seeking Information	
	Interview Half		Interview Half	
	1	2	1	2
DR	12 (55%)	10 (45%)	4 (57%)	3 (43%)
PT	19 (68%)	9 (32%)	1 (33%)	2 (67%)
	Chi-square= 0.48 ns		Chi-square= 0.93 ns	

Table 7.24: Distribution of Doctor and Patient Giving Information and Seeking Information by half of interview, broken down by the three principal agenda types. SOCIAL presenting problem. (Figures in brackets give row percentages).

Social agendas.				
	Giving Information		Seeking Information	
	Interview Half		Interview Half	
	1	2	1	2
DR	1 (20%)	4 (80%)	5 (50%)	5 (50%)
PT	10 (37%)	17 (63%)	0	0
	Chi-square= 0.54 ns		Chi-square=not calculable	

E. DISTRIBUTION OF DOCTOR AND PATIENT PROCEDURES BY QUARTER OF INTERVIEW

Overall frequency of doctor and patient procedures by quarter of interview is shown in table 7.25. Consulting Notes occurs most in the first quarter of the interview, and declines steadily thereafter. Investigation is distributed fairly evenly throughout the consultation, but shows a slight increase in the third quarter. Physical Examination has a very low proportional rate of occurrence in the last quarter of the interview (9 percent), and is reasonably balanced in the second and third quarter. Referral shows a slight increase in the second quarter of the interview, occurring 33 percent of the time, but is distributed fairly evenly across the remaining quarters. Treatment occurs less in the first quarter of the consultation (17 percent) but occurs fairly steadily across the last three quarters of the interview. When this overall rate of occurrence is examined according to doctor and patient, differences emerge (tables 7.26 and 7.27). For the doctor, Consulting Notes remains the same as in the overall analysis, and on the two occasions that patients do consult notes, this activity occurs in the second quarter of the interview. Doctors investigate proportionately more in the last two quarters of the interview (35 percent and 32 percent respectively) while proportionately patients are more evenly distributed in Investigation, although patients use of Investigation proportionately is slightly up in the first quarter of the interview (31 percent) and slightly down in the last quarter (20 percent). For both doctor and patient, Physical Examination occurs most in the second and third quarters, declining in the last quarter. For both parties, Physical Examination occurs 20 percent of the time in the first quarter of the consultation. There is a clear preference for doctors to Refer in the second quarter of the interview, marked proportionately by the highest percentage of all doctor procedures in all quarters of the consultation, 40 percent. Doctors do not refer much in the first and third interview quarters, but use this procedure slightly more often in the last quarter (26 percent). Patients are fairly balanced in their use of Treatment procedures, but doctors use this procedure more in the last two quarters of the consultation. Doctors also use Treatment to

a reasonably high degree in the second quarter of the interview (26 percent) but proportionately use it only 14 percent of the time in the first quarter. When comparisons are made between the frequency of occurrence by quarter of interview for doctor and patient, only one significant result is demonstrated (Table 7.28). There are no differences in doctor and patient use of Consulting Notes, Investigation, Physical Examination or Referral, but doctors and patients do significantly differ, at a statistical level, in Treatment procedure.

Table 7.25: Frequency of occurrence of Procedures by quarter of interview. (Figures in brackets give row percentages). Overall figures.

	Interview Quarter			
	1	2	3	4
Consulting Notes	148 (52%)	83 (29%)	37 (13%)	16 (6%)
Investigation	33 (20%)	33 (20%)	52 (32%)	45 (28%)
Physical Examination	20 (20%)	231 (38%)	200 (33%)	54 (9%)
Referral	18 (22%)	27 (33%)	16 (20%)	20 (25%)
Treatment	155 (17%)	234 (26%)	262 (29%)	247 (28%)

Table 7.26: Frequency of occurrence of Procedures by quarter of interview. (Figures in brackets give row percentages). Figures for doctor.

	Interview Quarter			
	1	2	3	4
Consulting Notes	148 (52%)	81 (29%)	37 (13%)	16 (6%)
Investigation	15 (14%)	20 (19%)	36 (35%)	33 (32%)
Physical	104 (20%)	202 (39%)	175 (33%)	43 (8%)
Referral	8 (19%)	17 (40%)	6 (14%)	11 (26%)
Treatment	71 (14%)	134 (26%)	162 (31%)	156 (30%)

Table 7.27: Frequency of occurrence of Procedures by quarter of interview. (Figures in brackets give row percentages). Figures for patient.

	Interview Quarter			
	1	2	3	4
Consulting Notes	0 (0%)	2 (100%)	0 (0%)	0 (0%)
Investigation	18 (31%)	13 (22%)	16 (27%)	12 (20%)
Physical Examination	16 (20%)	29 (36%)	25 (31%)	11 (14%)
Referral	10 (26%)	10 (26%)	10 (26%)	9 (23%)
Treatment	84 (22%)	100 (27%)	100 (27%)	91 (24%)

Table 7.28: Comparison of frequency of occurrence of procedures by quarter of interview between Doctor and Patient. (Figures in brackets give row percentages).

	Interview Quarter			
	1	2	3	4
Consulting Notes				
Doctor	148 (52%)	81 (29%)	37 (13%)	16 (6%)
Patient	0 (0%)	2 (0%)	0 (0%)	0 (0%)
	Chi-square= 4.87 ns			
Investigation				
Doctor	15 (14%)	20 (19%)	36 (35%)	33 (32%)
Patient	33 (20%)	33 (20%)	52 (32%)	45 (28%)
	Chi-square= 1.74 ns			
Physical Examination				
Doctor	104 (20%)	202 (39%)	175 (33%)	43 (8%)
Patient	120 (20%)	231 (38%)	200 (33%)	54 (9%)
	Chi-square= 0.19 ns			
Referral				
Doctor	8 (19%)	17 (40%)	6 (14%)	11 (26%)
Patient	10 (26%)	10 (26%)	10 (26%)	9 (23%)
	Chi-square= 3.13 ns			
Treatment				
Doctor	71 (14%)	134 (26%)	162 (31%)	156 (30%)
Patient	84 (22%)	100 (27%)	100 (27%)	91 (24%)
	Chi-square=13.79 $p<0.001$			

F. AGENDA OCCURRENCE IN FLOORHOLDINGS FOLLOWING PHYSICAL EXAMINATION

Table 7.29 shows the frequency of agenda occurrence for doctor and patient in the first three floorholdings following Physical Examination. Physical agendas occur most frequently for both doctor and patient, 227 and 51 respectively. Emotional agendas occur more often for patients than for doctors in this floorholding (11 and 2 respectively), as do social agendas (10 and 2 respectively). Patients use Conclusion and Video agendas in this floorholding, and each agenda occurs twice.

The second floorholding after Physical Examination shows each party's response to the agenda used by the first party immediately after Physical Examination. It is therefore a comment on the results just presented. Physical agendas are again most frequently used agenda for both parties. But whereas the frequency of occurrence was 51 for the patient and 27 for the doctor in the first floorholding following Physical Examination, the doctor now uses Physical agendas on 47 occasions while the patient uses Physical agendas on 28 occasions. Doctors continue in the second floorholding after Physical Examination with Emotional agendas on 11 occasions, the same as for the patient in the first floorholding, but patients show a slight increase over doctors' use of this agenda in the previous floorholding by referring to Emotional agendas on 5 occasions. Doctors show a slight increase over the patients' reference to Social agendas in the first floorholding, going from 10 (patient, first) to 14 (doctor, second). Conversation declines for both parties in the floorholding, occurring once for doctors and not at all for patients. Conclusion and Video agendas do not occur for patients in this floorholding, but occur for doctors 3 and 2 times respectively.

Table 7.29: Agendas which occur in the three floorholdings following Physical Examination.

First floorholding following Physical Examination						
	Agenda Type					
	Physical	Emotional	Social	Conversation	Conclusion	Video
DR	27	2	2	2	0	0
PT	51	11	10	2	2	2
Second floorholding following Physical Examination						
	Agenda Type					
	Physical	Emotional	Social	Conversation	Conclusion	Video
DR	47	11	14	1	3	2
PT	28	5	2	0	0	0
Third floorholding following PE						
	Agenda Type					
	Physical	Emotional	Social	Conversation	Conclusion	Video
DR	30	5	2	0	2	0
PT	44	8	13	0	2	3

The third floorholding to follow Physical Examination is a response to the second, and a continuation of the speaker's first agenda after Physical Examination. Doctors 'pick up' two Physical agendas which occur 30 times, whereas patients 'lose' 3 Physical agendas, and these occur on 44 occasions (compared to doctor, 47 and patient, 28 in the second floorholding). Doctors continue with 5 Emotional agendas and 2 Social agendas, reflecting the same frequency of occurrence as for patients in the second floorholding in these two domains. Patients 'lose' three Emotional agendas, and one Social agenda when compared to doctors in the second floorholding. These occur on 8 occasions in the emotional domain and on 13 occasions in the Social domain for patients in this floorholding. There are no conversational agendas for either party in this floorholding, but Conclusion occurs twice for both parties and Video on three occasions for the patient.

The interviews with and without examination are shown in table 7.30. There were 59 consultations with Physical Examination and 14 consultations without Physical Examination.

Table 7.30: Interviews with and without Physical Examination. Total No. of Interviews = 73.

Interviews <u>with</u> Physical Examination
1,2,4,5,6,7,8,9,10,12,13,14,15,16,17,18,19,20,22,23,26,27,28,29,30,31,32,33,34 35,36,38,39,40,41,43,46,48,50,51,53,57,58,59,60,61,62,64,66,67,68,69,70,72,73 74,75,76,77
59 Interviews contain Physical Examination
Interviews <u>without</u> Physical Examination
3,11,21,24,25,37,44,45,47,49,55,56,63,71
14 Interviews do not contain Physical Examination

G. PROCEDURES ASSOCIATED WITH PRINCIPAL AGENDAS FOR DOCTORS AND PATIENTS

Doctors' and patients' use of principal agendas according to procedures are compared in Table 7.31. Patients show no statistically significant difference in the extent to which procedures are associated with agendas, but doctors' results are significant at the 0.001 level. Proportionately, doctors spend more time than patients in Referral procedure when in the social domain, and less time than patients in the emotional domain. Doctors and patients spend proportionately the same amount of time in Treatment irrespective of agenda but doctors spend more time in Physical Examination in both the emotional and social domains.

Table 7.31: Association between principal agendas and use of procedures by doctor and patient. (Figures in brackets give row percentages).

Doctor Floorholdings				Patient Floorholdings		
Procedure	Agenda Type			Agenda Type		
	Emotional	Physical	Social	Emotional	Physical	Social
Consulting Notes	1 (1%)	120 (96%)	4 (3%)			
Investigation	3 (3%)	101 (97%)	0 (0%)	1 (2%)	58 (98%)	0 (0%)
Physical Examination	4 (1%)	312 (97%)	7 (2%)	0 (0%)	78 (100%)	0 (0%)
Referral	2 (5%)	40 (95%)	0 (0%)	1 (3%)	37 (94%)	1 (3%)
Treatment	33 (6%)	480 (93%)	3 (1%)	21 (6%)	350 (93%)	4 (1%)
	Chi-square=27.58 p<0.001			Chi-square= 9.10 ns		

H. ASSOCIATIONS BETWEEN PROCEDURES AND PROCESSES FOR DOCTORS AND PATIENTS

Tables 7.32 and 7.33 show the association between procedures and processes for doctors and patients. In each case the lower table shows the frequencies and proportions for the procedures excluding Introduction, Conclusion and Consulting Notes, and frequencies and proportions for processes excluding Recording Information. These categories were excluded because the two belong in practice almost exclusively to the doctor, while the other two almost by definition will vary little in their occurrence. Excluding these categories enables a rather more meaningful chi-square to be calculated, although the number of categories involved will almost inevitably reveal an association in the chi- square value.

For doctors, Treatment procedure occurs around 50 percent of the time across all processes and is the most common procedure. Proportionately, Treatment is most associated with Prescribing (61 percent), with Giving Information (52 percent) and with Seeking Information (42 percent). It is least associated with Discussing Information (40 percent). Investigation, in contrast, occurs most often in association with Discussing Information (30 percent) and least with Prescribing (6 percent) and Seeking Information (4 percent). Physical Examination occurs mostly in conjunction with Seeking Information (29 percent), Prescribing (31 percent) and Giving Information (25 percent), whereas Referral occurs mostly with Accepting Information and Discussing Information.

For patients, Treatment is again the most common procedure proportionately, and is most associated with Giving Information (71 percent). Discussing Information also occurs in association with Treatment to a high degree for patients (69 percent). Treatment is least associated with Accepting Information for patients (24 percent). Investigation proportionately occurs more often with Accepting Information than any other process, whereas Physical Examination occurs most in conjunction with Seeking Information (20 percent). Referral is proportionately associated most with Discussing Information.

Table 7.32: Association between Procedures and Processes for doctors. (Figures in brackets give row percentages).

Doctor	Procedure *						
	C	CN	I	IV	PE	REF	T
Process							
Accepting Information	0 (0%)	14 (0%)	2 (6%)	2 (6%)	4 (12%)	2 (6%)	9 (7%)
Discussing Information	0 (0%)	7 (0%)	0 (0%)	27 (30%)	14 (16%)	8 (9%)	33 (37%)
Giving Information	0 (0%)	24 (0%)	2 (.5%)	50 (11%)	111 (25%)	22 (5%)	228 (52%)
Prescribing	0 (0%)	0 (0%)	0 (0%)	11 (6%)	52 (31%)	3 (2%)	104 (61%)
Recording Information	11 (73%)	3 (20%)	0 (0%)	0 (0%)	1 (7%)	0 (0%)	0 (0%)
Seeking Information	0 (0%)	53 (15%)	25 (7%)	14 (4%)	100 (29%)	7 (2%)	146 (42%)

* Key:

C Conclusion

CN Consulting Notes

I Introduction

INV Investigation

PE Physical Examination

REF Referral

T Treatment

Contd ...

Table 7.32: Association between Procedures and Processes for doctors. (Figures in brackets give row percentages). Contd.

Doctor	Procedure *			
	INV	PE	REF	T
Accepting Information	2 (11%)	4 (21%)	2 (11%)	9 (47%)
Discussing Information	27 (33%)	14 (17%)	8 (10%)	33 (40%)
Giving Information	50 (12%)	111 (27%)	22 (5%)	228 (55%)
Prescribing	11 (6%)	52 (31%)	3 (2%)	104 (61%)
Seeking Information	14 (5%)	100 (34%)	7 (2%)	146 (50%)
	Chi-square=120.01 Degrees of freedom=12 $p<0.001$			

* Key:

INV Investigation

PE Physical Examination

REF Referral

T Treatment

Table 7.33: Association between Procedures and Processes for patients. (Figures in brackets give row percentages).

Patient	Procedure *						
	C	CN	I	IV	PE	RF	T
Accepting Information	0 (0%)	0 (0%)	0 (0%)	4 (5%)	23 (27%)	2 (5%)	57 (24%)
Discussing Information	0 (0%)	0 (0%)	0 (0%)	4 (11%)	3 (9%)	8 (16%)	20 (69%)
Giving Information	0 (0%)	0 (0%)	18 (5%)	37 (11%)	20 (6%)	24 (7%)	240 (71%)
Seeking Information	1 (1%)	2 (2%)	3 (3%)	13 (13%)	21 (20%)	5 (5%)	58 (56%)

Patient:	IV	PE	RF	T
Accepting Information	4 (27%)	2 (5%)	2 (5%)	57 (24%)
Discussing Information	4 (11%)	3 (9%)	8 (16%)	20 (69%)
Giving Information	37 (11%)	20 (6%)	24 (7%)	240 (71%)
Seeking Information	13 (13%)	21 (21%)	5 (5%)	58 (58%)
	Chi-square= 96.35 Degrees of freedom=9 $p<0.001$			

* Key:

C Conclusion

CN Consulting Notes

I Introduction

INV Investigation

PE Physical Examination

REF Referral

T Treatment

I. PROCEDURES AND PROCESSES USED BY INDIVIDUAL GENERAL PRACTITIONERS

Table 7.34 shows frequencies and percentages for processes used by individual general practitioners by doctor and patient floorholdings. Doctors seem to be well matched in their use of Seeking Information, although general practitioners 2 and 8 seek proportionately more information than other general practitioners. Patients of general practitioner 8 give proportionately more information, but patients of general practitioner 2 do not give more information than patients of other general practitioners. General practitioner 1 stands out as Accepting Information more of the time, but the nature of one extended consultation may account for this result. General practitioners 9 and especially 10, are marked in the extent to which they do not Accept Information, and patients of general practitioners 4 and 8 do not accept much information. General practitioner 1 discusses information more than other doctors, and patients of general practitioners 5 and 9 discuss information a little more often than patients of other general practitioners. General practitioners 2 and 5 give more information than other doctors, and patients of all doctors, with one exception, are fairly well matched in the extent to which they give information. The exception, patients of general practitioner 8, gives a lot more information than other doctors' patients, and this is by general practitioner 8's seeking information proportionately more often (see above). Doctors 3 and 4 prescribe more than the other doctors, while general practitioners 1 and 10 prescribe the least. Doctors 6 and 10 stand out as recording more information than other doctors. This category did not occur for patients sufficiently to make analysis possible. Table 7.35 shows frequencies and percentages for procedures used by individual general practitioners. As was mentioned above, Consulting Notes has been omitted from the patient floorholdings, and Introduction and Conclusion from doctor and patient floorholdings. There is considerable between doctor variation in the extent to which doctors consult notes. General practitioner 4, for example, consults notes a lot (44 percent) and doctors 6 and 7 also consult notes to a degree (25 percent and 22 percent respectively): doctor 6 also

recorded a lot of information (see table 7.33 above). Doctors 1, 3 and 5 use Investigation more than other doctors (especially doctors 1 and 3) whereas doctors 4 and 10 hardly ever use Investigation at all. Patients of doctors 1 and 3 are also in Investigation procedure rather more than other doctors' patients. Doctors 2 and 10 engage in considerably more Physical Examination than other general practitioners (53 percent and 51 percent respectively) but this is not the case for patients. Proportionately, doctor 2 does rather more Treatment than other general practitioners (82 percent) and doctors 4 and 8 do proportionately less Treatment (22 percent and 28 percent respectively). With the exception of the patients of doctors 4 and 8, who also spend less time in Treatment, patients spend proportionately more time in Treatment procedure than doctors.

Table 7.34: Frequency of the use of processes shown broken down by general practitioner. (Figures in brackets are row percentages).

Doctor floorholdings						
	Accepting Information	Discussing Information	Giving Information	Prescribing	Recording Information	Seeking Information
G.P. 1	37 (17%)	27 (12%)	82 (37%)	5 (2%)	3 (1%)	68 (31%)
G.P. 2	13 (5%)	12 (5%)	116 (45%)	11 (4%)	0 (0%)	106 (41%)
G.P. 3	19 (8%)	19 (8%)	86 (34%)	27 (11%)	5 (2%)	95 (38%)
G.P. 4	9 (8%)	6 (5%)	45 (38%)	14 (12%)	5 (4%)	41 (34%)
G.P. 5	27 (10%)	16 (6%)	123 (47%)	10 (4%)	17 (6%)	69 (26%)
G.P. 6	37 (5%)	40 (6%)	200 (28%)	28 (4%)	151 (21%)	263 (37%)
G.P. 7	33 (8%)	29 (7%)	111 (28%)	27 (7%)	58 (14%)	143 (36%)
G.P. 8	24 (9%)	25 (9%)	75 (27%)	11 (4%)	19 (7%)	124 (45%)
G.P. 9	16 (4%)	31 (8%)	147 (37%)	27 (7%)	60 (15%)	116 (29%)
G.P. 10	9 (3%)	9 (3%)	78 (27%)	10 (3%)	75 (26%)	111 (38%)
	Chi-square=366.95 Degrees of freedom=45 $p<0.001$					
Patient floorholdings						
	Accepting Information	Discussing Information	Giving Information	Prescribing	Recording Information	Seeking Information
G.P. 1	32 (14%)	15 (6%)	166 (72%)	0 (0%)	0 (0%)	18 (8%)
G.P. 2	46 (18%)	11 (4%)	179 (70%)	0 (0%)	0 (0%)	20 (8%)
G.P. 3	22 (9%)	6 (2%)	185 (76%)	0 (0%)	0 (0%)	30 (12%)
G.P. 4	6 (5%)	2 (2%)	76 (69%)	0 (0%)	0 (0%)	26 (24%)
G.P. 5	37 (15%)	19 (8%)	159 (64%)	0 (0%)	0 (0%)	32 (13%)
G.P. 6	68 (12%)	18 (3%)	446 (76%)	0 (0%)	3 (.5%)	49 (8%)
G.P. 7	33 (9%)	12 (3%)	258 (73%)	0 (0%)	1 (.5%)	40 (12%)
G.P. 8	13 (5%)	12 (4%)	234 (86%)	0 (0%)	0 (0%)	14 (5%)
G.P. 9	23 (7%)	25 (8%)	243 (74%)	0 (0%)	1 (.5%)	38 (12%)
G.P. 10	25 (12%)	5 (2%)	161 (75%)	0 (0%)	1 (.5%)	24 (11%)
	Chi-square=105.99 Degrees of freedom=27 $p<0.001$					

Table 7.35: Frequency of the use of processes shown broken down by general practitioner. (Figures in brackets are row percentages). (N.B. Introduction and Conclusion have been excluded for doctors and patients, and Consulting Notes has been omitted for patients).

Doctor floorholdings					
	Consulting Notes	Investigation	Physical Examination	Treatment	Referral
G.P. 1	11 (17%)	18 (28%)	27 (42%)	29 (45%)	0 (0%)
G.P. 2	4 (4%)	2 (2%)	56 (53%)	44 (42%)	0 (0%)
G.P. 3	6 (5%)	19 (15%)	46 (36%)	49 (38%)	8 (6%)
G.P. 4	34 (44%)	2 (3%)	25 (32%)	17 (22%)	0 (0%)
G.P. 5	18 (17%)	13 (12%)	25 (24%)	44 (42%)	6 (5%)
G.P. 6	74 (25%)	17 (6%)	103 (34%)	93 (31%)	13 (4%)
G.P. 7	37 (22%)	13 (8%)	45 (26%)	70 (41%)	6 (4%)
G.P. 8	36 (35%)	5 (5%)	28 (27%)	29 (28%)	6 (6%)
G.P. 9	39 (17%)	13 (6%)	80 (36%)	92 (41%)	1 (.5%)
G.P. 10	23 (13%)	2 (1%)	89 (51%)	56 (32%)	2 (1%)
	Chi-square=324.07 Degrees of freedom=36 $p<0.001$				
Patient floorholdings					
		Investigation	Physical Examination	Treatment	Referral
G.P. 1		13 (35%)	3 (8%)	21 (57%)	0 (0%)
G.P. 2		2 (7%)	5 (19%)	22 (82%)	0 (0%)
G.P. 3		11 (13%)	20 (24%)	48 (58%)	4 (5%)
G.P. 4		0 (0%)	4 (50%)	4 (50%)	0 (0%)
G.P. 5		7 (16%)	3 (7%)	30 (68%)	4 (9%)
G.P. 6		8 (8%)	15 (15%)	69 (68%)	9 (9%)
G.P. 7		8 (10%)	9 (11%)	53 (65%)	11 (14%)
G.P. 8		2 (7%)	4 (14%)	17 (61%)	5 (18%)
G.P. 9		6 (7%)	13 (14%)	71 (77%)	2 (2%)
G.P. 10		2 (4%)	5 (9%)	40 (75%)	4 (8%)
	Chi-square=231.54 Degrees of freedom=27 $p<0.001$				

J. DISTRIBUTION OF PROCEDURES AND PROCESSES BY DOCTOR AND PATIENT

Table 7.36 shows the distribution of procedures and processes for doctor and patient. The mean number of doctor floorholdings per interview containing Physical Examination is 7.2. This is the same mean number of doctor floorholdings in Treatment. These two procedures together share the highest mean scores of all doctor procedures. Consulting Notes has a doctor mean score of 3.9, Investigation 1.4 and Referral 0.6. Referral has the lowest mean score per interview for doctors. Physical Examination occurs to its highest degree for doctors around the midpoint. The most common procedure for doctors is Treatment, which has a modal value of 5. Treatment also has the highest mean score for patients, although this is not so high as it is for doctors (5.2 and 7.2 respectively). The procedure with the second highest mean score for patients is Concluding (2.0), followed by Physical Examination (1.1), Introduction and Investigation (both 0.8), Referral (0.5) and Consulting Notes (0.1). With Conclusion, Treatment is also the most common procedure for patients, with a modal value of 2.

The processes with the highest doctor mean scores are Seeking Information, followed closely by Giving Information (15.6 and 14.5 respectively). Recording Information has the third highest mean score (5.4) followed by Accepting Information (4.4). Prescribing has the lowest mean score at 2.3. The most common doctor process is Giving Information (mode=12) and this is followed closely by seeking information (mode=11). The highest mean score for patient processes is Giving Information (28.9) and this is followed by Accepting Information which has a patient mean score of 5.0. The third highest patient mean score is Seeking Information, which has a mean score of 4.0. The most common patient process is Giving Information, which has a modal value of 1, and the second most common patient process is Seeking Information. For the doctor, both Seeking Information and Giving Information occur around the midpoint to a high degree whereas for patients it is Giving Information which occurs to a extremely high degree around the midpoint.

Table 7.36: Distribution of procedures and processes. Figures given are the mean, median, mode, minimum and maximum number of floorholdings containing each procedure or process per interview.

Doctor					
Procedure	Mean	Median	Mode	Minimum	Maximum
Conclusion	1.7	1	1	0	9
Consulting Notes	3.9	2	0	0	32
Introduction	1.4	1	1	0	4
Investigation	1.4	0	0	0	12
Physical Examination	7.2	7	0	0	22
Referral	0.6	0	0	0	9
Treatment	7.2	6 5	0	22	
Process	Mean	Median	Mode	Minimum	Maximum
Accepting Information	4.4	2	0	0	26
Discussing Information	2.9	2	0	0	20
Giving Info.	14.6	12	12	1	47
Prescribing	2.3	2	0	0	10
Recording Information	5.4	2	0	0	30
Seeking Information	15.6	14	11	1	54

Contd ...

Table 7.36: Distribution of procedures and processes. Figures given are the mean, median, mode, minimum and maximum number of floorholdings containing each procedure or process per interview. (Contd.)

Patient					
Procedure	Mean	Median	Mode	Minimum	Maximum
Conclusion	2.0	2	2	1	10
Consulting Notes	0.1	0	0	0	1
Introduction	0.8	1	0	0	3
Investigation	0.8	0	0	0	9
Physical Examination	1.1	0	0	0	13
Referral	0.5	0	0	0	7
Treatment	5.1	4	2	0	19
Process	Mean	Median	Mode	Minimum	Maximum
Accepting Information	5.0	3	1	0	21
Discussing Information	1.7	1	0	0	8
Giving Information	28.9	26	12	4	103
Recording Information	0.8	0	0	0	2
Seeking Information	4.0	4	4	0	14

K. DISCUSSION

Considering the nature and function of the doctor-patient interview in context, it is possible to say that the patient does not consult the doctor primarily to provide him with information. That doctors do so, and that patients' provision of information in most cases is central to the diagnosis, is secondary to the patient's reason for seeing the doctor. The patient will not usually seek out the doctor to provide him with information but in order to elicit from the doctor a diagnosis. The emphasis is therefore on the patient seeking what the doctor can provide. This may be for instrumental aid such as a prescription or it may be for referral or it may be for treatment, but, mostly, the patient will seek the doctor for a diagnosis. The patient is almost always seeking, and the key to this seeking is provision of information.

It has been recognised that the doctor-patient consultation can be described in stages, that these stages are readily identifiable, and that the speech patterns identified in these stages may be related to patient outcome measures (Inui & Carter, 1985; Kaplan et al, 1989). Byrne (1976) described six stages in the general practice interview and, although Buijs et al (1984) have criticised this formulation, other raters have reported dividing the consultation with greater consistency (Stiles et al, 1979; Putman et al, 1985; Orth et al, 1987). Stages of the consultation which have been commonly described are the medical history or diagnostic stage, and the concluding prescriptive stage. Verbal events associated with these stages are patient exposition (information giving) and doctor explanation (factual information) (Winefield & Morrell, 1991). These authors also found that patients were more satisfied with consultations where they had discussed their own experiences and opinions during the second, prescriptive stage of the interview. Savage & Armstrong (1990) similarly divided general practice interviews according to the diagnostic and prescriptive phases, varying doctor style in the second which is particularly suited to giving treatment advice and prognosis.

The procedures and processes described in the present chapter are not predetermined categories. They may occur at any time in the consultation for either party.

Moreover, the stage of the consultation and the verbal event may occur independently. It is therefore not possible to make a direct comparison with previous studies. However, doctor and patient Giving and Seeking Information are verbal events which do seem to be associated more with some procedures than others, and these particular events appear to characterise the interview in a special way.

It was hypothesised in chapter 2 that the relative balance of Giving Information and Seeking Information would vary according to the timing of the interview (hypotheses 13, 14 and 15). These hypotheses were supported. In general there is an inverse relationship between doctor and patient Seeking Information according to half interview. Thus the more the doctor seeks information in the first half of the interview, the more the patient will seek information in the second half of the interview. Correspondingly, the more the doctor seeks information in the first half of the interview, the less the patient will seek information in the same half, and vice versa. A similar relationship is found for doctor and patient Giving Information. However, while doctors tend always to give more information in the second half of the interview (and correspondingly less in the first half of the consultation) patients continue to give information in the second half of the consultation. The main analysis of data in the present study has shown that doctor and patient following of one another's follow is a sensitive measure of the extent to which either party is in tune with the other. Doctors' and patients' Giving and Seeking of information is able to provide another such index, and Seeking Information seems to be particularly sensitive in this respect. This is demonstrated by examining these measures according to principal agendas.

In all three principal domains, it can be seen that patients always give proportionately more information than doctors, that doctors always seek more information than patients, and that in overall terms, doctors seek proportionately more information than patients give. As there appears to be an inverse relationship between doctor and patient Seeking Information, so there appears to be an inverse relationship between doctor and patient Giving and Seeking Information and principal agenda. Thus

while patients always give proportionately more information and doctors always seek more information, overall analysis shows that patients give the least information in respect of Physical agendas, give the most information in respect of Social agendas, and give twice as much information as doctors about Emotional agendas. Doctors correspondingly seek most information about Physical agendas, least about Social agendas and seek information intermediately about Emotional agendas.

Because these inverse relationships suggested a natural break and reversal in the consultation such as has been described by the authors cited above, further analysis of these processes was conducted according to half interview, domain and domains within presenting problems. The consultations were halved by number of floorholdings, not time, so it is possible that analysis by time would suggest another interpretation.

Within the principal agendas, patients give information to an increasingly greater extent according to domain as has been described above supporting the hypothesis that giving and seeking information varies according to agenda (hypothesis 16). However, although proportionately patients give slightly more information overall in the first half of the consultation, they give information to an increasing degree in the second half of the consultation according to agenda type. So, for example, patients give more information about Physical agendas in the first half of the interview, slightly less information about Emotional agendas in the same half of the consultation, but give more information about Social agendas in the second half of the consultation. Correspondingly, although doctors always give more information in the second half of the interview, they give more information about Physical agendas in the second half of the consultation, and less information about Social agendas than Emotional agendas in the same half. Patients always seek more information in the second half than in the first half of the interview, but in the physical domain doctors seek information twice as much as patients in the first half of the consultation. In the emotional domain, in contrast, doctors seek only slightly more information in the first half than in the second half of the consultation. And in the social domain doctors seek information according to half interview in a rather balanced

way. It is not possible to establish causal relationships and correlations have not been carried out to investigate the nature of any possible associations. However, questions arise about the possibility of such associations, For example, to what extent is doctors' Seeking Information in the physical domain in the first half of the consultation the result or cause of doctors giving less information in this domain in the first half of the consultation ? Is it because patients have given more information about Emotional agendas in the first half of the interview that doctors seek information in this domain only slightly more in the first half of the consultation ? Is doctors' Seeking Information in the social domain more balanced across interview half because patients give a lot more information about Social agendas in the first half of the consultation ? Does the nature of the agenda in some way affect the processes brought to bear on that agenda ? These questions can only be explored in the context of the data and the previous analysis, but there is some evidence that the nature of the agenda is functionally associated with doctor and patient processing of that agenda, and that doctors preferentially will process in the physical domain.

In the context of previous analysis, then, patients initiate the vast majority of Physical agendas, initiate a substantial number of Emotional agendas, and also initiate a lot of Social agendas. Doctors do not follow patients' emotional expression very frequently, and, indeed, analysis of doctor and patient problem solving shows that initially doctors limit patients' expression of emotional concerns on over 50 percent of occasions. However doctors follow patients' Physical agendas to a high degree and analysis of problem solving demonstrates that doctors rarely limit patients' expression of physical concerns and bring a range of problem solving activities to bear upon patients' Physical agendas. Present analysis shows that doctors are seeking twice as much information as patients in the physical domain in the first half of the consultation, and although doctors give more information in the second half of the interview, they give proportionately more information about Physical agendas in the first half of the consultation than they do in the other two principal domains. Putting previous and

current analysis together, the data suggest that perhaps because doctors are trained in the art of physical diagnosis, doctors are reaching the prescriptive phase of the consultation for patients' Physical agendas before they reach this stage for other domains. Patients initiate the Physical agenda, doctors follow the agenda, facilitate its expression, and bring problem solving strategies to bear in the agenda. Correspondingly they quickly seek a lot of information about the agenda, and are giving information about that agenda sooner than in the other two principal domains.

The doctors' preference for Physical over Emotional and Social agendas is further demonstrated by the corresponding deficit of positive doctor behaviour towards the latter. Proportionately patients are giving as much information about emotional issues in the first half of the consultation, and proportionately more information about social concerns in the same interview half, but because doctors seem preferentially to seek information about Physical agendas in the first half of the consultation, there is a lag in their processing of emotional and social issues. Analysis of doctor and patient problem solving further demonstrates that doctor problem solving in the emotional domain can be a function of doctors returning to that domain later in the consultation (chapter 8) and the analysis of principal agendas showed that doctors' level of engagement in the social domain increases with interview duration (chapter 4). Because patients' seeking of emotional information is only 1 percent more than patients' seeking of information in the physical domain in the second half of the interview, it is possible that doctors are giving patients more information in this half of the interview as a function of doctor and patient returning to the Emotional agendas previously raised and so obviating the patients' continued need to seek information in this domain. There is some support for this hypothesis and it is demonstrated by doctors giving proportionately more information about Emotional agendas in the second half of the consultation. Proportionately, patients seek information only 1 percent more in the emotional than the physical domain in the second half of the interview, and doctors give proportionately less information in the emotional domain than in the physical domain in the first half of the consultation. A

direct association between agenda type and information processing might predict that doctors would give equivalent information in the first half of the consultation for each agenda type. That doctors give proportionately more information about the physical over the emotional domain in the first half of the consultation lends further support towards the notion of doctors' preference for processing Physical agendas first, but patients' equivalent seeking of information in both domains in the second half of the interview suggests that patients may seek information independently of how much information has been given in the particular domain. The association between information processing in these terms and the social domain is much more clear cut. Patients seek most information about Social agendas in the second half of the consultation and doctors give most information about Social agendas in the second half of the consultation.

Analysis of doctor and patient agendas according to presenting problem and principal domain again highlights Seeking Information. However, it is extremely important to note that this discussion is concerned with proportions. The frequency of agenda occurrence within domain and presenting problem is sometimes very low. Although there is little variation from the overall information processing analysis according to agendas type and presenting problem for Acute Physical presentation and Emotional presentation (frequencies are too low to calculate for Social presentation), Chronic Physical presentations show non- significant results for doctor and patient Giving and seeking Information in the emotional domain. There is thus greater doctor and patient congruence which may be significant in its non significance.

The analysis of Acute and Chronic presentations showed that while patients shared the doctors' hesitancy about following Emotional agendas with an Acute Physical presentation, demonstrated by the low patient following of doctor following rates, patients were much more willing to follow doctors' following of Emotional agendas in the Chronic Physical presentation. Chi-square values of doctor and patient Giving and Seeking Information suggest a reciprocity in the emotional domain. The percentage values for doctor and patient Giving Information are more congruent than for doctor and

patient Seeking Information and it is likely that the patients' distribution of Seeking information has influenced this result. Patients are exactly balanced here in their seeking of information whereas doctors seek proportionately more information sooner than in any other domain in any other presentation: 73 percent of doctor Seeking Information occurs in the first half of the interview compared with 57 percent of doctor Seeking Information in the first half of the consultation in the emotional domain in the overall analysis (table 7.6). Doctors are also Seeking Information in the physical domain to a high degree with this presentation but the proportion here differs only by 1 percent from the main overall analysis. Thus, although doctors do not follow patients' follows very often in the emotional domain when the presentation is Chronic Physical, doctors are seeking information about this domain far earlier than in other presentation which suggests a doctor awareness of patients' emotional concerns that previous analysis has not identified.

The Acute Emotional presentation also identifies Seeking Information as a measure which is sensitive to agenda type. Although in the emotional domain both doctor and patient Seeking Information largely reflects the overall analysis, patients do differ in their Seeking Information activity in the physical domain and proportionately this difference is marked. Whereas in the overall analysis, patients' Seeking Information in the first half of the interview in the physical domain is 33 percent, here, in the same agenda type, it is only 11 percent. Proportionately, patients do not correspondingly seek more information in the first half of the interview in the emotional or social domains. Indeed patients do not seek any information at all about Social agendas in the first half of the interview when the presentation is Emotional. Patients are therefore not demonstrating a concern for Physical agendas in the first half of the consultation when the presentation is Emotional. Their concern for this domain is located in the second half of the consultation. As patients seek less information in the first half of the consultation in this presentation, doctors give proportionately more information in the emotional domain when compared to their Giving Information in this domain in other

presentations, but do not give proportionately more information about physical concerns in the first half of the consultation when comparisons are made with the other presentation. Indeed doctors give less information initially about physical concerns. Once again the data here point to a stronger association between agenda type and process than between process and process.

Discussing Information and Accepting Information have not been analysed in the same depth as Giving and Seeking Information, primarily because of lower frequencies. These are, however, very important categories, and arguably would reflect a patient centred approach. Discussing Information was the only category in the present coding system which was consistently less reliable. Containing aspects both of Giving and Seeking Information, it operates conceptually at a higher level and involves considerably more rater judgement. Discussing Information does not occur very often: Giving Information and Seeking Information occur five times more frequently than Discussing Information. This was expected (Chapter 2, hypothesis17). Doctors always discuss more information than patients, and proportionately do so to the same extent in each domain. While patients accept information proportionately more often in the physical domain, doctors accept more information in the social domain. It is possible that this may in some way reflect their respective expertise in these domains. Interestingly, doctors' and patients' Accepting Information is exactly equivalent in the emotional domain.

In the rationale to the present chapter it was argued that the purpose of the consultation is orientated towards the diagnosis, and that any consultation will be mapped according to the diagnosis made. The diagnosis will be directed towards physical concerns; will serve an intellectual function for the doctor (but may have emotional implications for both patient and doctor) and will largely determine the procedures subsequently used in the consultation. Because, by training, the doctor will be more overtly aware of the intellectual function of the diagnostic process, it is likely that doctors will demonstrate such awareness by adhering to discrete stages of the consultation. It is also likely that the doctor will adhere to these stages more than the

patient and that patients, because they will mostly have arrived at a provisional diagnosis before attending the surgery (Tuckett et al, 1985), will tend to begin the consultation prescriptively.

Analysis of interview procedures in the present sample showed that this was the case but perhaps to a lesser extent than predicted. As would be expected, to remind them of the patient's past history, doctors Consult Notes mostly in the first quarter of the interview; and patients only Consult Notes very rarely. Physical Examination occurred predominantly in the second and third quarters of the Consultation for both parties, suggesting that this procedure happens about half way through the interview and may signal a divide between the diagnostic and prescriptive phases of the consultation. Treatment occurs proportionately more often in the last two quarters of the consultation for doctors and will be the logical result of diagnosis, whereas patients use Treatment in a more balanced way throughout. This supports the idea that patients have reached a diagnosis earlier than doctors and are addressing that diagnosis through proposed treatments. Patients also use Investigation earlier in the interview than doctors, again suggesting that patients are exploring possible avenues in this respect as a result of their own provisional diagnosis. Doctors have a very clear preference for Referral in the last quarter of the interview, demonstrated by its 40 percent occurrence. Referral is a corollary either of inconclusive diagnosis or of a diagnosis which required the intervention of another agency. Patients are fairly balanced in their use of this procedure again indicating that patients have a notional diagnosis which they consider requires further intervention. Treatment, however, stands out as the procedure which most distinguishes doctors and patients and shows a statistically significant difference at the 0.001 level. Because Treatment is skewed more towards the latter part of the consultation for doctors, but is fairly balanced throughout the interview for patients, the hypothesis that patients consult the doctor with a provisional diagnosis is supported.

Physical Examination tends to occur around the midpoint (table 7.37), and represents an important stage in the consultation process for a number of reasons.

Physical Examination is likely either to confirm the doctor's provisional diagnosis, or confirm him in his decision to refer to another speciality; in Physical Examination doctor and patient have physical contact, the nature of which, with a few other rare exceptions, generally is found only in close or intimate relationships, and Physical Examination in confirming a diagnosis is likely to signal to the doctor a move from the diagnostic to the prescriptive phase of the consultation. Byrne & Long (1976) note that once this stage has been reached, having completed their private decision making, the doctor seems to change styles quite drastically. Since the studies in this thesis are concerned, among other things, with the extent to which doctors address patients' Emotional and Social agendas, it was decided to examine the extent to which these agendas occur in the three floorholdings immediately after Physical Examination.

The results show that although Physical agendas occur most frequently for both doctor and patient, patients refer to Emotional and Social agendas to a fairly high degree in the first floorholding following Physical Examination supporting the hypothesised ilnk between Emotional agendas and Physical Examination (hypothesis 12, chapter 2). Whether doctors exactly follow the agenda in the second floorholding, which will reflect turntaking and the possibility therefore of following the previous speaker's agenda, has not been assessed. However, the frequencies show a consistency which suggests that doctors do follow patients' emotional and social concerns in the second floorholding after Physical Examination. The third floorholding after Physical Examination indicates that if the patients' agendas have indeed been followed by the doctor in the second floorholding, the patient does not continue in either domain to the same extent in the third floorholding. Either the nature of the agenda is such that it is too sensitive to sustain further turntaking or the agenda has been addressed adequately.

The association between procedures and processes shows that these occur in a more predictable way for doctors than for patients. For example, at a formal level, Treatment is likely to be associated with Prescribing and with Giving Information and with Seeking Information from the patient about its acceptability. Investigation may be

more likely to occur with Discussing Information as the latter would explore various options in respect of the former, and Physical Examination is likely to be associated with doctor Seeking Information. Because patients seem to present with a provisional diagnosis of their own, these formal association are less likely to be found for patients. Results show that the foregoing was indeed the case. Patients differ from doctors in several ways. Treatment is most associated with Giving Information and Discussing Information and, surprisingly, is least associated with Accepting Information. Thus, although doctors are Giving Information about Treatment, patients are not necessarily accepting that information. However, because procedures may occur for doctor and patient independently it is not possible categorically to say that patients are tending not to accept information about Treatment. Investigation occurs more often with Accepting Information than with any other process. It is therefore possible that patients are more attentive when doctors are discussing various options in respect of this procedure than they are when doctors are information processing about Treatment.

The type and quality of information exchanged between doctors and patients has been recognised as an important part of the relationship. Earlier studies into the nature of this relationship tended to focus on the type of information at the expense of quality of information exchanged (Davis, 1988; Karsch et al, 1968; Ley et al, 1973; Bain, 1976, 1977) but more recent research has redressed that balance. Van der Kar et al (1992) evaluated patients' worry prior to and following their consultation with the general practitioner. The perception of patients concerning their problem and the need for more information about the problem played an important role in the degree of their worry. Patients who wanted more information about the complaint were more worried than patients who did not feel they required more information. The consultation was evaluated more positively by patients with regard to how their worry was discussed and the decrease in worry after consulting the general practitioner in patients who were positive about the interview was significantly higher than in patients who were less positive. Kaplan et al (1989) similarly show that less information supplied by the doctor is

associated with poorer health outcomes in the patient. They propose that doctors are able to influence the outcome of patients with chronic illness, not only with competent medical care, but by shaping how patients feel about their disease. These authors find a positive association between negative emotion (broadly defined as tension, frustration, anxiety, impatience, apprehension and self consciousness) and improved health outcomes. Roter (1977) and Stewart (1984) also found this association. Kaplan et al suggest that the expression of negative emotion may signal a recognition of the normal tension between doctors and patients, and its association with improved health status may reflect a changing of roles for both.

Although the link between information provision and patient satisfaction has clearly been identified, it is not enough for doctors simply to give information. How the doctor gives information is as important as the information per se. For example, Savage & Armstrong (1990) compared the effect of doctors using a directing and a sharing style in the prescription phase of the consultation. The rationale for their study was that patients who have been made to feel part of the decision making process are more likely to be satisfied and therefore to follow treatment advice. However, the counter to this is the argument that the doctor's primary function is to make the patient feel better by invoking paternalism, authoritarianism and domination - qualities lending themselves to a directive style of consultation which, it has been suggested, is better suited to patients who present with symptoms but no physical signs (Thomas, 1978).

Savage & Armstrong found that patients who received a directive style reported significantly higher levels of satisfaction on all outcome measures and that this was particularly striking with patients with physical problems. However, there were no significant differences between a sharing and the directive style in longer consultations in which the main treatment was advice and among patients with psychological or chronic problems. Although this study vividly demonstrates the way in which the 'how' of information giving is able to effect outcome, the study is flawed in a fundamental way. The sharing style, for the most part, was composed of questions. This begs the question

of how information was conveyed or given. Doctor style, the independent variable, is confounded with information giving. The directive style is more informative than the sharing style in the part of the interview most concerned with information giving. The outcome measure asks, for example, if the doctor displayed understanding of the patient's problem. In the directive style, the doctor made explicit his understanding, whereas in the sharing style he did not. It could therefore be argued that the outcome simply measures whether or not the manipulation of doctor style was successful. The results, it could be said, are measuring the very thing that was changed. However, the study eloquently demonstrates, although not perhaps in the anticipated way, that the way information is provided is as crucial as the information itself.

In a meta-analysis of studies of the doctor-patient relationship between 1962 and 1986, Roter (1989) identified 247 different communication variables addressed. Hall et al (1988) grouped these variables in six mutually exclusive categories: information giving, information seeking, social conversation, positive talk, negative talk, partnership building. The last category applies to physicians' communication only. These groupings were further categorised into the Task goals of the consultation, and the Socioemotional aspect of the visit. The former are considered to be medically relevant and likely to have an effect on patient compliance, while the latter are thought to be relevant to patient satisfaction. Task behaviour included information giving, information seeking, and technical competence, while Socioemotional behaviour included partnership building, social conversation, interpersonal competence and positive and negative talk.

Roter (1989) and Hall (1988) found an asymmetric pattern between the two domains. The median correlation between physician Task behaviours and patient satisfaction was 0.22, but the correlation between physician Socioemotional behaviours and patient Task behaviours (compliance and recall) was only 0.10) Hall et al found that the strongest relationships were between corresponding domains of communication: the median absolute correlation between physician Task behaviour and patient Task behaviour was

0.21 and the median correlation between physician socioemotional behaviours and patient reaction (satisfaction) was 0.26.

The authors propose that the concept of reciprocity provides an explanatory mechanism for this pattern of results and point out that this concept, regarded as critically important for understanding social relations, remains ambiguous. Put simply, the idea is that behaviours generate reciprocal, or like, behaviours (Gouldner, 1960; Berkowitz & Walster, 1976). Thus doctor and patient Task behaviours reciprocate one another as do doctor and patient Socioemotional behaviours. But the authors also propose that reciprocated exchange is not equally operative between different domains of communication. The doctors' Task behaviours may carry socioemotional significance for patients and one may expect to see a correlation between these two domains. However, task behaviour can take on socioemotional meaning through conveyance (e.g. voice quality) or interpretation. *Accordingly, doctors who speak with an interested voice* quality, or are otherwise active in the Task domain, may be interpreted by the patient as being interested and caring regardless of what he expresses through Socioemotional behaviours, because the patient has made a positive inference about the doctor's motivation for engaging in the Task behaviours. Roter, and Hall et al propose that the mechanism by which information achieves its therapeutic effects is through the patient's interpreted message of interest and caring. Therefore, generalisation of positive affect from the task domain will result in a Socioemotional response by the patient and this will be expressed as satisfaction or other affective behaviour. The weaker relation between doctor Socioemotional behaviour and patient task behaviour may be interpreted as a lack of reciprocity between these domains. Thus doctor Socioemotional behaviour may not have sufficient Task (or technical) significance to lead to strongly reciprocal Task responses in the patient. The physician who is positive may inspire liking in the patient but may effect no, or only weak, Task responses, such as attending to information or adhering to a treatment programme. Additionally, while information seeking is an important problem solving activity for the doctor, it may have little intrinsic value to the

patient. Information gathering, in contrast, may be viewed as enhancing the patient's power and increasing his ability actively to participate in problem solving. Hall et al, and Roter found that their meta-results also supported this hypothesis. Question asking was correlated negatively both with patient compliance and patient recall and was unrelated to patient satisfaction, while information giving was quite strongly related to all three.

Although it is clearly not comparing like with like, the above study has immediate relevance for the present chapter. The theory of reciprocity may account for the general trend for process to generate process: for example, doctor Seeking Information in the first half of the consultation generating patient Seeking Information in the second half, and so on. Giving Information and Seeking Information are clearly Task domains for the doctor. Hall et al and Roter do not identify these processes as patient tasks. This is perhaps because the majority of studies have examined the doctor's consultation behaviour rather than the patient's (Roter, 1989), but arguably they would be so. However, it is possible that when the Task agenda is clearly defined as medical, that is, as Physical, doctor and patient reciprocity of these two processes is maximised. But, when the Task agenda is less obviously medical and becomes, in effect, Socioemotional, the agenda interacts with doctor and patient reciprocity in the Task domain, so that the reciprocity of Giving and Seeking Information is less clear cut.

Such an interpretation is consonant with the results presented in this chapter. When the agenda is Physical, the presentation is Physical, Seeking Information is clearly reciprocal. When the agenda is Emotional and the presentation is also Emotional (that is the emotion has been medicalised), Seeking Information is also reciprocal. When the presenting problem is Acute or Chronic Physical, Emotional agendas interact with Seeking Information for the doctor, and when the presenting problem is Emotional, Physical agendas interact with Seeking Information for the patient. Giving Information tends not to demonstrate reciprocity to the same extent as Seeking Information and this may be because the latter is more instrumental or task orientated. Giving Information, in contrast, may interact with psychosocial issues in a more complex way. For example, the

data suggest that patients enter the consultation with a provisional diagnosis, manifest in patients addressing issues of Treatment, Referral and Investigation earlier in the consultation than doctors. It was said above that patients go to the doctor primarily to seek information or clarification, and that information giving is secondary for the patient although crucial for the doctor. Doctor Giving Information has a strong bias towards the second half of the consultation and occurs to a considerable extent in conjunction with Treatment, whereas both patient Giving Information and patients' use of Treatment occur in a more balanced way throughout. It is possible that while Giving Information and Treatment are clearly delineated as Task areas for the doctor (who must make a diagnosis) and indeed are regarded as Task areas by the patient (who has perhaps formulated a diagnosis) Giving Information, nevertheless, is interacting with psychosocial factors in a way that prevents its reciprocal flow. It is likely, for example, that any provisional diagnosis the patient may have made will be influenced as much by psychosocial concerns as by knowledge which is strictly medical. Thus patients are Giving Information, and are probably giving Information about the possible Treatment earlier in the consultation as a result of a priori inference. Further research is required to examine the extent to which information processing and consultation procedures interact with the principal domains and to identify the nature of those associations with greater clarity.

CHAPTER 8 : PROBLEM SOLVING

A. RATIONALE.

B. DEVELOPMENT OF CATEGORIES.

C. RULES FOR CODING.

D. DEVELOPMENT OF SCORESHEET WITH IMPLICATIONS FOR CODING.

E. RELIABILITY.

F. METHOD.

G. INITIAL PROBLEM SOLVING STRATEGIES USED BY DOCTORS AND PATIENTS FOR PRINCIPAL AGENDAS.

H. BREAKDOWN OF PROBLEM SOLVING OUTCOMES REACHED BY INITIAL STRATEGIES FOR DOCTORS AND PATIENTS IN PRINCIPAL AGENDAS.

I. INITIAL PROBLEM SOLVING STRATEGIES USED BY DOCTORS AND PATIENTS ACCORDING TO DOCTOR GENDER.

J. INITIAL PROBLEM SOLVING STRATEGIES USED BY DOCTORS AND PATIENTS ACCORDING TO INTERVIEW LENGTH.

K. NUMBER OF RETURNS TO PRINCIPAL AGENDAS AS A FUNCTION OF INITIAL PROBLEM SOLVING STRATEGY ADOPTED.

L. DISCUSSION.

A. RATIONALE

In chapter 4 the author drew attention to evidence for a mutual process of somatisation between doctor and patient. It was suggested that the way in which the doctor is perceived and perceives himself will mediate in some measure the extent to which psychosocial distress is presented to the doctor by the patient (McWhinney, 1989; Dale & Middleton, 1989; Verhaak, 1986) and that a theoretical shift towards viewing somatisation as a process rather than a category may be helpful both for prevention and for treatment (Murphy, 1989; Smith et al, 1986).

The data presented in this thesis indicate that both doctors and patients are uncomfortable with the presence of Emotional agendas in the general practice interview. Doctors in particular initiate far fewer Emotional agendas than do patients, and return to Emotional agendas far less. Doctors are also more likely to follow the patients' Physical agendas than their Emotional or Social agendas even where the patient has already followed the doctor in the previous floorholding. Neither doctors nor patients follow the other's Emotional agendas to a high degree when compared to the other two agenda types, and even when doctors have followed the patients' Emotional initiation patients are less likely to follow the doctor in the next floorholding than they are when the doctor has followed a patient on a previously raised Physical agenda. The author argued that insofar as a following is more likely than not to result in a following from the doctor in the emotional and social domains (but to a lesser extent than is the case for Physical agendas), and insofar as patients both initiate and return to a lot of emotional concerns, it may behove the doctor to allow his patients to initiate Emotional agendas in their own way by being responsive to patients' cues in the emotional domain rather than attempting to establish a debate, doctors are more likely to obtain patient following. (This is borne out further below). But it may also be that doctors who feel inadequate to deal with patients' psychosocial problems unwittingly contribute to the somatisation process by colluding with patients who focus on the physical domain. Patients after all almost always begin the interview with a Physical agenda as though to legitimise their presence

in the G.P. surgery. Indeed Harding et al (1980) found that most patients who do have a mental disorder gave a physical reason such as a headache, abdominal pain, cough, back pain or weakness as their reason for attending the surgery. It is also the case that doctors seem to be less happy with their ability to handle emotional concerns. For example, Rashid et al (1989) demonstrate that G.P.s are less satisfied with consultations in terms of their ability to communicate with patients and allow patients time to express aspects of psychological ill health, and Winefield & Murrell (1991) found that doctors were most satisfied with consultations in which medical problems and their solutions seem clear.

Porter & Gorman (1989) suggest that one way for the G.P. to detect somatisation disorder is to use a standardised screening questionnaire, and the General Health Questionnaire (Goldberg, 1972; 1978; Goldberg & Hillier, 1978) has been used quite extensively to this end particularly in conjunction with research. But as has been pointed out earlier, to give a doctor a questionnaire to identify either somatisation disorder or other psychological distress, is, in effect, to provide him with a way of identifying a patient's Emotional agenda. However, the data presented in this thesis support the hypothesis that patients are well able to express their emotional concerns, and that it is the doctor who is less able or willing to identify and deal with observable emotional considerations presented in the natural course of the interview.

The inadequacy of the traditional medical model in terms of accommodating the patient's inner and outer world was discussed in chapter 3 and has been an underlying theme of this thesis. For example, Tuckett et al (1985) found that in only 13 percent of their series of 405 consultations were doctors making an active effort to discover patients' ideas, and in 58 percent no effort was made at all. In his key lecture to the Royal College of Physicians in 1974, John Stevens spoke eloquently about the common patterns used by general practitioners in their strategies and tactics of solving both their patients' and their own problems. In particular he drew attention to the great pain and struggles he observed in trainees as they shifted from the invaluable skills they had learnt in eight years training in a closed system of diagnostic medicine to the more threatening

open system of problem solving in general practice. This was during his time as a researcher at McWhinney's department in Ontario - noted for its patient centred approach, and innovative in this respect. Central to the closed system of diagnosis (the traditional medical model, are the key ideas of History, Examination, Investigation, Diagnosis and Treatment. Stevens contrasts the open consultation quoting G.I. Watson (1967), "Neither the patient alone, nor the doctor alone, but the patient consulting his doctor is the central point of medicine. This is the supreme learning and teaching movement towards which our young doctors' training leads ... at this moment, behind and around him, visibly or invisibly, stand his family and his habits, his genetic and personal past ... around them both lies the community in which they live and work" (p.14), and speaks of the Kuhnian paradigm shift requisite for doctors who go on to become general practitioners, a concept also used by McWhinney (1983). Arguably, of course, it is all doctors and the medical profession itself which must negotiate this altered perspective. But that is to digress to wider concerns (Like et al, 1984; Feighter et al, 1975; Scherger et al, 1980; Smith & McWhinney, 1975).

It is noteworthy that Stevens refers to the second model, the open system of consultation, as being the model which embraces a problem-solving perspective and of course in its fullest sense this is true. Effective problem solving must necessarily take account of the wider systems with which a problem presents. This is the essence of the biopsychosocial perspective referred to in chapter 3 (Engel, 1977; 1980). However, through their grounding in the traditionally taught closed system of consultation, doctors do receive a thorough training in problem solving techniques. These skills are recognised as differential diagnosis. Differential diagnosis makes extensive use of hypothesis testing, identifies options for action, selects options for action, examines the possible consequences and monitors previous options (Like & Reeb, 1984). It also makes use of cognitive and behavioural strategies, offers hypotheses, prescribes drugs, describes alternative resources and makes referral to other agencies. Credit must be given where due, and the art of differential diagnosis is exemplary: where it falls short is in its failure

to accommodate any other system than the organic. Doctors are therefore well acquainted with problem solving but, as Stevens (1974) and McWhinney (1989) suggest, tend only to utilise problem solving in the physical domain.

General practice has been variously described but what most of these characterisations have in common is a delineation of the discipline in terms of its role as provider of health care for all the major events of the family: birth, infancy, childhood, adolescence, adulthood, ageing and death (McFarlane et al, 1971; Lesser, 1983; Shapiro, 1992; Murphy & Mattson, 1992). "Family medicine is a co-ordinated, multidisciplined approach to comprehensive health care of the family unit", McFarlane et al (1971). However, these investigators go on to point out that role, or function, is only one component of a discipline and that the second and vital component is field of knowledge. Field of knowledge is understood to mean the factual information required of the doctor, plus specific problem solving techniques uniquely applicable to the patient with undifferentiated complaints. They argue that the primary care physician should receive training in proportion to the cell size of the frequency and period prevalence of various problems, and their study shows that clear emotional problems account for 10.1 percent of complaints, and have a one year prevalence of 9.2 percent. This compares with a point prevalence of 39% found by Marks et al (1979) - who also showed that G.P.s detection of emotional disorders varies widely among G.P.s, with a mean ability in the range of 55 percent. In line with these results, Lesser (1985) maintains that general practice requires different interviewing approaches to its patients from other medical disciplines because of four distinguishing characteristics: a high prevalence of emotional disorder; a high rate of spontaneous improvement; the disguised presentation of emotional problems; the particular nature of general practice itself. Similarly, Like & Reeb (1984) note that employing biomedical hypotheses in general practice generally proves to be inadequate in the comprehensive evaluation and management of patients who present with illnesses which constitute complex mixtures of physical, emotional and social elements (Barsky, 1979; McWhinney, 1981). They build on the biopsychosocial perspective of Engel

(1977, 1980) - see chapter 3 - to propose an elaboration of the multidimensional hypothesis testing framework developed by Lazare et al (1979) for use in out- patient psychiatric clinics, for use in family practice. Like and Reeb (1984) found that this development is extremely useful in the care of patients who present with illnesses that are undifferentiated or are of an uncertain nature.

Given that multidimensional problem solving is germane to general practice, and given the evidence for the implementation in training of techniques which have been specifically developed for use in the speciality, it is salient to recapitulate upon what is meant by a problem. Lesser & Wakefield (1975) note that patients present with problems (author's italics) and rarely with major psychiatric disorders. But what is meant by a problem ? In the present system of interaction analysis a doctor or a patient agenda is defined as the explicit or implicit cause of concern of either party, and the agendas defined within the system represent the broad categories of topic addressed within the general practice interview. Agendas are the focus of the problem solving process. The Concise Oxford Dictionary defines a problem as that of, "Doubtful or difficult question ...(a) thing hard to understand". It seems fair, therefore, to maintain that what patients bring to consultation as their agendas, may also be regarded as their problems.

The variable ability of doctors to detect emotional problems in their patients has already been mentioned (Marks et al, 1979). Lazare & Eisenthal (1979) remark that in their research, "It is as if there were a conspiracy between both parties (in the interview) in which the patient agrees not to say what he wants and the clinician agrees not to ask". However, these writers go on to point out that there tends to be a great deal of wasted time and energy in an interview due to the patient's reluctance to state his request. They demonstrate that by eliciting the patient's request - his reason for attending the surgery - in an empathic manner, the clinician diminishes the patient's need to engage in evasive activities which test out the doctor's flexibility and concern, and by conveying to the patient the collaborative nature of the interview, doctors change the focus of the consultation towards the task. Both doctor and patient perspective may be altered as a

result of this process: the patient may be freed to explore psychosocial concerns in addition to or instead of physical concerns, and the doctor, rather than experiencing frustration and helplessness, may feel compassion when he learns that there is a positive way in which he may contribute to the patient's predicament. Lazare & Eisenthal (1979) point out that it is not uncommon for doctors who deal with patient populations culturally and socially different from their own to believe that patients want radical changes in their own symptomatology that are hard to fulfil. In believing that patients will expect such changes, doctors are liable to become angry at patients for having unreasonable demands. However, since the patient's request is frequently more modest than expected by the doctor, the patient, in stating his request, undercuts the doctor's projection. Lazare et al (1978) found that 63 percent of patients expressed specific requests for treatment with 37 percent expressing the request spontaneously and the remaining 26 percent verbalising a request after the doctors elicitation.

Central to enabling the patient to make his request is the thesis of regarding the patient as an expert (Tuckett et al, 1985; Campion, 1987). Negotiation on the request must begin with the patient's perspective, even if the doctor disagrees on what the patient thinks he needs. Lazare et al (1979) speaking of out-patient psychiatry, maintain that conflict between clinician and patient over their perspectives is not only a common occurrence, but also is frequently a central feature of the clinical process. Knowledge of the kind of conflict between the two parties is essential to initiating the process of negotiation. Conflicts may be about divergent and incomplete views as to the nature of the problem; about treatment priorities as well as goals of treatment, and may be about the doctor- patient relationship itself. It is the latter which is of greatest consequence to the clinical interview, and both doctor and patient have requirements of the other. The patient requires personal caring and technical competency while the doctor may require the patient not to be violent, to keep his appointments etc. The fewer the requirements the doctor has of the patient the wider the range of patients he is likely to be able to help. The crux of their thesis is the notion that conflict is normative: it is something to be expected,

understood and even desired. "It is a feature of normal interpersonal discourse in clinical and non-clinical settings, not the result, fault, or responsibility of either party. The resolution of such conflict ... is an essential aspect of clinical practice, not an unexpected or unwanted dimension of the clinician-patient interaction" (p. 162). Conflicts between groups and individuals may be resolved in a variety of ways (for example, legal processes, violence, chance methods such as flipping a coin etc.), but in clinical practice Lazare et al propose negotiation as being integral to conflict resolution. Although Byrne & Long (1984) saw the consultation as a goal seeking activity in which the goals of one participant may not be clear to the other, the clinical encounter is not usually or explicitly regarded as conflictual. But to regard it in this way is helpful. In chapter 4 various models of the doctor-patient relationship were discussed in terms of their ability to accommodate doctor and patient perspective, doctor and patient influence (control) and an awareness of wider psychosocial issues, see also Campion et al (1992). It was proposed that these three dimensions must be addressed in a way that balances both doctor and patient involvement on each for a model of the consultation to be fully functional. The Transformed medical model (which builds on the biopsychosocial perspective) proposed by McWhinney (1989) was found to encompass the three dimensions, and it is the extent to which doctor or patient negotiate around the conflict fundamental to these dimensions which informs the results of this thesis.

Lazare et al (1979) distinguish between distributive and integrative negotiation; in the former there is a competition for resources so that one party improves his position at the expense of the other, the relationship is competitive and information exchange must be handled with care: in the latter both parties share common motives, there is no competition for resources, one party is identified as a partner or co-participant, the relationship is co- operative and information exchange is open. In this situation the focus of negotiation is joint problem solving. Although the clinical encounter usually attempts to define the situation in terms of integrative negotiation, in practice it commonly contains elements of both integrative and distributive negotiation. Katon & Kleinman (1981) also

draw attention to the primacy of negotiation to the doctor- patient relationship, with the goal of negotiation being the reduction of conflict in a way that promotes co-operation. They quote Johnson & Johnson (1975) to provide a definition more salient to the doctor-patient relationship: "a process in which people who want to come to an agreement but disagree on the nature of the agreement try to work out a settlement; it is aimed at achieving an agreement that determines what each party gives and receives in a transaction between them". Katon & Kleinman see an effective doctor-patient relationship as being essential to negotiation and the most important part of this relationship is physician empathy. The authors point out that a patient or doctor may react negatively to one another because at an unconscious level they are reminded of unpleasant past experiences or individuals. The importance of physician self-awareness was discussed in chapter 6, Section A, but certain doctor characteristics have consistently been found to be associated with good problem sensors. Lesser (1985) identified a doctor personality which is outgoing, assertive and accessible, together with a sound medical knowledge, since the latter in conjunction with the former may enhance the doctor's differentiation of patient who present with emotional and physical disorders. An appreciation of psychiatric epidemiology is also necessary as well as an understanding of the ways in which patient and family members present. Goldberg et al (1982) showed that, "Self confident, outgoing physicians with high academic ability tend to make more accurate assessments, as do those who display certain specified behaviours bring their diagnostic interviews". Lesser (1981) demonstrates that these behaviours may be acquired through training and that their absence indicates that the doctor will not be good at problem detection. Factors involved in problem detection are identified as: a) the doctor being aware of, and able to pick up verbal cues; b) the doctor being able to use empathy, non-possessive warmth, genuineness, and unconditional positive regard. Lazare et al (1979) maintain that clinical sensitivity to disguised indirect communication is essential to the recognition and explanation of normative doctor-patient conflicts, and Goldberg & Huxley (1980) pin-point an interviewing style which is empathic and is

sensitive to both verbal and non- verbal cues. Lazare & Eisenthal (1979) note the importance of doctor persistence and doctor compassion in enabling the patient to make his request, while Stevens (1974) maintains that it is a lack of counselling skills which is "the devil in the machine of traditional medicine". However, as Lazare & Eisenthal (1979) caution, the difficulty in stating what one wants is the heart of the matter. It is deeply rooted in our culture that one should not ask, and they cite those circumstances of keeping to oneself, the wishes made on blowing out the candles, catching sight of a falling star, and breaking the wishbone. Similarly, the chances of obtaining certain positions are enhanced if someone else submits the applicant's name. Moreover, there is always the danger that your request will be rejected without negotiation or that it may be misunderstood (Rowland et al, 1989). Telling another person what you want from them, they maintain, is a most intimate and revealing communication. It is axiomatic that for negotiation to become possible, the doctor's sensitivity to the patient's request is essential.

From a psychodynamic orientation Katon & Kleinman (1981) found that a negotiative approach is especially helpful in dealing with the somatisation of mental illness, maladaptive coping response to chronic or terminal disorders, transference-countertransference problems, patient-family or doctor-family conflicts in labelling illness, inappropriate use of the sick role, divergence in ethnic and biomedical conceptual orientations, and doctor conflicts due to the unusual psychosocial demands of special treatment environments. From a far more behavioural perspective Lesser (1985) proposes a problem-based model as being the most effective and efficient interviewing approach to be taught in general practice. This is because patients present in general practice with problems rather than major psychiatric disorders, and require a quick resolution to their problems; because the nature of general practice requires focused, time-limited, pragmatic and efficient approaches which may be taught simply and acquired readily; a problem based approach may result in problem-oriented treatment, often brief, which takes account of the high rate of spontaneous recovery; a problem

based approach does not promote illness behaviour, and may be modified if the patient presents with a major psychiatric disorder.

In the context of psychiatry, Mayou (1978) found that medical students demonstrated difficulty in decision making even though they show considerable factual knowledge and impressive clinical skills with patients. He presents the case for a problem solving approach both as a means of identifying these difficulties and as a basis for teaching. Of his two groups, the one which received instruction in problem solving techniques was significantly more able to formulate an organised plan of treatment, and were also more able to define the aims and content of treatment strategies. Gask et al (1988) proposed a problem-based approach to teaching psychiatric skills to general practice trainees and found an improvement not only in diagnostic and interviewing skills, but in management skills. Moreover, trainees found at the outset to be less accurate in their diagnosis of psychiatric illness demonstrated the greatest degree of change after training. Using a problem based approach to teaching, Gask et al (1991) propose a model of problem based interviewing developed from P.B.I. training devised by Lesser (1985) at McMaster University. P.B.I. is skills based and problem oriented, emphasising the skills required to detect, explore and clarify the patient's current psychosocial problems. Gask et al include in addition key elements from the work of Goldberg et al (1980), Neighbour et al (1987), Pendleton et al (1984), Tuckett et al (1985), and outline skills which are appropriate to the general medical setting, address the nature of the problems seen, and take account of the time constraints imposed.

Reference to the specific nature of general practice was made above. In addition, links have been established between family practice and family therapy. Tomson (1990) suggests they are natural allies. He points out that good family doctoring is not the same as using the idea of a systems (biopsychosocial) consultation with all patients. While doctors are accustomed to think of the relationship between infection and resistance, they have difficulty in accepting the idea that a symptom has a function and the solution may be the problem. Nevertheless, concepts pertaining to family process are extremely

germane to general practice (Neighbour, 1982; McDaniels & Campbell, 1986; Rogers & Durkin, 1984) and it is this salience together with its problem oriented approach which made it a logical step to utilise these concepts to inform the problem solving phase of the present research.

Of particular influence has been by the McMaster model of family functioning (Epstein, Bishop & Levin, 1978). This model observes that "the primary model of today's family unit appears to be that of a laboratory for the social, psychological and biological development and maintenance of family members" (Epstein et al, 1976 p.1411). In order to fulfil this function, families are required to deal with many issues and problems. These fall into three areas: basic task areas, which are instrumental and fundamental in nature - for example the provision of food, money, shelter etc.; developmental task areas, encompassing family issues which arise from natural processes of individual and family growth over time; and hazardous task areas which include crises associated with critical experiences such as illness, accident, job change etc. In order to understand the family structure, organisation and transactional pattern dysfunctions associated with family difficulties, Epstein et al (1982) focus on the following six dimensions: problem solving, communication, roles, affective responsiveness, affective involvement, behaviour control. A family may be more effective or less effective on any dimension. They identify major structural components of therapy as the essential building blocks of treatment. These 'macrostages' are constant across therapists and are clearly operationalised as 'assessment', 'contracting', 'treatment' and 'closure'. Macro-stages are differentiated from micro- moves, the more specific intervention skills such as labelling, focusing and clarifying. Epstein et al point out that neither macro-stage nor micro-move is to be confused with 'style'. Style is based on the more personal qualities of the therapist "Different individuals can intervene (focus) in very different ways. The differences are style, the intervention (micro-move) is focusing, and both are directed at negotiating a course of treatment, the major steps of which are the macro-stages" (Epstein et al, 1981). The model stresses the active

collaboration of family members with the therapist at each stage. The focus of therapy (treatment) is the specific problem(s) presented by the family and identified in assessment. (The aim of therapy is to enable the family to become, in effect, its own therapist). The model is intended for professionals working with families to form the basis of their understanding of family functioning, and to provide a model that guides their approach to treatment. Its acceptance should not be limited to psychiatry, and nor is it: increasingly it has been regarded as an important development in family medicine (Comley, 1973; Epstein & McAuley, 1978; McFarlane et al, 1971). Although the model has not been followed exactly, its conceptual framework has influenced the development of the method for analysing General Practice consultations. However, the stages identified by Epstein et al in their problem solving dimension have been identified; both doctor and patient are conceived of as having available for negotiation: identification of the problem; communication of the problem to the appropriate person; development of action alternatives; decision of one alternative; action; monitoring the action; evaluation of success.

The model is based on a systems approach. The family is seen as a system within systems (individual, marital, dyad) and relating to other systems (extended family, schools, industry, religious). Important for treatment is that the therapist/general practitioner is concerned with the processes occurring within the family systems which in turn produce pathology in the individual. Therapy is thus directed to changing the system and hence the behaviour of the individual (Epstein & Bishop, 1973). It is fundamental to this approach that cultural, ethical and other similar values be approached sensitively and handled with care.

B. DEVELOPMENT OF CATEGORIES

The categories developed for use in the problem solving phase evolved from a taxonomy of ways in which doctors consulting with patients were likely to handle feelings and to handle social information. This was complied in conjunction with a consultant psychiatrist and a general practitioner. In each domain the taxonomy was 'guided' by

basic problem solving steps. For example, in the emotional domain, the problem solving step of exploring feelings would provide the rationale for possible ways in which the doctor might handle the patient's feelings. Similarly in the social domain except that the framework and task would be possible ways in which doctors might explore the patient's Social agenda. ' Problem solving' in each domain refers to the active problem solving strategies available to the doctor in contrast to more implicit problem solving strategies. The taxonomy is given in Appendix G.

There are three broad categories of behaviour specifically regarding Social and Emotional agendas, and all examine the processes through which the agenda is addressed. They are not necessarily mutually exclusive. The broad categories of 1 and 2 encompass strategies which facilitate and limit the expression of an agenda (respectively). Category 3 is based on the McMaster problem solving strategies described above, whereas category 4 represents more direct and specific approaches to problem solving. Although derived from the emotional and social domains, all four categories pertain equally to Physical agendas. On the score sheet the coding system identifies primary and secondary codes. Primary codes are the three broad categories of facilitation, limitation and problem solving (3 and 4). Secondary codes refer to the sub-categories of the primary code. For example 3.1a: the primary code is 3 - problem solving - the secondary code is the identification and exploration of a problem. Had the category been 3.1b, the primary code would have been as before but the secondary code would have been the identification and exploration of associated events.

Additionally, in an attempt to identify the difference between the doctor prescribing options or leaving the choice open to the patient, the idea of 'focus' is used. For example, a doctor focus might refer to those instances when the doctor prescribes options or examines consequences, whereas patient focus may refer to the doctor inviting the patient to suggest options or examine consequences. This was defined as locus of autonomy. Doctor and patient focus was not included in the analysis of results for this thesis.

Coding Procedure.

Coding is carried out in two phases. The first phase consists of analysing the problem solving strategies (as described above) used by both doctor and patient in the floorholdings immediately surrounding the agenda initiation. Specifically, the problem solving strategies used are coded for the floorholding immediately preceding the agenda initiation (PREVIOUS floorholding), the floorholding in which the agenda is initiated (CURRENT floorholding), the first floorholding following the initiation of the agenda (NEXT-1 floorholding), and the second floorholding following the agenda initiation (NEXT-2 floorholding). This phase is designed to provide information about the initial processing of agendas. The second phase of coding describes the range of problem solving strategies adopted for a specific agenda. All occurrences of the same agenda throughout the interview are coded according to the operational definitions described above, and a record made of which strategies have been used and whether by doctor or by patient. Some strategies may be used more than once, but the number of times a specific strategy is used is not recorded. Finally a record is made of the total number of returns made to the agenda by both doctor and patient.

C. DEVELOPMENT OF SCORESHEET WITH IMPLICATIONS FOR CODING

The scoresheet developed through three stages. These can be seen in Appendix H. The first scoresheet identified the agenda in receipt of problem solving process, the primary code for the process being activated, the secondary code and the focus of the problem solving strategies. Each matrix refers to a floorholding, and it was at first envisaged that only two floorholdings should be coded: the floorholding in which the agenda first arose, and the following floorholding. The second scoresheet built on the first, but included a matrix for the previous floorholding. Doctor or patient focus had changed to doctor or patient locus of autonomy since this more clearly expressed the concept under study. A category to identify whether or not the agenda had been not followed or followed in the next floorholding was added. This was to provide information as to the influence of the problem solving strategies being adopted upon subsequent behaviour

with respect to the agenda in question. The final scoresheet retained the format of the second scoresheet, but added a further matrix for the NEXT-2 floorholding. The rationale for this was to enable an examination of the behaviour of the person who initiated the agenda in the CURRENT floorholding, the next time they spoke, which in most cases would be the NEXT-2 floorholding. It was not considered necessary to note whether or not the agenda in the PREVIOUS floorholding had been followed or not followed because what was being considered was the type of agenda and the type of problem solving which preceded the CURRENT agenda. A further development was to distinguish between initial problem solving strategies and the outcome problem solving strategies. Initial strategies refer to the problem solving strategies which are used in the PREVIOUS, CURRENT, NEXT-1 and NEXT-2 floorholdings. In other words they are concerned with how the agenda in question is initially handled. The outcome measures identify how many of the problem solving steps are taken by both doctor and patient in the entire interview in relation to the agenda which is the focus of problem solving. Also included was a box to indicate on how many occasions either party returned to the CURRENT agenda. The rationale of this was again to see whether any specific problem solving behaviours were associated with the return rate of either party. Although, as Katon & Kleinman (1981) point out, not all problem solving steps need be taken for every problem, it was hypothesised that the outcome measures would provide an index of doctor and/or patient problem solving competency: the greater the range of problem solving strategies used, the more comprehensive the problem solving.

D. RELIABILITY

For purposes of estimating inter-rater reliability of the problem solving coding system, seven general practice consultations were picked randomly from the sample described previously in this thesis. These gave a total of twenty five agendas (7 Emotional, 7 Physical and 11 Social). These were then coded by two independent raters. Percentage agreement, percentage disagreement and kappa (Cohen, 1968) were calculated as

measures of inter-rater agreement. In all there were 27 codings of the CURRENT floorholding, 26 of the NEXT-1 floorholding and 21 NEXT-2 floorholdings.

The inter-rater agreement coefficients for the two raters are shown in tables 8.1 to 8.3. Values of kappa greater than 0.6 indicate satisfactory levels of agreement. Levels of agreement for the primary ratings were extremely high where percentage agreement and percentage disagreement were calculated. Cohen's kappa, which represents a measure of agreement corrected for chance levels of agreement, was also extremely high. The only disagreement was between the primary ratings of 1 and 3: Facilitation of expression of the agenda and Problem Solving respectively. Agreement between the two raters was also very good for secondary ratings. It is important to note that the two raters agreed 100 percent of the time for some categories because these categories did not appear in the sample of interviews rated (1.3; 2.2; 2.3; 3.2; 3.3; 3.5; 3.6; 4.1; 4.2; 4.4; 4.6). However, those secondary codes which were coded proved to be very reliable both in terms of percentage agreement and percentage disagreement, and in terms of their kappa value. Where disagreement occurred it was between the secondary codes 1.1, 3.1a and 3.1b. Conceptually the distinction between these categories lies in degree rather than mode: there is a continuum between acknowledging a problem (1.1), identifying and exploring a problem (3.1a) and identifying and exploring associated events (3.1b). Arguably, a greater degree of judgement is involved in identifying the presence or absence of, for example, monitoring previous options or criticising an agenda. Nevertheless, where they were coded, the reliability between raters on the secondary codes were found to show acceptable reliability.

Levels of agreement between raters for locus of autonomy showed high levels of percentage agreement for both patient and doctor locus of autonomy. However, the kappa for doctor locus of autonomy, though acceptable, is lower than for patient locus of autonomy.

Raters agreement on the outcome measures was also very good. All the options were covered in the sample with the exception of patients' use of 4.4 (Prescribing

Drugs). Levels of agreement were very high where levels of percentage agreement and disagreement were calculated. Values of kappa were extremely acceptable in all cases. Where disagreement occurred, it was on both doctor and patient use of 3.1b (Identification and exploration of associated events), and the doctors' use of 3.1c (Identification and exploration of associated earlier events).

Table 8.1: Inter-rater agreement coefficients for primary and secondary ratings of initial problem solving strategies used in the PREVIOUS, CURRENT, NEXT-1 and NEXT-2 floorholdings.

	Agreed Present	Agreed Absent	Disagreed	% Agreement	% Disagreement	Kappa
Primary Rating						
1	19	54	1	98.6	1.4	0.97
2	6	68	0	100	0	1.00
3	42	31	1	98.6	1.4	0.97
4	6	68	0	100	0	1.00
	Agreed Present	Agreed Absent	Disagreed	% Agreement	% Disagreement	Kappa
Secondary Rating						
1.1	17	56	1	98.6	1.4	0.97
1.2	2	72	0	100	0	1.00
1.3	0	74	0	100	0	1.00
2.1	5	69	0	100	0	1.00
2.2	0	74	0	100	0	1.00
2.3	0	74	0	100	0	1.00
2.4	1	73	0	100	0	1.00
3.1a	36	37	1	98.6	1.4	0.97
3.1b	3	69	2	97.3	2.7	0.74
3.1c	1	73	0	100	0	1.00
3.2	0	74	0	100	0	1.00
3.3	0	74	0	100	0	1.00
3.4	1	73	0	100	0	1.00
3.5	0	74	0	100	0	1.00
3.6	0	74	0	100	0	1.00
4.1	0	74	0	100	0	1.00
4.2	0	74	0	100	0	1.00
4.3	5	69	0	100	0	1.00
4.4	0	74	0	100	0	1.00
4.5	1	73	0	100	0	1.00
4.6	0	74	0	100	0	1.00

Table 8.2: Inter-rater agreement coefficients for ratings of locus of autonomy of initial problem solving strategies used in the PREVIOUS, CURRENT, NEXT-1 and NEXT-2 floorholdings.

		Rater 2		
		DR	PT	No Locus
Rater 1	DR	1	0	0
	PT	1	68	0
	No Locus	0	0	4

	Raters Agreement					
Locus	Agreed Present	Agreed Absent	Disagreed	% Agreement	% Disagreement	Kappa
DR	1	72	1	98.6	1.4	0.66
PT	68	5	1	98.6	1.4	0.90

Table 8.3: Inter-rater agreement coefficients for ratings of outcome problem solving strategies used in the PREVIOUS, CURRENT, NEXT-1 and NEXT-2 floorholdings.

Outcome Rating	Agreed Present	Agreed Absent	Disagreed	% Agreement	% Disagreement	Kappa
Patient						
3.1a	19	6	0	100	0	1.00
3.1b	11	13	1	96.0	4.0	0.92
3.1c	7	18	0	100	0	1.00
3.2	2	23	0	100	0	1.00
3.3	3	22	0	100	0	1.00
3.4	2	23	0	100	0	1.00
3.5	2	23	0	100	0	1.00
3.6	1	24	0	100	0	1.00
4.1	1	24	0	100	0	1.00
4.2	2	23	0	100	0	1.00
4.3	9	16	0	100	0	1.00
4.4	0	25	0	100	0	1.00
4.5	1	24	0	100	0	1.00
4.6	2	23	0	100	0	1.00
Doctor						
3.1a	16	9	0	100	0	1.00
3.1b	11	13	1	96.0	4.0	0.92
3.1c	4	20	1	96.0	4.0	0.87
3.2	9	16	0	100	0	1.00
3.3	7	18	0	100	0	1.00
3.4	3	22	0	100	0	1.00
3.5	4	21	0	100	0	1.00
3.6	2	23	0	100	0	1.00
4.1	4	21	0	100	0	1.00
4.2	4	21	0	100	0	1.00
4.3	11	14	0	100	0	1.00
4.4	8	17	0	100	0	1.00
4.5	4	21	0	100	0	1.00
4.6	4	21	0	100	0	1.00

E. METHOD

The sample of 73 general practice interviews used in the assessment of reliability for the system of interaction analysis presented in chapter 3, as well as for the analysis of principal agendas, procedures and processes (chapters 4 to 7), was used to code doctor and patient problem solving behaviour according to the coding procedure outlined above (section B).

All doctor and patient initiated Emotional and Social agendas were scored, but only the first Physical agenda to occur in each interview was coded. This was because only a sample of Physical agendas was required for purposes of comparison to the Emotional and Social agendas, one of the main objectives of the study being to compare doctors' handling of emotional and social issues with their handling of patients' physical concerns.

F. INITIAL PROBLEM SOLVING STRATEGIES USED BY DOCTORS AND PATIENTS FOR PRINCIPAL AGENDAS

The cell numbers in the following tables are sometimes fairly low. It is therefore important to exercise caution in interpretation since the likelihood of making a Type I error is high. Nevertheless, within this structure, clear trends in doctor and patient problem solving behaviour do emerge. Table 8.4 shows the different initial strategies by doctor and patient for the three different agenda types in the current floorholding. The strategies 1 to 4 refer to the principal coding of the problem solving strategy not broken into further specific strategies. In the current floorholding doctors tend to initiate Emotional agendas with a 1 (facilitation) or a 3 (problem solving), but initiate more often with a 1. Doctors almost always initiate Physical agendas with a 3, and initiate Social agendas with a 3 much of the time. They also initiate Social agendas with a 1, but use 3s proportionately more often. This suggests that when doctors initiate Physical and Social agendas they do so using deeper and more active strategies than they do when initiating Emotional agendas. Emotional agendas seem to be initiated by doctors in a more facilitative or cursory way. Patients present a similar pattern to doctors in their use of

initial strategies in the CURRENT floorholding, but the pattern is far more pronounced in the emotional domain. In other words, patients seem to initiate Emotional agendas very tentatively: 47 type 1 and 17 type 3 (26.5%) for patients, compared to 10 type 1 to 7 type 3 for doctors (41.2%). Patients use a very high proportion of active 3 type problem solving strategies when they initiate in the physical domain. They also use a number of specific 4 type strategies. Overall, in the CURRENT floorholding both doctors and patients use deeper initial strategies to initiate Physical and Social agendas than they use to initiate Emotional agendas. *Comparatively patients are more tentative than doctors* in their initiating of Emotional agendas, but doctors show a slight bias towards being more facilitative rather than active in the initial strategies they use. The difference between the initial strategies used in the CURRENT floorholding is statistically significant for both doctors and patients.

Table 8.4: Different initial strategies adopted by doctor or patient for the three principal agendas in the CURRENT floorholding. The strategies 1 to 4 refer the principal coding of the problem solving strategy not broken down further into specific strategy.

	DOCTOR Strategy Type			
	1	2	3	4
Emotional	10	0	7	1
Physical	1	0	8	0
Social	8	0	29	0
	Chi-square= 11.84 $p<0.05$			
	PATIENT Strategy Type			
	1	2	3	4
Emotional	47	0	17	1
Physical	3	0	91	6
Social	10	0	47	0
	Chi-square=102.95 $p<0.001$			

In table 8.5 the different initial strategies adopted by doctor and patient for the three principal agendas in the NEXT-1 floorholding are shown. The results are presented in reverse order to reflect the responsive natures of the floorholding, that is the patient is responding to the doctors' initial agenda and strategy and vice versa. Thus, in response to the doctors initial strategy type, patients use the initial strategies 1 and 3 equally in the emotional domain. However, proportionately they use a lot of 2 type (limiting) initial strategies (42.9%). Out of 14 doctor initiations, on occasions patients continue on the Emotional agenda, but on 6 occasions they block the emotional domain. In the physical domain patients occasionally limit the doctor's expression, but more frequently use 1s or 3s as their initial responsive strategy, with 3s being favoured. In the social domain patients overwhelmingly respond to the doctor's initial strategy with a 3 type strategy, suggesting that patients are willing to process Social problems more deeply and actively. Responding to the patients' initial agenda and strategy in the NEXT-1 floorholding, doctors follow patients' Emotional agenda most often by limitation (over 50% are blocked). When doctors do use initial problem solving strategies on the patients' Emotional agenda, they are split roughly between acknowledging the problem (1 type) and processing the problem more deeply using 3s and 4s. This is in contrast to the physical domain where proportionately doctors process Physical agendas more deeply than the reverse. Proportionately a patient's Physical agenda is rarely blocked but neither is it problem solved very actively by doctors in the NEXT-1 floorholding. Doctors use 1 type strategies and 3 type strategies in a fairly balanced way in response to patient initiated Social agendas. Patients' Social agendas are blocked more often by doctors than their Physical agendas, but not nearly as often as patients' Emotional agendas are blocked by doctors in the NEXT-1 floorholding. Proportionately Emotional and Social agendas receive slightly more active problem solving from doctors, in that doctors use relatively more specific 4 type strategies in the NEXT-1 floorholding for these two domains. However, specific problem solving in the NEXT-1 floorholding is not common.

Table 8.5: Different initial strategies adopted by doctor or patient for the three principal agendas in the NEXT-1 floorholding. The strategies 1 to 4 refer to the principal coding of the problem solving strategy not broken down further into specific strategy.

	DOCTOR Strategy Type			
	1	2	3	4
Emotional	4	6	4	0
Physical	2	3	5	0
Social	4	1	31	4
	Chi-square= 21.48 $p<0.01$			
	PATIENT Strategy Type			
	1	2	3	4
Emotional	10	41	7	4
Physical	22	5	52	5
Social	16	13	18	4
	Chi-square= 70.26 $p<0.001$			

Table 8.6: Different initial strategies adopted by doctor or patient for the three principal agendas in the NEXT-2 floorholding. The strategies 1 to 4 refer to the principal coding of the problem solving strategy not broken down further into specific strategy.

	DOCTOR Strategy Type			
	1	2	3	4
Emotional	0	1	3	0
Physical	3	0	8	0
Social	6	1	17	1
	Chi-square= 5.48 ns			
	PATIENT Strategy Type			
	1	2	3	4
Emotional	0	1	6	4
Physical	3	1	71	7
Social	6	3	21	2
	Chi-square= 52.55 $p<0.001$			

The NEXT-2 floorholding, which continues the agenda initiated by each party in the current floorholding, and the initial strategies adopted for the three principal agendas by doctor and patient in response to the NEXT-1 floorholding, are shown in Table 8.6. The doctors' NEXT-2 floorholdings are not statistically significant in terms of the initial strategies used. However, the general trend suggests that in all domains, 3 type strategies are more common and this is particularly the case in the social domain. In the NEXT-2 floorholding, doctors hardly ever use specific 4 type strategies for the agenda they had raised when the floorholding was CURRENT, and when they do it is in the social domain. Patients, in contrast, overwhelmingly follow their own agendas in the physical and social domain, and overwhelmingly do so using deeper and more active strategies. When patients follow their CURRENT Emotional agendas in the NEXT-2 floorholding, they do so using deeper initial strategies, but they follow their own Emotional agendas far less than they follow their Physical and Social agendas. This may be because the doctor has blocked or limited the patient's CURRENT Emotional agenda in the NEXT-1 floorholding: over 50 percent of patient CURRENT Emotional agendas are subsequently blocked by doctors, see table 8.5. The differences for the initial strategies used in the NEXT- 2 floorholding are statistically significant for patients. Table 8.7 compares the initial strategies adopted in the NEXT-1 and NEXT-2 floorholdings on the three principal agenda types, for doctors and for patients. There is a statistically significant difference in the type of initial strategy used by doctors in the emotional domain in the NEXT-1 and NEXT-2 floorholdings, but not in the physical domain. There is also a statistically significant difference in the type of initial strategies used by doctors in the social domain in the NEXT-1 and NEXT-2 floorholding. Whereas doctors tend to continue in 3 type strategies in the latter, they tend not to use as many 2 type strategies in the NEXT-2 floorholding. It is possible that once an agenda has been established and followed by the patient, natural turn-taking processes the agenda over a succession of floorholdings. Patients use statistically significant initial strategies in the NEXT-1 and NEXT-2 floorholdings in the emotional and physical domains, but do not do so in the social

domain. This suggests that Social agendas are in some way more robust when handled by the patient.

Table 8.7: Table comparing the initial strategies adopted in the NEXT-1 and NEXT-2 floorholdings. Numbers refer to the frequency with which each initial strategy was adopted in that floorholding for each specific agenda type.

DOCTOR FLOORHOLDINGS				
	Emotional Agendas Strategy Type			
	1	2	3	4
NEXT-1	10	41	7	4
NEXT-2	0	1	3	0
	Chi-square= 11.96 $p<0.01$			
	Physical Agendas Strategy Type			
	1	2	3	4
NEXT-1	22	5	52	5
NEXT-2	3	0	8	0
	Chi-square= 1.49 ns			
	Social Agendas Strategy Type			
	1	2	3	4
NEXT-1	16	13	18	4
NEXT-2	6	1	17	1
	Chi-square= 8.79 $p<0.05$			
PATIENT FLOORHOLDINGS				
	Emotional Agendas Strategy Type			
	1	2	3	4
NEXT-1	4	6	4	0
NEXT-2	18	1	6	4
	Chi-square= 13.26 $p<0.01$			
	Physical Agendas Strategy Type			
	1	2	3	4
NEXT-1	2	3	5	0
NEXT-2	5	1	71	7
	Chi-square= 21.95 $p<0.001$			
	Social Agendas Strategy Type			
	1	2	3	4
NEXT-1	4	1	31	4
NEXT-2	6	3	21	2
	Chi-square= 3.14 ns			

G. BREAKDOWN OF PROBLEM SOLVING OUTCOMES REACHED BY INITIAL STRATEGIES FOR DOCTORS AND PATIENTS IN PRINCIPAL AGENDAS

The outcome statistics compare the *initial* problem solving strategy used by doctor and patient in the CURRENT floorholding (not broken down into secondary codes), with the number of problem solving strategies reached for that agenda later in the interview. Table 8.8 shows the secondary outcome strategies reached by initial primary strategy adopted, broken down by nature of the agenda and whether doctor or patient initiated, for Emotional agendas. When patients *initiate* Emotional agendas with a 1 type strategy (n=47), 3 type problem solving strategies are done 35 times by patients on their own agenda later in the interview. When patients initiate Emotional agendas with 3 type strategies (n=17) 3 type strategies are done 25 times by patients on their own agenda later in the interview. When patients initiate Emotional agendas with 1 type strategies (n=47), the agenda receives more specific 4 type problem solving strategies from the patient later in the interview on 12 occasions. When patients initiate Emotional agendas with a 3 type strategy (n=17) the agenda receives more specific 4 type problem solving strategies from the patient later in the interview on 8 occasions.

Table 8.8: Secondary outcome strategies reached by initial primary strategy adopted, broken down by nature of agenda and whether doctor or patient initiated the agenda. EMOTIONAL AGENDAS.

Initial Strategy in CURRENT floorholding								
	Doctor initiated				Patient Initiated			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
N	10	0	7	1	47	0	17	1
Outcome								
Patient:								
3.1a	3	0	5	1	26	0	13	1
3.1b	2	0	1	0	2	0	7	0
3.1c	0	0	0	0	4	0	2	1
3.2	0	0	0	1	1	0	0	0
3.3	0	0	0	0	0	0	1	0
3.4	0	0	0	0	1	0	1	1
3.5	2	0	1	0	0	0	0	0
3.6	1	0	1	0	1	0	1	0
4.1	1	0	0	1	5	0	4	0
4.2	2	0	1	0	1	0	0	0
4.3	0	0	1	0	6	0	3	1
4.4	1	0	0	0	0	0	1	1
4.5	0	0	0	0	0	0	0	0
4.6	0	0	0	0	0	0	0	0
Doctor:								
3.1a	2	0	5	1	20	0	10	1
3.1b	1	0	2	0	4	0	1	0
3.1c	0	0	0	0	3	0	1	0
3.2	1	0	0	1	2	0	2	1
3.3	1	0	0	1	2	0	2	1
3.4	1	0	0	0	1	0	2	1
3.5	2	0	1	0	0	0	1	0
3.6	1	0	1	0	1	0	1	0
4.1	1	0	3	1	18	0	9	0
4.2	2	0	1	0	4	0	1	0
4.3	0	0	1	0	10	0	7	1
4.4	1	0	0	0	1	0	2	1
4.5	0	0	0	0	1	0	0	0
4.6	0	0	0	0	1	0	1	0

When doctors initiate Emotional agendas with a 1 type strategy (n=10), on eight occasions the agendas received 3 type problem solving strategies subsequently by the patients. When doctors initiate Emotional agenda with 3 type strategies (n=7), 3 type problem solving strategies are used by patients on 8 occasions later in the interview. When doctors initiate Emotional agendas with 1 type strategy (n=10) on few occasions the agenda receives more specific 4 type problem solving strategies later in the interview from the patient. When doctors initiate Emotional agendas with 3 type strategies (n=7) on two occasions the agenda receives more specific 4 type problem solving strategies later in the interview from patients. When patients initiate an Emotional agenda with a 1 type strategy (n=47), doctors will problem solve later in the interview by using a 3 type strategy 33 times (compared to 35 occasions by patients). When patients initiate an Emotional agenda with a 3 type strategy (n=17) doctors will specifically problem solve them later in the interview by using 4 type strategies on 20 occasions (compared to 25 times by the patient). When patients initiate an Emotional agenda with a 1 type strategy (n=47) doctors will problem solve later in the consultation by using a specific 4 type strategy on 35 occasions (compared to 12 times by the patient). When patients initiate an Emotional agenda with 3 type strategies (n=17), doctors will problem solve using a more specific 4 type strategy 20 times subsequently in the interview (compared to patients' 8 times). Calculated percentage wise the data show that if patients initiate Emotional agendas with a 1 type versus a 3 type initial strategy, of all the occasions it would be possible for them to receive a 3 type outcome strategy from the doctor later in the interview they are more likely to do so if they initiate with a 3 type strategy (8.8 percent versus 14.6%). Similarly when patients initiate Emotional agendas with a 1 type strategy versus a 3 type strategy, of all the occasions when it would be possible to receive an explicit 4 type strategy from the doctor later in the interview, they are more likely to do so if they initiate with a 3 type strategy (12.4 percent versus 19.4 percent). Overall, it seems that when the doctor's initial strategy is a 1 (that is he acknowledges the problem and is facilitatory), patients will actively problem solve later in the interview by using 3

type strategies to a similar extent that they actively problem solve when they also initiate an Emotional agenda with a 1 type strategy. In contrast, when the doctor's initial strategy is a 3, patients will problem solve fairly actively in terms of 3 type problem solving strategies later in the interview, but the extent of their problem solving on this strategy will be less active than if they themselves had used the initial strategy of a 3 to initiate an Emotional agenda. When the doctor's initial strategy is a 1, patients are far more likely (proportionately 40 percent more likely) to participate in specific 4 type problem solving later in the interview, than if the doctor's initial strategy for initiating the Emotional agenda is a 3. In the latter case, patients will actively problem solve only 25 percent of the time using 4s. In the emotional domain patients use a fair range of problem solving strategies. Those not used by patients were 3.2 (identification and exploration of associated events); 3.5 (monitoring previous options); 4.2 (behavioural strategies); 4.5 (describing resources) and 4.6 (referral to other agencies). Doctors used all but one of the problem solving categories, although 3.1c (identification and exploration of associated earlier events); 3.2 (identification of options for action); 3.3 (selection of option); 3.4 (examining possible consequences); 3.5 (monitoring previous options); 3.6 (identifying or communicating with others); 4.2 (behavioural strategies); 4.5 (describing resources) and 4.6 (referral to other agencies) were used infrequently. It must be noted that while most strategies were used, the baseline for *possible* use was the number of agendas initiated by each initial strategy. Thus, of the 47 patient initiated 1 type strategies, doctors had the potential to do all 14 problem solving strategies (3s and 4s) on 47 occasions later in the interview. The data are able to show that while doctors may not routinely use the problem solving strategies later in the interview, they nevertheless have the range of skills available to them for use. In table 8.9, the secondary outcome strategies reached by initial problem solving strategies adopted, broken down by nature of agenda (Physical), and whether doctor or patient initiated, are shown. Analysis of principal agendas (chapter 4) showed that doctors do not subsequently initiate Physical agendas. The very low number of doctor initiations on initial strategies 1, 2 and 4 is

therefore not surprising, particularly as only the first Physical agenda to occur in each interview was coded. The number in these three cells are too low to interpret meaningfully. However, when the doctor does initiate a Physical agenda (n=8), he will always do so using a 3 type initial strategy, and will bring a comparatively high level of problem strategies to bear on his own Physical agenda later in the interview. Of a possible 112 occasions when a strategy could be used (that is each Physical agenda initiated by the doctor receiving all the problem solving strategies), problem solving strategies 3 and 4 were used 55 times later in the interview. Although not extremely high, there is proportionately a lot more problem solving occurring in the physical domain when compared to the emotional and social domains: of a possible 98 occasions when a 3 and 4 type strategy could have been used by a doctor on his own agenda in the emotional domain, such strategies were used on 14 occasions, and of a possible 406 possible occasions when a 3 and 4 strategies could have been used by a doctor on his own agenda in the social domain, such strategies were used on only 20 occasions. When this is broken down by 3 and 4 type outcome strategies, the data show that the doctor uses 3 type strategies on 35 occasions later in the interview, and 4 type strategies on 17 occasions later in the interview. Percentage-wise, then, doctors use 3 type strategies 54.7 percent of the time, and 4 type strategies 35.4 percent of the time on their own Physical agendas. When patients initiate a Physical agenda with a 1 type strategy (n=3), he will receive 13 3-type strategies from the doctor later in the consultation. Calculated as a percentage of total possible 3 type outcome strategies for initial 1 and 3 type strategies respectively, the data show that the patient will receive proportionately more 3 type strategies from the doctor if he initiates with a more tentative 1 type strategy (48.1 percent versus 43.0 percent). When patients initiate a Physical agenda with 3 type strategies (n=91), they will receive 212 4 type strategies from the doctor later in the consultation. Percentage-wise, of total possible 4 type outcome strategies, the data show that patients proportionately receive more 4 type strategies from the doctor if they initiate a Physical agenda with a type 1 rather than a type 3 initial strategy (55.6 percent versus

33.3 percent).

Table 8.9: Secondary outcome strategies reached by initial primary strategy adopted, broken down by nature of agenda and whether doctor or patient initiated the agenda. PHYSICAL AGENDAS.

Initial Strategy in CURRENT floorholding								
	Doctor initiated				Patient Initiated			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
N	1	0	8	0	3	0	91	6
Outcome								
Patient:								
3.1a	1	0	8	0	3	0	83	6
3.1b	1	0	5	0	2	0	57	6
3.1c	1	0	0	0	0	0	20	2
3.2	0	0	4	0	3	0	13	0
3.3	0	0	2	0	0	0	10	0
3.4	1	0	2	0	2	0	16	0
3.5	1	0	4	0	1	0	38	0
3.6	0	0	2	0	1	0	2	0
4.1	0	0	0	0	0	0	3	0
4.2	0	0	2	0	1	0	14	0
4.3	0	0	4	0	3	0	34	1
4.4	0	0	4	0	1	0	19	0
4.5	0	0	0	0	1	0	0	0
4.6	0	0	0	0	1	0	11	0
Doctor:								
3.1a	1	0	8	0	3	0	81	6
3.1b	1	0	4	0	2	0	44	5
3.1c	1	0	0	0	0	0	17	2
3.2	1	0	7	0	2	0	35	2
3.3	1	0	6	0	2	0	56	2
3.4	1	0	4	0	1	0	25	4
3.5	1	0	5	0	1	0	41	0
3.6	0	0	4	0	2	0	14	2
4.1	0	0	0	0	2	0	16	2
4.2	1	0	4	0	1	0	41	4
4.3	1	0	5	0	3	0	63	3
4.4	1	0	7	0	2	0	70	4
4.5	0	0	0	0	1	0	3	0
4.6	0	0	1	0	1	0	19	2

Table 8.10 shows the secondary outcome strategies reached by initial primary strategy adopted, broken down by nature of agenda (Social), and whether doctor or patient initiated. When patients initiate Social agendas with a 1 type initial strategy (n=10), the patient will do two 3 type strategies on the Social agendas later in the interview. When patients initiate Social agendas with a 3 type strategy (n=47), the patient will do 39 3-type strategies in the Social agendas later in the interview. When patients initiate Social agendas with an initial 1 type strategy, they will not do any 4 type strategies later in the consultation, and when they initiate in the social domain with 3 type initial strategies later in the interview. When doctors initiate Social agenda with a 1 type initial strategy (n=8), they receive five 3 type problem solving strategies from patients later in the interview. When doctors initiate a Social agenda with a 3 type initial strategy (n=29) they receive seventeen 3 type strategies from patients later in the consultation. When doctors initiate in the social domain using 1 type initial strategies (n=8), they do not receive any 4 type strategies later in the interview from the patient, and when doctors initiate in the social domain using 3 type initial strategies (n=29), they receive four specific 4 type outcome strategies from patients.

Table 8.10: Secondary outcome strategies reached by initial primary strategy adopted, broken down by nature of agenda and whether doctor or patient initiated the agenda. SOCIAL AGENDAS.

Initial Strategy in CURRENT floorholding								
	Doctor initiated				Patient Initiated			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
N	8	0	29	0	10	0	47	0
Outcome								
Patient:								
3.1a	2	0	10	0	2	0	24	0
3.1b	0	0	2	0	0	0	11	0
3.1c	1	0	0	0	0	0	0	0
3.2	1	0	2	0	0	0	1	0
3.3	1	0	3	0	0	0	2	0
3.4	0	0	0	0	0	0	0	0
3.5	0	0	0	0	0	0	0	0
3.6	0	0	0	0	0	0	1	0
4.1	0	0	0	0	0	0	1	0
4.2	0	0	2	0	0	0	2	0
4.3	0	0	1	0	0	0	2	0
4.4	0	0	0	0	0	0	0	0
4.5	0	0	1	0	0	0	0	0
4.6	0	0	0	0	0	0	0	0
Doctor:								
3.1a	3	0	9	0	2	0	22	0
3.1b	0	0	1	0	0	0	10	0
3.1c	0	0	0	0	0	0	2	0
3.2	0	0	3	0	0	0	5	0
3.3	1	0	0	0	0	0	6	0
3.4	0	0	1	0	0	0	1	0
3.5	0	0	0	0	0	0	0	0
3.6	1	0	0	0	0	0	2	0
4.1	0	0	1	0	1	0	2	0
4.2	0	0	1	0	0	0	2	0
4.3	1	0	3	0	1	0	3	0
4.4	0	0	0	0	0	0	2	0
4.5	1	0	1	0	0	0	0	0
4.6	0	0	0	0	0	0	1	0

When patients initiate Social agendas using 1 type initial strategies (n=10), doctors will do two 3 type strategies later in the interview on those Social agendas. When patients initiate Social agendas with a 3 type initial strategy (n=47), doctors will do ten 3 type strategies on the Social agendas later in the interview. If the patients initiate in the social domain using 1 type initial strategies (n=10) they will receive two explicit 4 type strategies later in the interview. If patients initiate in the social domain using 3 type initial strategies (n=47) they will receive ten explicit 4 type strategies from the doctor later in the interview. When doctors initiate Social agendas with 1 type initial strategies (n=8), they will do five 3 type initial strategies on their own Social agenda later in the interview. When doctors initiate Social agendas with 3 type initial strategies (n=29), they will use 3 type outcome strategies five times later in the consultation. If doctors initiate in the social domain using 1 type strategies (n=8) they will do two explicit 4 type strategies later in the interview, and if doctors initiate Social agendas with 3 type initial strategies (n=29), they will do explicit 4 type strategies later in the interview. Table 8.11 compares the number of times each of the outcome measures was used by doctor and patient for the three principal agendas. Numbers are the totals of each agenda in the sample, and Chi-square values compare the ratio of strategies used by doctor and patient. This shows that although there are proportional differences in the way the outcome categories are used within the three principal agendas, the ratio of categories used by both doctors and patients between the principal agendas is fairly constant. Indeed the only statistically significant difference is between the three principal agendas when the outcome strategy 3.3 (selection of an option) is used. Selection of an option is more evenly distributed between doctor and patient when the agenda is Social. Thus doctor and patient problem solving behaviour does not appear to differ much later in terms of the ratio of categories used for Physical, Emotional and Social agendas.

Table 8.11: Comparison of the frequency of use of the outcome measures by Doctor and Patient for the three principal agendas. Ns are the total number of each agenda in the sample. Chi-square values compare the ratio of strategy use by doctor and patient.

	AGENDA							
	Emotional		Physical		Social		Chi^2	Sig.
Outcome	Dr	Pt	Dr	Pt	Dr	Pt		
3.1a	47	37	70	70	36	34	0.76	ns
3.1b	11	7	47	38	12	9	0.21	ns
3.1c	6	4	16	14	1	1	0.15	ns
3.2	2	6	15	36	4	8	0.16	ns
3.3	1	6	8	47	6	7	6.72	<0.05
3.4	2	4	14	23	0	2	1.20	ns
3.5	2	3	30	33	0	0	0.11	ns
3.6	3	3	3	14	1	3	2.42	ns
4.1	10	31	3	14	1	4	0.33	ns
4.2	3	7	14	37	4	4	1.66	ns
4.3	10	18	29	51	4	7	0.002	ns
4.4	2	4	16	56	0	1	0.69	ns
4.5	1	1	1	4	0	2	1.48	ns
4.6	0	2	8	16	0	1	1.42	ns
N	81		76		91			

H. INITIAL PROBLEM SOLVING STRATEGIES USED BY DOCTORS AND PATIENTS ACCORDING TO DOCTOR GENDER

Tables 8.12 and 8.13 compare the initial strategies adopted by doctor and patient in each domain when the general practitioner is male or female. There are no significant differences in the initial strategy used by male G.P.s in the CURRENT floorholding and in the NEXT-2 floorholding in each of the principal domains. However the NEXT-1 floorholding, which is the response to the patient, does show a statistically significant difference (Chi-square=12.3, $p<0.05$). This pattern is the same for female G.P.s (Chi-square=39.96, $p<0.001$). Both male and female G.P.s differ in their initial problem solving response to the patient, depending on whether the patient's agenda is Physical, Emotional or Social.

Patients, in contrast, show significant differences in the initial strategies they use between the 3 main agenda types, in the CURRENT, NEXT-1 and NEXT-2 floorholdings. This suggests that patients are modulating the initial strategies they use in each domain to a far greater extent than doctors, and they continue to differ in their response in the CURRENT, NEXT-1 and NEXT-2 floorholdings. The uniformity of the pattern between male and female G.P.s versus patients suggests that although there is less variability between doctors than between patients because there are less doctors in the sample (ratio 10:73), there is nevertheless a degree of variation within doctors which is fairly constant in terms of interviewing technique.

Table 8.12: Comparison of Initial strategies adopted by doctor and patient when the G.P. is male. The strategies 1 to 4 refer to the principal coding of the problem solving strategy not broken down further into specific strategy.

MALE G.P.s								
	CURRENT Floorholding:							
	Doctor				Patient			
	Strategy Type				Strategy Type			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Emotional	7	0	5	1	27	0	7	1
Physical	1	0	7	0	3	0	51	2
Social	4	0	17	0	8	0	29	0
	Chi-square=9.11 ns				Chi-square=56.53 p<0.001			
	NEXT-1 Floorholding:							
	Doctor				Patient			
	Strategy Type				Strategy Type			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Emotional	7	20	6	2	3	4	3	0
Physical	12	3	29	3	2	1	5	0
Social	11	7	11	3	2	1	19	2
	Chi-square=12.93 p<0.05				Chi-square=31.94 p<0.001			
	NEXT-2 Floorholding:							
	Doctor				Patient			
	Strategy Type				Strategy Type			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Emotional	0	1	2	0	13	1	4	2
Physical	3	0	7	0	4	1	37	4
Social	4	1	9	0	3	3	15	0
	Chi-square=4.37 ns				Chi-square=33.91 p<0.001			

Table 8.13: Comparison of Initial strategies adopted by doctor and patient when the G.P. is female. The strategies 1 to 4 refer to the principal coding of the problem solving strategy not broken down further into specific strategy.

FEMALE G.P.s								
	CURRENT Floorholding:							
	Doctor				Patient			
	Strategy Type				Strategy Type			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Emotional	3	0	2	0	20	0	10	0
Physical	0	0	1	0	0	0	39	2
Social	4	0	12	0	2	0	18	0
	Chi-square=2.64 ns				Chi-square=46.33 p<0.001			
	NEXT-1 Floorholding:							
	Doctor				Patient			
	Strategy Type				Strategy Type			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Emotional	3	21	1	2	1	2	1	0
Physical	10	2	23	2	0	2	2	0
Social	21	6	7	1	2	0	12	2
	Chi-square=39.96 p<0.001				Chi-square=16.57 p<0.01			
NEXT-2 Floorholding:								
	Doctor				Patient			
	Strategy Type				Strategy Type			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Emotional	0	0	1	0	5	0	2	2
Physical	0	0	1	0	1	0	34	3
Social	2	0	8	13	0	6	2	
	Chi-square=0.71 ns				Chi-square=31.14 p<0.001			

I. INITIAL PROBLEM SOLVING STRATEGIES USED BY DOCTORS AND PATIENTS ACCORDING TO INTERVIEW LENGTH

Tables 8.14, 8.15 and 8.16 compare the initial strategies adopted by doctors and patients for short, medium and long interviews. The strategies 1 to 4 refer to the primary coding of the problem solving strategy not broken down into secondary codes. The criteria for short, medium and long interviews is that used in chapter 6. This is taken from Howie et al (1991) who distinguish between short, medium and long consultations. Short consultations are defined as those with a mean duration of less than 7 minutes, medium consultations are those with a mean duration between 7 and 9 minutes, and long consultations are those with a mean of 9 or more minutes.

The significance pattern for initial strategies used by doctors and patients for short, medium and long interviews in the three principal domains is fairly consistent irrespective of interview length. Thus, for the doctor, there is no statistically significant difference in each domain between the initial strategy used in the CURRENT floorholding or in the NEXT-2 floorholding, but there is a difference in the initial strategy used for each agenda in the NEXT-1 floorholding. This is consistent across short, medium and long interviews, and repeats the pattern found in the comparison of male versus female G.P.s for the doctor. Once again this demonstrates a certain homogeneity within doctors' initial problem solving strategies when initiating in the different domains and responding to their own agendas. It further demonstrates that doctors use different initial problem solving strategies in response to patients according to the type of agenda being initiated.

The preceding pattern is reversed for patients where there are differences between initial strategies used and the different domains in the CURRENT and NEXT-2 floorholding, but no statistically significant response to the doctor (NEXT-1). In this respect, and in the short and medium interviews, the pattern for patients' initial strategies used according to principal agendas is slightly different from the pattern found for patients in the comparison of the strategies they use for either male or female general

practitioner. Patients show no difference in their response to G.P.s (NEXT-1) in the short and medium interviews, but do demonstrate a difference in their response to doctors in long interviews (Chi-square=12.79, $p<0.05$). Patients vary in their initial strategies in each domain in the CURRENT and NEXT-2 floorholding irrespective of length of interview, and this is consistent with the pattern found in comparison of patients' initial problem solving behaviour according to the gender of the general practitioner.

Table 8.14: Comparison of Initial strategies adopted by doctor and patient for short interviews. The strategies 1 to 4 refer to the principal coding of the problem solving strategy not broken down further into specific strategy.

SHORT INTERVIEWS (n=31 interviews, 92 agendas)
(mean duration less than 7 minutes)

CURRENT Floorholding:								
	Doctor				Patient			
	Strategy Type				Strategy Type			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Emotional	4	0	3	0	18	0	7	0
Physical	0	0	3	0	0	0	32	2
Social	2	0	10	0	3	0	14	0
	Chi-square=4.95 ns				Chi-square=39.82 p<0.001			
NEXT-1 Floorholding:								
	Doctor				Patient			
	Strategy Type				Strategy Type			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Emotional	4	14	4	1	3	2	1	0
Physical	10	1	25	0	1	0	2	0
Social	5	3	4	2	1	1	10	2
	Chi-square=34.77 p<0.001				Chi-square=10.00 ns			
NEXT-2 Floorholding:								
	Doctor				Patient			
	Strategy Type				Strategy Type			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Emotional	0	0	1	0	4	0	3	1
Physical	0	1	4	0	2	1	30	1
Social	2	0	7	0	2	0	6	1
	Chi-square=1.30 ns				Chi-square=12.66 p<0.05			

Table 8.15: Comparison of Initial strategies adopted by doctor and patient for medium interviews. The strategies 1 to 4 refer to the principal coding of the problem solving strategy not broken down further into specific strategy.

MEDIUM INTERVIEWS (n=19 interviews, 64 agendas)

(mean duration between 7 and 9 minutes).

CURRENT Floorholding:								
	Doctor				Patient			
	Strategy Type				Strategy Type			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Emotional	1	0	1	0	16	0	3	1
Physical	0	0	1	0	1	0	24	1
Social	3	0	4	0	1	0	16	0
	Chi-square=0.77 ns				Chi-square=40.11 $p<0.001$			
NEXT-1 Floorholding:								
	Doctor				Patient			
	Strategy Type				Strategy Type			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Emotional	3	12	2	2	0	1	1	0
Physical	5	1	16	1	0	1	1	1
Social	4	0	8	1	2	0	14	0
	Chi-square=29.00 $p<0.01$				Chi-square=7.33 ns			
NEXT-2 Floorholding:								
	Doctor				Patient			
	Strategy Type				Strategy Type			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Emotional	0	0	0	0	9	0	1	2
Physical	2	0	0	0	2	0	21	2
Social	2	0	2	0	1	1	8	1
	Chi-square=1.50 ns				Chi-square=27.64 $p<0.001$			

Table 8.16: Comparison of Initial strategies adopted by doctor and patient for long interviews. The strategies 1 to 4 refer to the principal coding of the problem solving strategy not broken down further into specific strategy.

LONG INTERVIEWS (n=23 interviews, 92 agendas)

(mean duration more than 9 minutes)

CURRENT Floorholding:								
	Doctor				Patient			
	Strategy Type				Strategy Type			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Emotional	5	0	3	1	13	0	7	0
Physical	1	0	3	0	2	0	29	3
Social	3	0	16	0	6	0	17	0
	Chi-square=8.33 ns				Chi-square=24.70 p<0.001			
NEXT-1 Floorholding:								
	Doctor				Patient			
	Strategy Type				Strategy Type			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Emotional	3	15	0	1	1	3	0	1
Physical	7	3	11	3	1	2	11	3
Social	7	3	6	1	1	0	6	1
	Chi-square=26.57 p<0.001				Chi-square=12.79 p<0.05			
NEXT-2 Floorholding:								
	Doctor				Patient			
	Strategy Type				Strategy Type			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**
Emotional	0	1	2	0	5	1	2	1
Physical	1	0	4	0	1	0	20	4
Social	2	1	8	1	3	2	7	0
	Chi-square=3.48 ns				Chi-square=18.52 p<0.01			

J. NUMBER OF RETURNS TO PRINCIPAL AGENDAS AS A FUNCTION OF INITIAL PROBLEM SOLVING STRATEGY ADOPTED

Tables 8.16 to 8.19 show the mean number of returns to the principal agendas as a function of the initial strategy used. Number of returns refers to the number of occasions the initiated agenda is returned to in the rest of the interview. Each figure represents the number of instances with that number of returns for the corresponding initial strategy. Each table examines the number of returns for the corresponding initial strategies used in respect of the initial floorholdings coded. Cell numbers are often low and therefore caution is needed when generalising from the sample. Although shown on the tables, initial 4 type strategies are not discussed for the aforementioned reason. Table 8.17 examines the current floorholding for doctor and patient for the mean number of returns to principal agendas later in the interview as a function of strategies used in each domain. Whether patients use an initial strategy of a 1 or a 3 in the emotional domain, they seem to return later in the interview. This tendency is more pronounced when patients initiate with a 1 type initial strategy. In the physical domain in the CURRENT floorholding, it is almost always the case that doctors and patients return to Physical agendas more often when either party uses a 1 type initial strategy. Doctors hardly ever return to Social agendas irrespective of initiating party or initial strategy used. However, patients quite often return to Social agendas when they have initiated the Social agenda using a 1 type initial strategy.

Table 8.17: The number of returns to the principal agendas as a function of the initial strategy used. Each figure represents the number of instances with that number of returns for the corresponding initial strategy.

CURRENT FLOORHOLDING - EMOTIONAL AGENDAS

	No. of doctor returns										
	0	1	2	3	4	5	6	7	9	12	Mean
Dr's Initial Strategy											
1	5	1	3	0	0	1	0	0	0	0	1.20
3	3	1	1	1	1	0	0	0	0	0	1.43
4	1	0	0	0	0	0	1	0	0	0	3.00
Pt's Initial Strategy											
1	19	10	7	2	2	3	1	1	1	1	1.85
3	4	6	3	2	2	0	0	0	0	0	1.83
4	0	0	0	0	0	0	0	0	0	0	0

	No. of patient returns											
	0	1	2	3	8	Mean						
Dr's Initial Strategy												
1	7	1	1	0	1	1.10						
3	2	2	2	1	0	1.23						
4	0	0	0	1	0	3.00						
Pt's Initial Strategy	No. of patient returns											
	0	1	2	3	4	5	6	7	9	10	15	Mean
1	6	7	10	3	7	6	3	3	0	1	1	3.36
3	3	6	2	5	0	0	0	0	1	0	0	2.00
4	0	1	0	0	0	0	0	0	0	0	0	1.00

Contd ...

Table 8.17: The number of returns to the principal agendas as a function of the initial strategy used. Each figure represents the number of instances with that number of returns for the corresponding initial strategy. Contd.

CURRENT FLOORHOLDING - PHYSICAL AGENDAS

	No. of doctor returns						
	0	1	Mean				
Dr's Initial Strategy							
1	1	0	0				
3	4	4	0.50				
4	0	0	0				
Pt's Initial Strategy	No. of doctor returns						
	0	1	2	3	4	8	Mean
1	2	0	0	0	0	0	0
3	55	20	11	4	1	0	0.64
4	3	1	2	0	0	0	0.83

	No. of patient returns					
	0	1	2	3	Mean	
Dr's Initial Strategy						
1	0	0	1	0	2.00	
3	3	3	2	0	0.88	
4	0	0	0	0	0	
Pt's Initial Strategy	No. of patient returns					
	0	1	2	5	7	Mean
1	0	2	0	1	0	2.33
3	64	14	10	0	2	0.53
4	3	2	1	0	0	0.50

Contd ...

Table 8.17: The number of returns to the principal agendas as a function of the initial strategy used. Each figure represents the number of instances with that number of returns for the corresponding initial strategy. Contd.

CURRENT FLOORHOLDING - SOCIAL AGENDAS

	No. of doctor returns				
	0	1	Mean		
Dr's Initial Strategy					
1	6	2	0.25		
3	21	8	0.28		
4	0	0	0		
Pt's Initial Strategy	No. of doctor returns				
	0	1	2	3	Mean
1	7	1	1	1	0.60
3	30	13	3	1	0.47
4	0	0	0	0	0

	No. of patient returns											
Dr's Initial Strategy												
	0	1	Mean									
1	7	1	0.13									
3	29	0	0									
4	0	0	0									
Pt's Initial Strategy	No. of patient returns											
	0	1	2	3	4	5	6	7	9	10	15	Mean
1	6	7	10	3	7	6	3	3	0	1	1	3.36
3	3	6	2	5	0	0	0	0	1	0	0	2.00
4	0	1	0	0	0	0	0	0	0	0	0	1.00

Table 8.18 shows the problem solving strategies used and the mean return rate as a function of those strategies in the three principal domains for doctor and patient in the NEXT-1 floorholding. This floorholding represents either party's response to the other party's initiated agenda. In the emotional domain it does not seem to be the case that doctors return more often as a function of their initial type 2 strategies in response to the patient's Emotional agenda: at least they return less when responding to the latter than when responding in the NEXT-1 floorholding with 3 type strategies.

In the physical domain in the NEXT-1 floorholding, more returns seem to be a function either of the doctor initially responding to the patient in a facilitative way, using a 1 type strategy, or as a function of the doctor responding to the patient with a 2 type initial strategy. The mean number of returns to the social domain in the NEXT-1 floorholding as a function of the initial strategy used varies very little either for doctor or patient. However, the number of observations here are too low to be meaningful.

Table 8.18: The number of returns to the principal agendas as a function of the initial strategy used. Each figure represents the number of instances with that number of returns for the corresponding initial strategy.

NEXT-1 FLOORHOLDING - EMOTIONAL AGENDAS

	No. of doctor returns										
	0	1	2	3	4	5	6	7	9	12	Mean
Dr's Initial Strategy											
1	4	2	1	1	0	0	0	1	0	1	2.60
2	13	12	6	3	4	1	1	0	1	0	1.68
3	2	0	3	0	0	1	0	0	0	0	1.83
4	2	1	0	0	0	1	0	0	0	0	1.50
Pt's Initial Strategy	No. of doctor returns										
	0	1	2	3	4	5	6	7	9	12	Mean
1	2	1	1	0	0	0	0	0	0	0	0.75
2	2	1	2	0	0	1	0	0	0	0	1.67
3	1	1	1	1	1	0	0	0	0	0	2.00

	No. of patient returns											
	0	1	2	3	4	5	6	7	9	10	15	Mean
Dr's Initial Strategy												
1	1	2	2	1	1	0	1	0	0	0	0	2.38
2	5	8	7	5	5	6	1	3	1	1	1	3.44
3	2	2	1	1	1	0	0	0	0	0	0	1.57
4	1	1	2	0	0	0	0	0	0	0	0	1.25
Pt's Initial Strategy	No. of patient returns											
	0	1	2	3	8	Mean						
1	3	0	0	0	1	2.00						
2	2	2	2	0	0	0.75						
3	1	1	1	1	0	1.50						

Contd...

Table 8.18: The number of returns to the principal agendas as a function of the initial strategy used. Each figure represents the number of instances with that number of returns for the corresponding initial strategy. Contd.

NEXT-1 FLOORHOLDING - PHYSICAL AGENDAS

	No. of doctor returns						
	0	1	2	3	4	8	Mean
Pt's Initial Strategy							
1	10	6	3	1	1	1	1.23
2	3	2	0	0	0	0	0.40
3	32	10	7	2	1	0	0.65
4	4	1	0	0	0	0	0.20
Dr's Initial Strategy	No. of doctor returns						
	0	1	Mean				
1	1	1	0.50				
2	3	0	0				
3	2	3	0.60				

	No. of patient returns					
Dr's Initial Strategy						
	0	1	2	5	7	Mean
1	16	4	1	1	0	0.50
2	1	3	0	0	1	2.00
3	40	8	4	0	0	0.31
4	3	0	2	0	0	0.80
Pt's Initial Strategy	No. of patient returns					
	0	1	2	3		
1	1	0	1	0	1.00	
2	0	3	0	0	1.00	
3	2	1	2	0	1.00	
4	0	0	0	0	0	

Contd...

Table 8.18: The number of returns to the principal agendas as a function of the initial strategy used. Each figure represents the number of instances with that number of returns for the corresponding initial strategy. Contd.

NEXT-1 FLOORHOLDING - SOCIAL AGENDAS

	No. of doctor returns				
Dr's Initial Strategy					
	0	1	2	3	Mean
1	8	7	1	0	0.56
1	10	0	2	1	0.33
3	11	5	2	0	0.50
4	1	2	0	1	1.25
Pt's Initial Strategy	No. of doctor returns				
	0	1	Mean		
1	3	1	0.25		
2	0	1	1.00		
3	22	9	0.29		
4	3	1	0.25		

	No. of patient returns						
Dr's Initial Strategy							
	0	1	2	3	4	6	Mean
1	8	4	4	0	0	0	0.75
2	8	0	5	0	0	0	0.77
3	12	3	1	0	1	1	0.83
4	1	2	1	0	0	0	1.00
Pt's Initial Strategy	No. of patient returns						
	0	1					
1	3	1	0.25				
2	1	0	0				
3	31	0	0				
4	4	0	0				

Table 8.19 examines the mean number of returns to the principal agendas for doctor and patient as a function of the initial strategies used by each party in the NEXT-2 floorholding. It is axiomatic that for either doctor or patient behaviours to occur in the NEXT-2 floorholding, both parties must have followed one anothers' CURRENT initial strategy in the NEXT-1 floorholding. In the emotional domain, doctors returning later in the consultation appears to be a function of their limiting the patient's Emotional agenda (which would have followed the doctor's initiation of emotion in the CURRENT floorholding), and most especially, and to a high degree, when patients have limited the doctor's following of the Emotional agenda initiated by the patient. Patients return more often to Emotional agendas as a function of either the doctors' initial 3 type strategy in the NEXT-2 floorholding, or their own initial 1 type strategy in the NEXT-2 floorholding. Both these strategies are facilitative of emotion, and indicate that sequences of emotion have been established.

In the physical domain, returns later in the interview seem to be a function of the patient limiting the agenda in the NEXT-2 floorholding. However, there is not a great deal of difference between the mean number of returns and initial strategies used by either party in the NEXT-2 floorholding.

Returns to Social agendas later in the interview do not seem to be a function of doctor or patient behaviour in the NEXT-2 floorholding. Whatever strategy either party uses it does not seem to greatly effect the mean number of returns in the social domain. Overall, a greater number of mean returns to principal agendas later in the consultation by either party seems to be a function of doctors' and patients' initial problem solving behaviour in the emotional domain.

Table 8.19: The number of returns to the principal agendas as a function of the initial strategy used. Each figure represents the number of instances with that number of returns for the corresponding initial strategy.

NEXT-2 FLOORHOLDING - EMOTIONAL AGENDAS

	No. of doctor returns										
	0	1	2	3	4	5	6	7	9	12	Mean
Dr's Initial Strategy											
1	0	0	0	0	0	0	0	0	0	0	0
2	0	0	0	1	0	0	0	0	0	0	3.00
4	1	0	1	0	1	0	0	0	0	0	2.00
Pt's Initial Strategy	No. of doctor returns										
	0	1	2	3	4	5	6	7	9	12	Mean
1	7	3	3	2	0	1	0	0	1	1	2.28
2	0	0	0	0	0	0	0	1	0	0	7.00
3	1	2	3	0	0	0	0	0	0	0	1.33
4	2	0	1	0	1	0	0	0	0	0	1.75

	No. of patient returns											
	0	1	2	3	8	Mean						
Dr's Initial Strategy												
1	0	0	0	0	0	0						
2	0	1	0	0	0	1.00						
3	1	0	1	1	0	3.67						
Pt's Initial Strategy	No. of patient returns											
	0	1	2	3	4	5	6	7	9	10	15	Mean
1	1	2	3	1	4	1	3	1	0	1	1	4.56
2	0	1	0	0	0	0	0	0	0	0	0	1.00
3	1	1	1	3	0	0	0	0	0	0	0	2.00
4	0	2	1	0	0	1	0	0	0	0	0	2.25

Contd...

Table 8.19: The number of returns to the principal agendas as a function of the initial strategy used. Each figure represents the number of instances with that number of returns for the corresponding initial strategy. Contd.

NEXT-2 FLOORHOLDING - PHYSICAL AGENDAS

	No. of doctor returns						
	0	1	Mean				
Dr's Initial Strategy							
1	3	0	0				
3	4	4	0.50				
Pt's Initial Strategy	No. of doctor returns						
	0	1	2	3	4	8	Mean
1	2	2	0	1	0	0	1.00
2	0	0	1	0	0	0	2.00
3	45	14	8	2	1	1	0.68
4	4	1	1	0	1	0	1.00

	No. of patient returns					
	0	1	2	3	Mean	
Dr's Initial Strategy						
1	0	2	1	0	1.33	
3	4	1	3	0	0.88	
Pt's Initial Strategy	No. of patient returns					
	0	1	2	5	7	Mean
1	3	2	0	0	0	0.40
2	0	1	0	0	0	1.00
3	51	13	5	1	1	0.49
4	2	2	3	0	0	1.14

Contd...

Table 8.19: The number of returns to the principal agendas as a function of the initial strategy used. Each figure represents the number of instances with that number of returns for the corresponding initial strategy. Contd.

NEXT-2 FLOORHOLDING - SOCIAL AGENDAS

	No. of doctor returns				
	0	1	Mean		
Dr's Initial Strategy					
1	5	1	0.17		
2	1	0	0		
3	13	4	0.24		
4	1	0	0		
Pt's Initial Strategy	No. of doctor returns				
	0	1	2	3	Mean
1	4	2	0	0	0.33
2	2	0	0	1	1.00
3	13	6	2	0	0.48
4	0	2	0	0	1.00

	No. of patient returns							
	0	1	Mean					
Dr's Initial Strategy								
1	5	1	0.17					
2	1	0	0					
3	17	0	0					
4	1	0	0					
Pt's Initial Strategy	No. of patient returns							
	0	1	2	3	4	5	6	Mean
1	6	0	0	0	0	0	0	0
2	2	0	1	0	0	0	0	0.67
3	10	1	1	0	0	0	0	0.25
4	0	1	1	0	0	0	0	1.50

K. DISCUSSION

A system for the analysis of doctor and patient problem solving in general practice has been developed and shown to be reliable and valid. The system allows for the coding of both qualitative and quantitative aspects of problem solving behaviour. Four distinct types of problem solving activity are described; within these broad categories depth of processing is described by analysing the use of specific problem solving strategies. The first occurrence of each agenda is coded in detail, this is then followed by an analysis of the use of problem solving strategies by patient and doctor in subsequent floorholdings within the interview. The system has been applied to a set of naturally occurring general practice interviews and the results analysed in terms of strategy use, the timing and depth of problem solving for the three principal agenda types; Physical, Emotional, Social.

The problems solving data lend themselves to cameo representation of the way in which doctors and patients approach the three principal agendas. By inference, the participants' perception of the different domains, manifest in their behaviour, may substantially influence the nature of the consultation.

Patient returns to an agenda are a function of the initial problem solving which occurs for that agenda (supporting hypothesis 22, chapter 2). This is particularly true when the agenda is Emotional or Physical. In the emotional domain, it appears that if the doctor is to engage the patient *both* in exploratory problem solving (using 3 type strategies) and specific problem solving activity (using 4 type strategies), it pays the doctor to initiate an Emotional agenda tentatively by using facilitatory skills (1 type strategies). However, the patient will use a similar proportion of exploratory 3 type strategies later in the interview irrespective of whether it is doctor or patient who initiated the Emotional agenda with a 1 type strategy. The pattern is reversed somewhat for the patient in that the deeper (or stronger) the initial strategy used by the patient in the emotional domain (that is the patient initially uses 3 type strategies rather than the more tentative 1 type strategies), the deeper the strategy reached by the patient on his own agenda later in the interview.

When doctors initiate Emotional agendas using either 1 type or 3 type strategies, they will problem solve by using 3 type strategies on their own agendas later in the interview to a fair degree. In terms of using the more specific 4 type problem solving skills on their own agendas it seems that doctors will not problem solve very often irrespective of their initial strategy being a 1 or a 3. When patients initiate an Emotional agenda with either a 1 or a 3 type strategy, the pattern of doctors subsequently engaging in exploratory 3 type problem solving is similar to the extent to which patients themselves subsequently engage in exploratory 3 type problem solving. However, when patients initiate an Emotional agenda with either a 1 or 3 type strategy doctors will engage in specific 4 type problem solving later in the interview to a reasonable extent. This is particularly the case when patients initiate the Emotional agenda with a 3 type strategy rather than a 1 type strategy.

The overall frequency of occurrence of problem solving (which is not the same as the ratio of occurrence to maximum possible for each category) suggests that it pays the doctor to initiate in the emotional domain tentatively, using facilitative skills (see above), while it probably pays the patient to initiate an Emotional agenda positively, using a 3 type initial strategy, in terms of engaging the doctor in problem solving skills later in the consultation.

In the physical domain it seems that both doctor and patient commonly initiate Physical agendas using a 3 type initial strategy, indicating that each party is fairly clear about the nature of the agenda, and is using deeper initial problem solving strategies. Doctors use all the problem solving strategies at their disposal when patients initiate with a 3 type initial strategy (but 4.5, describing resource, least), and used all but one (3.1c, selecting an option) when the patients initiate with a 1 type initial strategy. Interestingly, it appears that when patients are more tentative in their initiation of a Physical agenda, demonstrated by their use of a 1 type initial strategy, doctors problem solve more vigorously later in the interview. This is the reverse of the pattern found in the emotional domain. However, caution is required in interpreting the outcomes brought to bear on

patients' initiations with 1 type strategies, as the number of initiations with this strategy is low (n=3).

In the social domain it seems that it does not very much matter whether a doctor initiates with a 1 or a 3 type initial strategy in terms of engaging the patient in exploratory 3 type strategies later in the interview: proportionately the degree of problem solving is roughly equal (7.8 percent versus 12.8 percent). This pay off diminishes somewhat for the patient in terms of engaging the doctor in explicit 4 type strategies later in the consultation. The proportion of 4 type strategies engaged in by the doctor is roughly equal (3.3 percent versus 3.5 percent) regardless of the initial strategy used.

Doctors in this sample achieve a higher patient response in terms of 3 type problem solving strategies later in the interview than they do 4 type problem solving strategies. But they are more likely to engage the patient in explicit 4 type problem solving strategies later in the interview if they initiate their Social agenda with 3 type initial strategies. Patients are far more likely to use 3 type problem solving strategies on their own agendas later in the interview if they initiate with a 3 rather than a 1 type initial strategy in the social domain. Doctors, in contrast, use more 3 type outcome strategies on their own agendas if they have initiated with a 1 rather than a 3 type initial strategy. Generally speaking, doctors do more problem solving than patients on their own Social agendas, and patients do most when they have initiated more deeply with a 3 type initial strategy, and tend to problem solve by using more exploratory 3 type problem solving techniques later in the consultation.

In overall terms, grouping together 3 and 4 type strategies and generalising within the sample, patients seem to problem solve in response either to the doctor or to their own more deeply initiated Social agendas, whereas doctors show a slight preference for problem solving in the social domain when they have initiated a Social agenda. Doctors and patients problem solve more in the emotional domain than they do in the social domain, but they do so most and to a fairly high degree in the physical domain. Grouping together the 1 and 3 type initial strategies and assessing the extent to which

secondary outcome categories are utilised by doctors, it can be seen that in the physical and emotional domains they use all problem solving steps available to them but use the range more comprehensively when Physical agendas are being used.

In the NEXT-1 floorholding, both doctors and patients demonstrate a reluctance to problem solve Emotional agendas. Both parties tend to block the others' Emotional agenda when it has been initiated, but doctors tend to do so fare more often than patients. Doctors rarely block patients' Physical agendas, but occasionally limit patients' Social agendas. Doctors use a preponderance of 3 type strategies in response to patient initiated Physical agendas, whereas patients use a preponderance of 3 type strategies in response to Social agendas initiated by doctors. Both parties are using deeper strategies in these two domains (respectively) and this may reflect their respective areas of 'expertise'. Overall, doctors use more 4 type strategies than patients in all three principal domains, but even so, doctors use of 4 type (specific) problem solving strategies appears to be limited in the NEXT-1 floorholding. The difference between the initial strategies used in the NEXT-1 floorholding are statistically significant for both doctor and patient.

It appears that in the NEXT-2 floorholding, both doctors and patients problem solve by using deeper 3 type initial strategies. The NEXT-2 floorholding shows the initiating party, who has had his agenda processed by the other party in the NEXT-1 floorholding, responding to his CURRENT agenda in the NEXT-2 floorholding. The balance of problem solving seems to shift from facilitative or acknowledging 1 type strategies in the CURRENT floorholding, to more active and specific 3 and 4 type problem solving strategies in the NEXT-2 floorholding. Type 1 initial strategies are seldom used by either party in the NEXT-2 floorholding, and very little blocking occurs. Patients tend to use more specific strategies than doctors, but even so, the specific 4 type strategies are infrequently used in this initial part of the problem solving process.

Patients' mean return rate to Emotional agendas is higher when their initial strategy in the CURRENT floorholding is more tentative, suggesting either that they are testing the doctors' responsiveness to the emotional domain (as hypothesised by Lazare

et al, 1979), or that doctors are failing to follow patients cues on the emotional domain, as supported in the analysis presented in chapters 4 to 6. However, it is almost always the case that doctors and patients return to Physical agendas more often when either party uses a 1 type initial strategy in the CURRENT floorholding. This suggests that the more tentative the mention of a Physical agenda, the more that agenda is returned to later in the interview by either party. Doctors hardly ever return to Social agendas irrespective of initiating party or initial strategy used in the CURRENT floorholding, but patients quite often return to Social agendas when they have initiated the Social agendas using a 1 type initial strategy in the CURRENT floorholding. Once again, patients are more active in returning, and this seems to be a function of a more tentative initial strategy. As in the emotional domain, patients are seen to be testing doctors' responsiveness, but they may also be demonstrating their greater expertise in the social domain. However, since the least amount of problem solving occurs in the social domain, patients are perhaps returning legitimately for active solutions.

In chapter 4, it was suggested that the quality of returns may be different for doctors and patients: for the latter, returns may represent the need to have an agenda addressed, whereas for the doctor it may reflect having time to return later in the consultation. The mean number of doctor returns to an Emotional agenda later in the interview is almost exactly the same irrespective of whether the doctor is blocking the patient's Emotional agenda or whether the patient is limiting the doctor's Emotional agenda. Doctors seem to return to the emotional domain later in the consultation if they have responded to the patient's Emotional agenda in a facilitative way, by using a 1 type strategy, perhaps indicating a doctor sensitivity and willingness to return when they have legitimated the presence of the patient's Emotional agenda by responding to it in an acknowledging way. Doctors also return to Emotional agendas more if the patient's response to the doctor's Emotional agenda was a fairly positive 3 type initial strategy in the NEXT-1 floorholding, and doctor's are more likely to return to emotion they have initiated later in the consultation. When the doctor's response to the patient's Emotional

agenda in the NEXT-1 floorholding is a 2 type strategy, patients are much more likely to return to the emotional domain later in the interview. Patients are also more likely to return to emotional concerns later in the interview when the doctor's response in the NEXT-1 floorholding has been to acknowledge the patient's Emotional agenda with a 1 type initial strategy. Thus, it would seem that whether doctors limit or legitimise the patient's emotion, patients will return to emotion later in the interview. This can be interpreted either that patients feel able to continue with emotional considerations because they know the doctor has not disallowed emotion, or that they return to emotion because the doctor has limited its expression. However, patients are more likely to return to emotion when it has not been sanctioned by the doctor initially. It is possible to deduce from this that if doctors are tolerant of emotion initially, patients may return to emotion less, later in the consultation.

In the physical domain in the NEXT-1 floorholding, more returns seem to be a function either of the doctor initially responding to the patient in a facilitative way, using a 1 type strategy, or as a function of the doctor responding to the patient with a 2 type initial strategy. It therefore seems that patients return to the physical domain later in the interview if they know doctors have acknowledged a physical concern, or that they return to the physical domain perhaps out of concern that the doctor has limited their expression of the agenda.

The mean number of returns to the social domain in the NEXT-1 floorholding as a function of the initial strategy used varies very little either for doctor or patient. However, any pattern in the social domain is obscured by the number of observations which are too low to be meaningful. It is axiomatic that when doctor or patient behaviours occur in the NEXT-2 floorholding, both parties must have followed one another's CURRENT initial strategy in the NEXT- 1 floorholding. Examination of the mean number of doctor and patient returns as a function of the NEXT-2 floorholding shows that doctor returning later in the consultation appears to be a function of their limiting the patient's Emotional agenda (which would have followed the doctor's

initiation of emotion in the CURRENT floorholding), and most especially, and to a high degree, when patients have limited the doctor's following of the Emotional agenda initiated by the patient. This indicates that when a sequence of floorholdings on emotion has been established and the patient inhibits the sequence, doctors are much more likely to continue on emotion than on any other occasion in the present analysis. As such it provides further evidence for the patient being wary as to the appropriateness of emotion to the consultation, but also evidence for doctors' willingness to return to emotion if they have legitimised its presence by following it initially, and if patients have limited the doctors' following. This could be interpreted either that the doctor wishes to remain in control, or that the doctor is being receptive to the patient's hesitancy in continuing in the emotional domain.

In the physical domain, returns later in the consultation seem to be a function of the patient limiting the agenda in the NEXT-2 floorholding, although there is not, in fact, a great deal of difference between the mean number of returns and initial strategies used by either party in the NEXT-2 floorholding. Returns to Social agendas later in the interview do not seem to be a function of doctor or patient behaviour in the NEXT-2 floorholding. Whatever strategy either party adopts initially does not seem greatly to affect the mean number of returns in the social domain.

Overall, a greater number of mean returns to principal agendas later in the consultation seems to be a function of doctors' and patients' initial problem solving behaviour in the emotional domain.

To summarise, doctors appear to be happier when patient emotion is clearly identified and positively expressed. Doctors do not initiate a great deal of emotion, and when they do, they tend to do so using deeper initial problem solving strategies. When an Emotional agenda develops over a sequence of floorholdings, the balance moves from more tentative 1 type initial strategies (when these are used by doctors) to deeper 3 type problem solving strategies. Doctors are more likely to engage in problem solving later in the interview when patients initiate emotion with readily identifiable 3 type strategies, and

will more frequently return to emotion later in the consultation if patients respond to the doctors' Emotional agenda with deeper 3 type strategies. Interestingly, doctors will return much more, and to a high degree, if patients inhibit a sequence of emotional floorholdings (in NEXT-2) when doctors have followed (in NEXT-1) the patients' CURRENT Emotional agenda. This may reflect a responsive doctor style, but may also suggest that if the doctor has facilitated the patients' agenda he is unwilling to relinquish control of what has been identified: doctors after all considerably limit patients' emotional expression by using 2 type initial strategies.

As has been reported earlier, patients bring a lot of emotion to the consultation, and return to their Emotional agendas to a high degree. However, in problem solving terms, in contrast to what appears to be the doctors' preference, patients initiate their emotion rather tentatively - acknowledging its prescience rather than declaring its presence. It is as though patients are uncertain about the legitimacy of emotion in the general practice setting and are testing the doctors' responsiveness. When doctors initiate emotional concerns directly, patients tend to block their expression and demonstrate reluctance to continue. However, when doctors have followed emotion initiated by patients, patients tend to proceed from more tentative 1 type problem solving strategies in their CURRENT floorholdings, to deeper 3 type strategies in their NEXT-2 floorholdings. It is as though reassured by the doctor's 'sanction' of emotional expression (demonstrated by the doctor following the patient in the doctor's NEXT-1) the patient is more able to identify the nature of the emotion previously hinted. Patients tend to initiate their emotion hesitantly, using 1 type initial problem solving strategies, and this results in less problem solving by doctors later in the interview. On those occasions when patients do initiate with deeper strategies, doctors will problem solve more actively. Patients will return to emotional considerations later in the consultation whether doctors have facilitated emotional expression or not, but are more likely to return if doctors have limited its expression. They will also return to Emotional agendas to a fairly high degree if, in NEXT-2, doctors block their CURRENT Emotional agenda. The

scenario suggests that although patients bring much emotion to the consultation, they are unsure about its validity, and so give doctors emotional leads or cues. When the doctors' NEXT-1 strategy is to limit emotional expression, patients will return to their Emotional agendas to a fairly high degree, and will return also when doctors have followed patients' following doctors. If patients have continued on their own agenda tentatively in NEXT-2, by using a 1 type strategy, they will return to Emotional agendas very frequently (mean 4.56), but will return less often if they have used deeper 3 type strategies in their NEXT-2 floorholding.

Thus, overall, doctors and patients seem to have a mismatch in their behavioural and problem solving approaches to emotional expression. Patients appear to be uncertain about their own emotion, about the doctors' emotional expression, and about the doctors' emotion as it pertains to patients. Patients are far more likely to return to Emotional agendas if the doctors response in NEXT-1 has been to facilitate (as opposed to acknowledge clearly), indicating that patients are looking for a *degree* of certainty about the legitimacy of their agenda once raised. They are more likely still to return to emotion later in the interview if the doctor has used deeper 3 type initial strategies on the doctor's current Emotional agenda in NEXT- 2, but this is in response to the doctors' rather than the patients' agenda. Patients do limit the doctors' response to patients CURRENT Emotional agendas (in NEXT-2), suggesting that patients are wary when doctors are receptive of their emotion, and when they do, doctors return to the emotion to a very high degree later in the consultation. However, patients also return to emotion to a high degree when doctors have limited the emotion that patients have followed in NEXT-1, and return more when they have continued on their CURRENT Emotional agenda in NEXT-2, with a 1 type strategy. Patients appear to be modulating their response to and expression of emotional concerns with considerable dexterity. They seem to be looking for sensitivity to their emotion on the part of the doctor, but not an eager responsiveness. When the doctors raise Emotional agendas deeply, patients tend to shy away, but if they stay with the agenda and problem solving deepens in the initial sequence, patients seem

reassured enough to return to emotion later in the consultation. Doctors, on the other hand, appear to be looking for more clarity of expression in the emotional domain. It is as though, having identified emotion, they 'go for it' rather than being sensitive towards its unfolding. This supports the notion that doctors are perhaps less in tune with emotional concerns, and less aware of the nuances that patients present. When patients present with clear emotion, doctors do follow patients, will problem solve to a reasonable degree, and will problem solve most when patients have initiated their emotion with a 3 type initial strategy. This is consistent with the results presented in chapter 5 showing that doctor following of patient Emotional agendas, and patient pay off in the emotional domain, is highest when the nature of the presentation is emotional. Doctors do problem solve in the emotional domain, and indeed use all the problem solving strategies available. But the range of strategies are not used very often, and the problem solving analysis provides information as much about the way in which agendas are handled by doctor and patient as about the problem solving techniques brought to bear upon them.

Doctors are far more positive in their use of problem solving strategies in the physical domain. Doctors generally do not initiate very often in the physical domain, and this reflects the nature of the consultation (see chapter 4), but when they do, they overwhelmingly do so using 3 type initial strategies. Sequences begun with 3 type strategies usually continue on 3 type strategies in NEXT-2, and doctors very rarely block or limit patients' expression of Physical concerns. Doctors engage in problem solving later in the interview to a high degree whether patients initiate their Physical agendas with 1 or 3 type initial strategies, but do so more vigorously when patients have initiated with 1 type strategies. Similarly doctors return to patients' Physical agendas later in the consultation if 1 type initial strategies have been used, or if the patient has inhibited the doctor in the patients' NEXT-2. These behaviours all suggest that the doctor, as would be expected, is extremely in tune with Physical concerns, is keen to problem solve thoroughly in the physical domain, and where there is physical uncertainty (demonstrated

by the use of more tentative 1 type initial strategies) is anxious to consider the range of problem solving strategies available.

Patients, too, are fairly clear in their handling of Physical agendas. They usually initiate using deeper 3 type initial strategies, and along with doctors, problem solve to a fair extent in the physical domain. Patients are more likely to return to Physical agendas later in the consultation if either doctor or patient have used more facilitative , less clear, 1 type initial strategies in the responsive NEXT-1 floorholding, or if the doctor then limits the patient's expression. Although patients return to the physical domain, and do so as a function of NEXT-2 floorholdings, the type of strategy used by either party in this category has little bearing, and their return rate is very low.

The overall picture of doctor and patient problem solving behaviour in the physical domain suggests that both parties are very much in tune. When patients initiate with 1 type strategies, as if to clarify the tentative initiation, doctors return later in the interview to a high degree. Generally, both doctor and patient initiate Physical agendas using deeper 3 type initial strategies, and both parties, and especially doctors, use the full range of problem solving strategies available to a fairly high degree.

Using problem solving skills on Social agendas, doctors use deeper 3 type initial strategies, and limit patients' social expression to a fair degree. They do not, however, limit social expression to the extent that they limit emotional expression, but do so more than they limit patients' Physical agendas. The emphasis continues on the 3 type strategies from the CURRENT to the NEXT-2 doctor floorholding, but doctors are fairly balanced between using deep 3 type strategies and more facilitative 1 type strategies in the NEXT-1 which reflects the doctor's response to the patient's Social agenda. Doctors rarely return to Social agendas, and on the very rare occasions they do, do so when patients have limited the doctor's Social initiation. Doctors do not engage in much problem solving later in the consultation, and when they do, they use a limited range of the available options. Doctors do not demonstrate the problem solving capability in the social domain that they are able to show in the emotional domain, neither do they have

the problem solving 'energy' which they manifest in the physical domain. The impression is one which suggests that doctors may have a rather indifferent approach to social considerations.

Patients do not seem to manifest the same caution when expressing their social concerns that they show when expressing their Emotional agendas. Type 3 initial strategies are more common in the CURRENT, the NEXT-1 and the NEXT-2 floorholdings. Patients return more to Social agendas when they have initiated using more tentative 1 type initial problem solving strategies, but do not return very often as a function of doctor or patient behaviour in the initial phase of problem solving. Patients do not engage in problem solving later in the interview to the extent they do in the emotional domain, and not nearly as much as they do in the physical domain. However, when they do engage in problem solving, it is mostly in response to doctor or patient 3 type initial strategy. Patients seem fairly confident in their expression of social concerns, but do not seem to be able to engage the doctor in very active problem solving in this domain.

Overall, neither party problem solves in the social domain to the extent they use problem solving skills in the other two principal domains. This pattern was not predicted in the hypotheses, where it was suggested that Physical agendas may receive a wider range of problem solving strategies than either Emotional or Social agendas (hypotheses 19 and 20). Although Social agendas are initiated by both parties using deeper 3 type initial strategies doctors follow patients' initial strategy with a 1 almost as much as a 3. Doctors limit social expression quite a lot, but not to the extent that they limit emotional expression. When doctors have initiated Social agendas they continue in their NEXT-2 floorholding using deeper problem solving strategies. When patients have initiated tentatively with 1 type strategies they tend more often to return to Social agendas later in the interview. Generally patients are more active than doctors in the social domain, and they use deeper problem solving strategies overall. Doctors limit patients' Social agendas to a fair degree, and often follow patients' social concerns in a facilitative way. Given

that patients are more active in the social domain, the doctors' less energetic problem solving seems inappropriate. That patients are more active in the social domain, suggests that the deficit of problem solving later in the consultation may be a function as much of the doctors' lack of expertise in handling social considerations as of the patient being unable to.

There is then some limited evidence to support the hypothesis that later problem solving (in the OUTCOME phase) is a function of initial problem solving (hypothesis 21). However the number of observations is small, making interpretation difficult.For Emotional agendas deep processing of the agenda is more common when patients initiate using 3 type strategies, and when doctors initiate using 1 type strategies. For Physical agendas patients' agendas are more deeply processed if the patient initiates using a 1 type strategy. Finally for Social agendas there is a trend for more deep processing of the agenda to be associated with the use of 3 type strategies initially by both doctor and patient.

The analysis of problem solving according to doctor gender and interview length demonstrates a homogeneity of doctors' initial response which, given its stability, may reflect aspects of training. Irrespective of gender or interview length (short, medium or long), doctors' initial problem solving strategies and doctors' initial problem solving strategies in response to patients (in NEXT-2), was not significantly different in any of the principal domains. However, doctors do differ in their response to the patients' CURRENT floorholding according to agenda type. Patients, in contrast, differ in the initial problem solving strategies they use in the three principal domains when they initiate, when they follow their initiation in the NEXT-2 floorholding, and when they follow the doctor (patients' NEXT-1) according to doctor gender. The pattern is slightly different for interview length in that patients are consistent in their initial problem solving response to the doctor (patients' NEXT-1) in short and medium interviews, according to principal domain, but differ in the initial strategies they use according to domain in long interviews.

In terms of the rationale for the present chapter, analysis of doctor and patient problem solving supports the underlying thesis. There is continuing evidence for processes contributing mutual somatisation: patients are hesitant in their expression of emotion, while doctors either limit its expression or prefer to focus on clearly defined Emotional agendas. There is support for the hypothesis that doctors are not 'at home' with psychosocial issues: doctors problem solve in the emotional domain when emotional expression is clear; they tend to block Emotional agendas when Emotional agendas are cued; and tend to limit social expression, or follow social expression tentatively, and not to problem solve later in the interview in the social domain. There is abundant evidence that doctors are experts in medical problem solving: doctors initiate Physical agendas using deeper problem solving strategies, they problem solve considerably late in the consultation, and do so especially when the patients have been cautious in their initiation. They use all the problem solving strategies available, and do so to a high degree.

Writers such as Stevens (1974) and Sacks (1973, 1981, 1984, 1985) have spoken eloquently about the imperative to regard the doctor-patient consultation in terms of personhood, doctor and patient alike. Indeed the thrust of the transformed medical model proposed by McWhinney (1983, 1989) is to do just that. Stevens, in 1974, distinguished General Practice at least in part, by the paradigm shift required by embarking doctors from traditional medicine to biopsychosocial problem solving. There is little doubt that general practice differs importantly from other specialities, in ways discussed in section A, above and in section D of chapter 9, but in all medicine the following insight must surely pertain:

> Diseases have a character of their own but they also partake of our character; we have a character but we also partake of the world's character: character is monadic or microcosmic, worlds within worlds within worlds, worlds which express worlds. The disease - the man - the world together, cannot be considered separately as things in themselves.

(Sacks, 1973 p.206).

Research continues to suggest, however, that despite evidence to indicate that the basic reason for many consultations is not that the person necessarily has a disease (Bridges & Goldberg, 1985; Goldberg et al, 1988; Goldberg, 1980), or that anxiety about a symptom or pressure by family and friends to present symptoms to the doctor may be just as important as its severity (Stewart et al, 1975), doctors do continue to consider diseases apart from persons (Pickering, 1989). For a general practitioner to be aware of psychosocial issues is not to suggest that they become psychiatrists or social workers. To acknowledge a mother's natural distress when she has miscarried, or to be sympathetic to a man whose business has collapsed (both examples from the data for this thesis) is to be nothing more than human. And as many researchers have shown, social support, broadly defined as emotional concern, instrumental aid, information, and appraisal, is an important mediator in the disintegration from natural stress to pathological distress: Tolsdorf (1976), Cobb (1976), House (1981) and Bowling (1991). The present problem solving analysis suggests that to acknowledge an Emotional or Social agenda will result in less patient returns to that agenda later in the consultation, and as such may be more efficient. Efficiency need not be anathema to personhood; doctors too are people: people operating within time limits, with many patients to consider, and with their own worlds attending them. There is thus a distinction between acknowledging the inevitable waxing and waning of fortune and health (and referring to other agencies when appropriate), and identifying psychiatric caseness (Shepherd & Wilkinson, 1969; Sharp & King, 1989). Sharing a psychological diagnosis with a patient may only be a preliminary strategy of problem solving management, but it may be all that is required for transient mood disorders with high spontaneous remission rates (Goldberg & Bridges, 1987; May, 1992). When stress or distress are disallowed, or are unrecognised, the misattribution of bodily symptoms which may mediate that distress, to organic disease, is likely to become more pronounced (Murphy, 1989). This, too, is inefficient, and arguably will encourage certain patients along the road to somatisation as

defined by Goldberg & Bridges (1988), and discussed in chapter 4 above. Goldberg & Bridges (1987) point out that it is to be expected that general practitioners will have their own views as to whom, among patients, is to be considered a psychiatric 'case'. This is because psychiatric research assessments, which replace unstandardised clinical assessments, do not show complete agreement, and because, more crucially, each system of classification requires slightly different combinations of symptoms for each equivalent diagnosis. So, for example, a patient who has suffered depressive symptoms need only have done so for 14 days to warrant the classification 'major depressive disorder' according to DSM-III and may have recovered sufficiently not to be so diagnosed by a research psychiatrist. But a general practitioner may identify depressive symptoms within a week of their onset, and know a person sufficiently to be able to predict the diagnosis. However, Goldberg & Bridges (1987) also found patients who satisfied criteria for psychiatric caseness but who had been classified as having entirely physical illnesses by the general practitioners. Goldberg & Bridges propose that these patients are somatising their problems, and indicate that their distress may usually be detected by the General Health Questionnaire (Goldberg, 1978). Bridges & Goldberg (1985) show elsewhere that pure psychiatric onset is quite rare in general practice, and accounts for only 5 percent of new illness. However, in the same paper they also demonstrate that psychiatric illness as defined by modern research criteria occurs in between one quarter and one third of all new episodes of illness seen in primary care settings. Most of these illnesses occur as somatised presentations of what is fundamentally a psychiatric disorder, or in conjunction with known physical disease.

A continuum between natural emotional expression, emotional expression of a more extreme nature - such as attends a bereavement, somatised presentations of psychiatric disorder, psychiatric disorder in conjunction with known physical disease, and pure psychiatric onset may be argued for. A similar continuum but of a different order, may be proposed in the social domain: a patient may mention problems with the car, may have difficulty getting to the chemist, may be unable to go to work or may have

nowhere to live. At every point in each domain, there will be implications for the general practitioner to note, to stay with, and to problem solve. Although the General Health Questionnaire (Goldberg, 1978), and similar screening techniques, are able to detect psychiatric disorder in somatising patients, the author proposes that general practitioners who are sensitive to patients' *many* emotional leads and cues, and who are trained in psychosocial problem solving, would require such techniques only for clearly delineated purposes such as research or equivocal casesness.

It is important once more to draw attention to the fact (see Chapter 3) that in the present data set patients appear to be hesitant about the place of emotion in the general practice consultation. They tend to initiate emotion with cues, and do limit doctors' expression of emotion as well as doctors' following of their own emotion. However, consonant with the findings of Goldberg et al (1993), patients also move from more provisional 1 type initial problem solving strategies to deeper 3 type strategies when doctors are responsive to their Emotional agendas; they engage in more extensive problem solving later in the interview when doctors have initiated emotion in a facilitative way, and problem solve to a considerable degree. Although patients seem to back off when doctors have initiated Emotional agendas too deeply, they return to a lot of emotion and do so more frequently when they have continued their emotional expression in a tentative manner in the initial stages of problem solving. Patients' behaviour suggests that telling someone what you want is indeed a, "Most ultimate and revealing communication" (Lazare & Eisenthal, 1979), and that this is almost certainly the heart of the matter. Moreover it further substantiates the findings of Cox et al (1981) which showed that quite apart from specific techniques, a lack of undue probing and questioning seems to facilitate emotional expression, and may illuminate the finding of May (1992) that general practitioners' detection of psychiatric illness during the consultation did not improve patient satisfaction afterwards.

The naturalistic data presented in this chapter show two things which have important implications for the above discussion. Firstly, doctors and patients are in tune

with one another in problem solving terms in the physical domain. Doctors and patients fall increasingly to disharmony in the social and emotional domains. Secondly, doctors are skilled in problem solving in the physical domain, and use the full range of problem solving strategies available to them. They are also able to use most of these strategies in the emotional domain when the emotion is clearly identified. That they do not routinely do so in the emotional and social domains suggests that doctors are not identifying or acknowledging the emotional and social cues, and doctors do limit expression in these domains. There are a number of reasons why this might be so: concern at not being able to deal with the problem in the time available; concern as to the appropriateness of emotional and social issues in the medical setting; anxiety, perhaps at a preconcious level, as to the way in which the patients' agenda will touch the doctor's own experience, and having received a training which focuses on the disease rather than on the person. As Maguire et al (1989) point out, few doctors have been trained to handle such reasonable but difficult questions as the nature and prognosis of their illness or complications of treatment. But if this paints a pessimistic picture, it also hints of potential. Doctors *are* able to problem solve and patients *do* bring social and emotional information to the general practice consultation. It was noted earlier that conflict is a crucial part of negotiation and that negotiation is an important part of problem solving. Doctors are at ease in the physical domain, patients bring emotional and social issues to the consultation, and there is the potential to reconcile doctor and patient agendas (Levenstein et al, 1989). Goldberg et al (1987), for example, propose a three stage model for teaching general practitioners to enable patients to reattribute somatic symptoms to psychological rather than physical aetiology. Patients need to feel understood, they need to be encouraged and to change their agenda, and must be anabled to make the link between agendas. Evaluating the effectiveness this training, which utilises a problem solving approach, Gask et al found that trainees were able to facilitate change in patients' agendas.

Cox et al (1981b, 1988), Hopkinson et al (1981) and Cox (1989) have also demonstrated a variety of ways by which expression of emotion may be encouraged. They show that a brisk, highly controlling style in which the interviewer directs the interviews range of topics covered is likely to reduce emotional expression. Their research was in the psychiatric setting with mothers and children, but the results indicate that these techniques may be taught and that they may be generalisable to other medical settings (Maguire et al, 1989). Mayou (1978) presents the case for teaching a problem solving approach as a means of helping students in their decision making skills; Gask et al (1987, 1988) suggest that measurement and feedback can help general practitioners to learn about their consultation behaviour and change it for the better and show how this is achieved, and Gask et al (1991) propose a model of problem based interviewing which emphasises the patients' current psychosocial problems.

Aborelius et al (1991) indicate that consultations characterised by uncertainty may be so as a corollary of the doctor not allowing himself to use his feelings of uncertainty. They propose what amounts to six problem solving techniques to enable the general practitioner to identify the source of his uncertainty and so minimise the difficulty. When doctors feel unable to explore their feelings of uncertainty with the patient, doctors may be more inclined to undertake more therapeutic actions to mask their uncertainty. Since uncertainty is likely to be associated with lack of clarity about the nature of the problem (or agenda: compare doctor low follow rates of patients' Emotional agendas when the presenting problem is Chronic Physical), and since Emotional and Social agendas receive less problem solving from doctors when they are less clearly identified by the patient, it is conceivable that, in consultations characterised by uncertainty, psychosocial attention may be associated with unnecessary therapeutic actions. As Berger (1967) observes, "the easiest - and sometimes the only possible - form of conversation is that which concerns or describes action: that is to say action considered as technique or as procedure" (p.99). Thus, while Smits et al (1991) found a positive correlation between performing obligatory examination and paying attention to psychosocial aspects of the consultation,

they also found that psychosocial attention went with unnecessary therapeutic actions. It is possible that unnecessary diagnostic manoeuvres may be part of a doctor behaviour pattern of doing a lot of work without a patient oriented and goal directed approach. The latter criteria do not exclude the notion that doctor uncertainty may lead to more therapeutic actions, and that such actions are more likely to be associated with unclear agendas and with less appropriate problem solving.

The present study of problem solving by doctors and patients within the general practice interview is, of necessity, limited by its design. The investigation has been exploratory in nature, and has identified problem solving strategies used by doctors and patients in a series of naturally occurring consultations. Although substantial, the sample is not large and reflects the consulting style of only ten general practitioners. However, the study is able to show that the problem solving categories are extremely reliable, and that the measures have good face validity. Analysis of doctor and patient problem solving behaviour shows that doctors use all available problem solving strategies in the physical domain, and do so in the emotional domain when patients have clearly identified their emotional agendas. Doctors frequently limit social and emotional expression, and rarely problem solve in the social arena. Patients bring a lot of emotion to the interview, but do so cautiously, giving the doctor cues and leads rather than by expressing their emotion directly. Patients shy away when doctors probe too deeply about emotional concerns, but will problem solve to a high degree later in the interview, particularly when the doctor facilitates emotional expression initially. The study suggests that both doctors and patients would benefit from doctors being taught problem based interviewing techniques, and that the categories developed may fruitfully be used to assess the effectiveness of such training in the future. This is in line with recommendations by the Royal College of General Practitioners that the nature of the consultation should, among other things, be concerned with the doctor's ability to define problems and involve patients in their correct management (Royal College of General Practitioners, 1985).

CHAPTER 9 : CONCLUSION

A. MAIN FINDINGS.

B. LIMITATIONS.

C. FUTURE RESEARCH.

D. CONSIDERATIONS.

A. MAIN FINDINGS

Two independent and major reviews around the mid eighties identified similar problems in the research of doctor-patient relationships (Wasserman & Inui, 1983; Tuckett & Williams, 1984). Both drew attention to the way in which systems of interaction analysis had focused on frequency and process variables at the expense of consultation content and what content might mean both to doctor and to patient. Based upon their extensive review, Wasserman & Inui proposed that any further investigation should adhere to seven research criteria. These are outlined in chapter 3 above.

The system of interaction analysis described in the present thesis adheres strictly to these criteria. Doctor and patient agendas are conceived of as the content variables of the system. They are the problems, implicit and explicit, which people bring to the consultation. Ten agendas are identified, but of principal interest are the doctors' and patients' Physical, Emotional and Social agendas. For the consultation to proceed and problem solving to be conducted, these problems must be acted upon in some way or another. The six procedures generally used within the doctor-patient encounter are therefore categorised. These not only provide a frame of reference for the consultation, but *significant markers in consultation* sequence. The crucial link between agendas and procedures, is supplied by information processing. Although itself a procedure, information processing describes how procedures are linked to problems and take six forms. The unit of analysis in the study is the floorholding, and note is made of whether either party has initiated, returned to, followed or not followed the other person's agenda. The system is based upon observation analysis of videotape and audiotape recordings. Conceptually, a problem solving perspective informs the approach, and this is derived from the McMaster model of family functioning (Epstein et al, 1978). The system assesses doctor and patient behaviour across three dimensions: tolerance of power, doctor and patient perspective, and awareness of psychosocial issues. With training, the system is reliable, and has good face validity.

When applied naturalistically to a series of 73 naturally occurring general practice consultations, the system proved to be sensitive to doctor and patient differences on all

measures. It identified that patients bring a lot of emotional concerns to the consultation. Patients initiate a lot of Emotional agendas, and return to Emotional agendas to a high degree. Emotional agendas occur at a fairly constant rate throughout the interview for patients, whereas doctors tended to address Emotional agendas more in the second half of the interview. Patients used many more Emotional agendas than doctors and were more likely to initiate Emotional agendas. Patients more frequently followed doctors' Emotional agendas than the reverse, but doctors were more likely to follow patients if patients had previously followed the doctors. Patients initiated the majority of Physical agendas reflecting the way in which doctors and patients behave in the consultation: at the beginning of the interview doctors would generally ask how they might help the patient, and patients would generally respond by initiating a Physical agenda. Both doctor and patient followed one another to a high degree when Physical agendas were raised. Physical agendas were the most frequently used agenda by both parties, and both parties sustained Physical agendas to a proportionately comparable level throughout the consultation. Both doctor and patient initiated a similar number of Social agendas but patients were more likely to follow doctors to follow patients. As with Emotional agendas, although to a less marked degree, doctors were more likely to follow the patient if the patient had already followed the doctor. Social agendas occur proportionately to a comparable level throughout the interview for both parties, but to a far lesser extent than Physical agendas. If the patient wishes the doctor to follow on an Emotional or Social agenda, it appears that it 'pays' the patient to follow the doctor in the previous floorholding. The results suggest that the doctor can give validity to the patient's Emotional and Social agendas by following and by being responsive to them.

It was hypothesised that the nature of the patient's presenting problem might influence both doctor and patient behaviour. Tuckett et al (1985) point out that in providing primary care, general practice consultations deal with a varied set of problems, and that patients attending the surgery are at different stages of care. It was therefore decided to categorise the consultation according to Acute and Chronic presentation according to agenda type. Acute and Chronic problems were operationally defined, and rules for assigning the presenting problem drawn up.

Differences were found in doctor and patient behaviour assessed with the method of interaction analysis described. Doctors initiate Physical agendas comparably to patients when the presenting problem is Acute Physical, and doctors return to patients' Emotional agendas to the same extent as patients when the presenting problem is Acute Emotional. Doctors do not very often follow patients' Emotional agendas when the presenting problem is either Acute or Chronic Physical. Patients seem to share the doctors' reluctance to process Emotional agendas when the presenting problem is Acute Physical, but readily engage with doctors when they are followed in the emotional domain and the presenting problem is Chronic Physical. This is shown in the extent to which either party follows the other when they have first been followed. Doctors seem to be aware of the social implications of both physical and social presentations but the most notable differences between doctors' and patients' handling of principal agendas emerge in the emotional domain. In terms of doctor and patient influence, demonstrated by the following rate by either party of the other's agenda, doctors continue to have more influence in the consultations than patients: doctors are always followed more by patients than patients are followed by doctors. However, when the presenting problem is social doctors seem to follow patients' Physical agendas slightly less in the next floorholding.

Any general assessment of doctors' technique, and in particular patient centredness, needs to consider the extent to which individual doctor style, doctor gender, and length of consultation may effect the results. These aspects of the interaction are referred to as between doctor variations. When the system of interaction analysis was applied to the sample differences again emerged and there was considerable doctor variation on some measures. General practitioners always had a greater proportionate return to the physical domain whereas patients always have the highest proportional return to the emotional domain. The data showed additionally that general practitioners could be categorised according to the balance of, and extent to which they return to, the emotional and physical domain, and the extent to which a doctor returned to a given domain did not appear to go along with the nature of the presenting problem. There appears to be a very high pay-off for both patient and doctor in the physical domain, and very little variation between doctors. However, the pay-off for either doctor or

patient in the emotional domain shows far greater variation, and this is particularly demonstrated in the extent to which the doctor follows the patient. The data also suggest that the nature of the presenting problem may influence the extent to which it pays doctors and patients to follow one another in this domain. However, in an exploratory study such as this, the extent to which the differences are due to variations in doctor style; particular doctor's response to presenting problems; the nature of the presenting problem itself or the nature of Emotional agendas, cannot be determined. Doctors vary much less between themselves in the pay off for Social agendas.

The mean length of doctor-patient interviews in the present sample was 7.72 minutes, and the mean number of floorholdings per interview was 57. The standard deviation for the majority of doctors was roughly comparable, but one doctor stood out as having exceptionally long interviews while another doctor stood out as having exceptionally short consultations. The data were further divided according to doctor interview style. This was defined by the mean interview duration of each general practitioner to give an indication of a given G.P.'s tendency towards a given style. Thus doctors could take a 'short', 'medium' or 'long' consultation style. The majority of interviewers fell into the first category, and the sum of 'medium' and 'long' interview style was not much more than the total of 'short' consultations. Although there were no differences between the three interview styles, differences did emerge between doctor interview style and the way in which principal agendas were handled. For both doctors and patients, as would be expected, the longer the consultation, the more either party follows the others' agenda. But whereas doctors return more to Physical agendas when their interview style is longer, patients return more to Emotional agendas. A positive association of consultation length (defined according to doctor style) with doctor initiation of Social agendas, and patient returning to Social agendas was established. A further association was established between interview style and doctors' returning to Physical and Emotional agendas. In the longer style doctors and patients return to Physical agendas comparably, but patients return more often to emotional concerns than doctors. Although a longer consultation style begets

more following from either party, when longer consultations are defined according to doctor style, each party follows the others' principal agendas less as interview style becomes longer.

When attention to psychosocial issues was defined as doctor initiating, or returning to patients' Emotional or Social agendas, and comparisons were made between doctors with a 'short' interview style, and doctors with a 'long' interview style, it did not seem that doctors with a 'short' consultation style devoted less time to psychosocial issues than doctors with a 'long' consultation style. However, doctors with the latter consultation style seemed to follow Social agendas that patients have initiated or returned to more frequently than doctors with the former consultation style. The significant measure was therefore doctor following.

Proportionately, female general practitioners seemed to initiate, follow, and return less to emotion than their male colleagues. This pattern is reversed in the social domain where female general practitioners initiated, followed, and returned to, more Social agendas. Female doctors' patients, in contrast, initiated proportionately more emotion than male doctors' patients, and also returned to more emotion than patients of male general practitioners. Both genders had a high pay-off for initiating, following, returning to in the physical domain. When female doctors return to Emotional agendas they were more likely to obtain a following by the patient in the next floorholding than their male colleagues. However, when male doctors have followed their patients' Emotional agendas they are rather more likely to obtain a patient follow in the next floorholding than female doctors. The reverse was found to be the case in the social domain. Overall, analysis of between doctor variation did appear to suggest that individual doctors may have stable characteristics which will influence the distribution of any overall analysis. These individual differences will inevitably influence the extent to which general recommendations can be made from the sample.

Analysis of the data in terms of procedures and processes provided an alternative and complementary way of mapping the consultation. In terms of information processing it seemed that the category Giving Information provided an important marker in consultation sequence. In the first half of the interview, divided according to floorholding rather than time, patients would give more information on balance, whereas doctors would give more information in the

second half of the consultation. But, in all principal domains, patients always gave more information overall than doctors, and this giving of information increased according to domain. Thus patients give proportionately more information in the emotional domain than doctors in the physical domain. When assessed according to the nature of the presenting problem, this did effect the pattern of information giving according to agenda type. Doctors gave information proportionately eight times more in the second half of the interview in the social domain when the presenting problem was Chronic Physical. (In contrast to the overall pattern of giving twice as much information in the second half of the consultation) When the presenting problem was Acute Physical doctors gave information proportionately four times more often in the social domain and patients also gave more information in the second half of the interview. In this patients departed from their usual consultation map. When the presenting problem was emotional, doctors did not give any information in the first half of the consultation in the social domain, and when the presenting problem was social, doctors gave information proportionately four times more often than patients in the second half of the interviews in the emotional domain, and also in the emotional domain patients gave information at a fairly constant rate throughout the interview.

The category Seeking Information also proved to be a useful marker in consultation sequence, but not to the extent that previous studies have suggested. The results did not demonstrate the clear transition from the doctor seeking proportionately more information to the patient seeking proportionately more information. Although doctors tended to seek more information than patients in the first half of the consultation, patients sought information throughout the interview and only slightly more in the second half. Overall, across all agenda types and not according to half interview, doctors sought twice as much information as patients in the physical domain, three times more information than patients in the emotional domain and five times more information than patients in the social domain. So while doctors and patients gave and sought information in a fairly balanced way in the physical domain, they were less in tune with Emotional and Social agendas: in the latter doctors sought more information than patients were willing to give, and the discrepancy was more marked with Social agendas than

Emotional agendas. When Seeking Information was looked at according to the nature of the presenting problem and by half interview, it again seemed to be the case that presentation altered the pattern. When the presenting problem was Chronic Physical, patients sought as much information in the first half of the interview as in the second half of the interview in the emotional domain, and in the social domain, again with the Chronic Physical presentation sought no information at all. When the presentation was Acute Physical, patients seemed always to seek considerably more information in the second half of the interview. This tendency was more marked still when the presentation was emotional and in the Emotional domain. Thus patients in the latter sought six times more information in the second half of the interview than the first. Again in the emotional presentation, but this time in the social domain, patients sought as much information in the first half of the interview as they sought in the second half of the interview. Patients seeking of information in the different domains when the presenting problem was social was too infrequent to calculate meaningfully.

In all three domains, doctors discussed more information than patients, and proportionately to about the same degree in each agenda type. Patients accepted nearly twice as much information as doctors in the physical domain, doctors and patients accept approximately the same amount of information as patients in the emotional domain, but doctors accepted more than twice as much information as patients in the social domain. Discussing Information and Accepting Information were not analysed further.

Procedures are closely linked with the diagnostic course of the consultation. As would be anticipated, patients rarely Consulted Notes whereas doctors Consulted Notes mostly at the beginning of the interview. Physical Examination tended to occur around the midpoint of the consultation for both parties. Treatment occurred in the later stages of the interview for the doctor, but patients tended to be in Treatment mode throughout. This may reflect patients discussing previous treatment procedures in the first half of the consultation. The pattern found for Treatment was similar for Referral and may reflect similar processes operating. Conversation for both parties increased through the quarters of the interview, suggesting that Conversation is in a function of parties relaxing rather than using Conversation as a 'setting'

procedure at the beginning of the interview. When procedures were analysed according to doctor, between doctor differences did emerge. However, the variance may be due as much to the type of problem presented as to doctor style. For both doctors and patients all the procedures were associated more with Physical agendas. Doctors used Consulting Notes proportionately more in conjunction with Social agendas than Emotional agendas, and Investigation proportionately more in the emotional than the social domain. Both doctors and patients used Treatment procedure proportionately more with Emotional agendas than they did with Social agendas, and doctors occasionally referred to Social agendas in Physical Examination. Although Referral and Investigation did occur in conjunction with Emotional and Social agendas, the frequency of occurrence was too low to be calculated meaningfully.

Categories to assess the extent to which problem solving procedures were used by doctors and patients in the consultation were devised. There were four main categories concerned with facilitative behaviours, limiting behaviours, problem solving behaviours and instrumental problem solving techniques, and these were subdivided further. Each category was numbered one to four. Initiated agendas were assessed according to these problem solving strategies initially and subsequently. Initial assessment was conducted on the speaker's current floorholding, his previous floorholding, his next-1 floorholding, and his next-2 floorholding. Subsequent assessment examined the extent to which problem solving categories 3 and 4 were carried out on the given agenda later in the interview. A note was made of the number of returns to the initiated agenda by either party later in the consultation. All Emotional and Social agendas were scored, but only the first Physical agenda in each interview was rated. The categories proved to be extremely reliable. They also showed excellent construct and face validity.

Problem solving results showed that doctors and patients, but especially doctors, used all the problem solving categories in the physical domain, and that this was true irrespective of whether the agenda had been raised with a type 1 or type 3 initial strategy. Patients tended to initiate Emotional agendas using type 1 strategies, and this would result in doctors using less problem solving strategies later in the interview. Doctors also limited patients' expression of

their emotional concerns to a very high degree. However, when patients initiated Emotional agendas with type 3 initial strategies, doctors would problem solve rather more later in the interview. Problem solving skills were not used at all extensively later in the consultation by either doctor or patient in the social domain. Doctor returns to patient Physical agendas appeared to be a function of them raising the agenda in a facilitative manner. The data thus demonstrated that while doctors and patients are in tune in the physical domain to the extent that patients can 'cue' the agenda and the doctor will explore the agenda fully and bring problem solving skills to bear on that agenda, doctors are not in tune with patients in the emotional and social domains. Patients bring a lot of Emotional agendas to the consultation, but seem to raise them in a facilitative way. This frequently results in the doctor either not noticing the patient's cue or deliberately blocking the emotional expression. When doctors do follow patients' type 1 initial strategies, they problem solve less later in the consultation than when patients have clearly defined their emotional concern at the time of initiating the Emotional agenda. In other words, doctors tend to problem solve in the emotional domain only when emotion is clearly defined. This supports the analysis according to the nature of the presenting problem in that here, as there, doctors demonstrate that when they are clear about the agenda they will be more in tune with patients. The trouble is that emotional considerations tend to require sensitive handling for them to become explicit.

Throughout this thesis, irrespective of analysis, a general theme has emerged. Both doctors and patients seem confident and able to deal with Physical agendas. Both doctors and patients are more able to handle Social agendas than Emotional agendas, but neither seems particularly confident. All measures are sensitive to considerable variation between doctors and patients in their handling of Emotional agendas. Emotional agendas account for 23 percent of all patient initiations, and 32 percent of patient initiations of principal agendas. In an approach to the consultation which is oriented to the patient and which has problem solving perspectives, emotional and social considerations cannot be overlooked. Yet the present study has shown that although general practitioners are able to enhance patients' emotional expression, both by being sensitive to its cues and by giving it validity within the interview, they rarely do so.

Patients' emotional and social problems, implicit and explicit are, however, demonstrably present.

B. LIMITATIONS

Because the study has described the development of a system of interaction analysis for the general practice consultation, it has been exploratory in nature; there is no 'gold standard' against which to assess its criterion related validity. Although acceptable reliability was achieved, the system requires reasonably in depth training for this to be so. In the first round of coding, of the three raters, the general practitioner identified more Social than Emotional agendas, the psychiatrist identified an abundance of Emotional agendas, and the psychologist identified an intermediate number of each. This suggests that professional background might influence the identification of these agendas. While this information is useful in terms of recognising the ways in which different training approaches may contribute to consultation process, it is crucial to the appropriate application of the system that, temporarily, such differences should be suspended. Of all the categories, Discussing Information was the most unreliable. This is a difficult category conceptually in that it contains aspects of both Seeking Information and Giving Information but is of a higher order than either. The system is cumbersome in terms of the quantity of data it yields, and requires time to apply. On average, for example, it took about a day to rate an interview on all measures (problem solving measures excluded). It is possible, however, that it could be used selectively for different purposes according to the type of information required. This flexibility is inherent in the system. The sample, although substantial enough to develop the system upon, was comparatively small in terms of generalising the results of the naturalistic investigation. It could also be criticised as being unrepresentative of general practice consultations on a number of counts. Firstly, the general practitioners in the sample may have been more sympathetic to psychosocial issues since all were associated with G.P. training at some level. This would bias the findings in favour of Emotional and Social agendas. These problems may in fact be even less sympathetically dealt with by doctors not so affiliated. Secondly, all patients seen were presenting to the general practitioner with the first episode of a given complaint. Thus, although chronic conditions were readily identifiable, their presentation was in terms of a new episode of the problem. This criterion excluded a substantial number of patients and might

distort the findings when they are compared with the total population of general practice patients. Thirdly, some patients were interviewed prior to their consultation. This interview formed part of a separate study, but the intervention may have predisposed these patients to behave differently in the interview. This, too, might distort the results slightly. Fourthly, although it has been suggested that doctor behaviour is not altered by the presence of the video camera (Pringle & Stewart-Evans, 1990), there was at least one general practitioner in the sample who was clearly conscious of its presence: it was referred to by him in several of his consultations. Lastly, patients, too, referred to the presence of the video camera, clearly indicating an awareness of its vicinity. As with the doctors, this awareness may have influenced their approach to the consultation. Although the problem solving measures proved to be very robust in the reliability assessment, a number of the categories were not assessed. This was due to their very low rate of occurrence across the entire sample, and hence their non-occurrence within the sample randomly picked for the reliability assessment. The generalisability of the sample, for all the above reasons, must be questioned. This is particularly the case when frequencies are low as in the analysis of between doctor variation or the presentation of social problems in the analysis according to the nature of the presenting problem. Notwithstanding these limitations, however, the system yields in depth analysis of general practice consultations and is able to identify very clear areas for future research.

C. FUTURE RESEARCH

In the three principal domains differences between doctor and patient handling of these agendas were readily identified. Doctors and patients seemed to require little intervention in the physical domain: both responded to Physical agendas with apparent ease, and acted upon them quite thoroughly. This was not the case for Emotional and Social agendas. It is therefore these two agendas together with their concomitant perspectives that future research must address. There are a number of ways that this might be done, and what follows represent only a few suggestions.

Given that patients initiate Emotional agendas quite hesitantly, and given that doctors tend to respond to agendas more preferentially on those occasions that patients make their

emotional problems more explicit, there is a case for training a group of general practitioners in a cue following style to criterion standard. Such a group could be compared with another group of general practitioners who have been trained in a screening style. Both groups would then be assessed on measures of patient satisfaction determined by both quantitative and qualitative measures. It might be hypothesised that a 'cue following' style would be preferential for, and sensitive to, patients' emotional concerns. A screening style, on the other hand, may be more robust in identifying and dealing with patients' social issues. The system of interaction analysis presented in this thesis would be given further validity, and areas for general practitioner training could be delineated clearly.

If the hypothesis that a cue following style enables general practitioners to identify Emotional agendas more proficiently is supported, and the hypothesis that a screening style helps general practitioners to handle Social agendas more effectively is similarly supported, there would be a case for their more general application in training, and assessment of their efficacy over time.

Future research might also address the question of doctors' ability to problem solve in the emotional and social domains. Since doctors are able to problem solve in the former, but tend to do so when emotion has been clearly identified, gives further impetus to the development of a cue following style for the detection of Emotional agendas. However, doctors do not extensively problem solve in the emotional domain even when emotion is explicit. Nor do they problem solve much in the social domain. There is therefore a strong case for training general practitioners in the application of the problem solving techniques (they demonstrably possess in the physical domain) to patients' Emotional and Social agendas. Again, an experimental comparison between groups could be assessed against measures of patient satisfaction derived both quantitatively and qualitatively. Future research might also develop a form of the system of interaction analysis for application in undergraduate training. Such a form would be a more simplified version of the system presented in this thesis and would be designed for immediate student assessment and feedback. Any simplified form of this kind would lend itself also to application in postgraduate training.

D. CONSIDERATIONS

Any future research must of course take into account the fundamental issues that are at stake when investigating the nature of the doctor-patient encounter. First, in measuring the interaction it is probable that the meaning of the relationship will be changed - however imperceptibly. Second, in categorising the consultation the investigator is largely committing himself to quantitative research methodology. This may be mitigated in part by including qualitative techniques to triangulate hypotheses, but the commitment to quantitative research and its concomitant language is there. As well as heeding recommendations born out of past research, however, it behoves the enquirers in to the nature of this partnership to pause for a while to reflect. In the Introduction I described the tenets of quantitative and qualitative research, and explored some of the ways in which the language of the researcher permeates both the subject and the application of his investigation. I drew attention to different modes of discourse available to the investigator, and pointed out that mostly it is a utilitarian rather than a metaphysical language which prevails. I suggested that while qualitative research may claim to partake of the latter, and perhaps does to a degree, it is frequently subsumed by the ponderous credibility of quantitative discourse. Through two literary vignettes I attempted to draw out the way in which stylistic considerations may affect the reader's conceptual and emotional response to a subject, and to hint at the provisional but enduring nature of language. I also hoped to persuade my reader to consider the possibility that descriptive research is able to give new life to old methods of enquiry. Crucially distinguishing the descriptive method of research from other forms of scientific endeavour is the presence of the author in his work. The descriptive research writer is confident in his elucidation but not concerned about exposing his fallibility. He will know that his hypotheses are generated as much from within himself as from sources of data, and will surrender himself and his language to the inevitable passage of time. Time will throw new light onto the subject of study and the researcher will be changed through time. Time is finite, because organic diseases are finite, hypotheses are finite, the investigator is finite. But the speculation they generate may have infinite variety. If this is the language of

health, such diversity lends itself to anecdotal presentation. The anecdote makes public that which was private, is circumscribed by the teller's interpretation of the tale, and tends to proceed through examples. What the general practitioner hears from his patient is a story and what he brings to the consultation is his story. But doctor and patient are 'trained' to filter their stories. Through past and childhood visits to the doctor, the patient learns that the doctor's language is at one level different from his own. Through his experience in training the doctor has learnt that the language of diagnosis is his most professional discourse. Although it may be that the doctor responds to the patient as a person, the reason for the patient's visit to the surgery is to see him as a doctor. So the patient's story is compromised by context. The process is described by Balint (1964) as he illuminates the way in which general practitioners come to prefer diagnosing physical illnesses over problems of the whole personality. The doctor is conditioned by his training to think first of physical diagnosis since physical illness is more serious and dangerous than functional disorder. Although this is only partly true, physical diagnoses remain more credible. They are more tangible, having something definite and manifest about them. Moreover, doctors know more about physical illness and so feel more confident to deal with physical rather than functional problems. The patient consults the doctor as an expert, however, to identify an emotional or social story. There is another issue at stake, and it is deeply related to what has been said so far. Ancient civilisations appointed a medicine man to heal, and to protect their people (where possible) from death. The medicine man was accredited with special powers, could invoke magic, and was granted special status. He was absolved from work and was provided for by the community. The medicine man was different from other people, and his difference made him separate. Nowadays doctors are similarly nourished by disease and fear of disease, and remind us at some deep level that we are not infinite. This is given clarity by Berger (1967) when he observes the manner in which the doctor becomes an accomplice to the patient's departure from health: "Suddenly it was silent. The men had stopped hammering but were kneeling on the ground. They knelt and looked at the doctor. His hands were at home on a body. Even these new wounds which had not existed twenty minutes before were familiar to him. Within seconds of being beside the

man he injected morphine. The three onlookers were relieved by the doctor's presence. But now his very sureness made it seem to them that he was part of the accident: almost its accomplice." (p.18). This idea of the doctor being separate is important for it is the divorce of the doctor from the patient that enables two rather paradoxical phenomena to occur. Because we have all known separation these phenomena are familiar, but the doctor-patient relationship brings them into focus. On the one hand it is his separateness that facilitates the physician in treating the patient's disease. But on the other hand it is being apart that enables him to reflect upon the nature of health and to restore us. The experienced doctor will diagnose the disease but will ally himself with the patient in health. The paradox is that experience comes only with time. Rendering the doctor apart enables us to believe not that separation is necessarily with us but that if separation were to come about, it would be an essential condition. In my Introduction I described the way in which the doctor is distanced by the discourse that informs his training and I trust that I have shown since that he is rendered apart from his patient on many levels - the linguistic, the stylistic, the conceptual and the cultural. It is additionally suggested that the doctor is further distinguished by a commitment to the 'ideal of service' in the manner of Conrad's sailors. Thus: "The Service stands for all those traditional values which a privileged few who have faced and met the challenge esteem: esteem not as an abstract principle but as the very condition of practising their craft efficiently. And at the same time the service also stands for the responsibility which the few must always carry for the many who depend upon them" (Berger, 1967 p.52). This is a noble ideal but for the doctor it is also double edged. The doctor as the central character in an emergency (and television ratings indicate the power of this scenario) has little time to reflect. But as he moves on and comes to reflection, the doctor might suspect that in curing others he is curing himself, and that in fulfilling the need of others he is able to fulfil his own (Berger, 1967). In his seperatedness the healer is wounded: the doctor is exquisitely at one with his patient. The modern general practitioner has a further cross to bear. It has been suggested that the general practitioner is being forced to invoke the 'magic' of medical research to give him professional credibility. Until quite recently the general practitioner defined himself in terms antithetical to research

(Shapiro, 1992). Traditionally, general practice was about people not data, and being the oldest of the specialities it was confident in its ability to leave research to other branches of medicine. But recently family practice has been reinvented. Suddenly there are Departments of General Practice in our universities, there are flourishing health centres in our communities, general practitioners hold their own budgets and general practitioners must audit their practice. General practitioners are finding themselves side by side with their consultant colleagues and are expected to be familiar with developments in research. At all levels the general practitioner must demonstrate his credibility. Outside by profession, the general practitioner is outside within his profession. The general practitioner must justify himself and the temptation is to do so out of the ashes from which the speciality was born. Quantitative research beckons. But there is an impulse which is resisting this temptation. Although committed to publishing quantitative reports, the international journal, Family Practice, devotes a significant proportion of its content to qualitative research, and does not exclude essays which pertain entirely to theoretical or anecdotal considerations. Within it, Shapiro (1992) concludes her plea for research in general practice to allow its own standards and values to be continuously emergent by quoting from the children's story: "Real isn't how you are made. It's a thing that happens to you. You become. It takes a long time ... And sometimes it can hurt" (Williams, 1981 in Shapiro, 1992 p.97). Perhaps, after all, the meaning of an episode lies outside and envelops the tale. We might improve the interpersonal consultation skills of doctors with techniques and will no doubt manage to extend the range of doctors' problem solving capabilities. We will instruct and we will research. At best we may intimate the qualities of the doctor-patient encounter through examples, but I rather doubt that we will ever be able to teach experience or command the language of health. On the one hand, "If we are to understand the *quality* of awakening, and the awakened state - health - we must depart from the physiological and neurological terms which are generally used and heed the terms which patients themselves tend to use" (Sacks, 1973 p.213). And yet on the other hand, "The easiest - and sometimes the only possible - form of conversation is that which concerns or describes action: that is to say action considered as technique or as procedure" (Berger, 1967 p.99). Maybe it is only by being outside that doctors

can ever be in tune with patients. To force an equation perhaps, in being 'outside' doctors create the necessary tension for negotiation and resolution. Sensitive doctors who assimilate their patients' language through action may become better doctors. Better doctors are more likely to help patients become better patients. Through their experience better patients will enable the best doctors to become good patients. Good patients will sustain an initial and natural reticence in the formal company of good doctors ... To assess the doctor, then, inevitably is to assess the patient, and to know the patient is to know the doctor. Precisely because he can *become* a patient a doctor may also practice medicine: "Medicine cannot be reduced to coherent and logically consistent terms - it is dependent on innumerable variables of intangibles, on 'magic', and above all on the trusting relationship between physician and patient." (Sacks, 1981 p.239).

"... Let us descend now therefore from this top
Of speculation; for the hour precise
Exacts our parting hence ..."
J. Milton Paradise Lost, XII, 588-90.

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APPENDIX A

Patient Consent Form

Today your doctor's surgery is being video-recorded for medical research and teaching.

We will only do this with your permission, and we will not mind if you don't wish to be recorded.

If you are willing for your consultation to be recorded please sign this consent form and hand it back to the receptionist. If you do not want to be recorded please tell the receptionist, and return the form unsigned.

CONSENT FORM

Name: .....

(to be completed by receptionist)

I am willing for my consultation with the doctor to be video-recorded for research and teaching purposes only.

I understand that I am free to withdraw this consent after the consultation if I change my mind.

Signed: .....

Date: .....

APPENDIX B

Example of Audio Transcript

DOCTOR:

Hello, I think I buzzed twice, I've got Rachel with me, OK thanks. Right Rachel what can I do for you?

Is it itchey?

And you've been to the hospital recently haven't you?

But this seems to be a different rash?

So it came up that suddenly?

And its got steadily worse?

Right we'll have a look at that in a second erm was there another problem that you had as well.

Have they given you a date?

Where are you working at the moment?

How's it going?

PATIENT:

Erm for starters I've got a rash on my chest I came here about 3 weeks ago to see Dr Cranney and he have me some cream and it hasn't done anything for it at all.

Yes it does irritate yes.

Yes about my head.

Yes I don't think its connected, the other one is when I worry about things, this one, actually I thought this one was going to be like that because it started the morning I was going to be a bridesmaid and erh, that was in October, since then its gone worse.

Yes

Yes

Erm only that I'd been to the hospital about my throat and I'm going to have my tonsils out and its a bit sore.

No I'm on the waiting list.

In Rose Lane Chemist

Well I've been there since March and its a bit of a problem cause I work 9 - 6 and I only get Wednesday afternoon off and so to come here I've

had to have a days holiday and its not a busy shop at all so once your cleaned the shop and stocked the shelves you are just standing there.

And your getting bored.

Yeah I'm looking round for something else and well I've got another job but the shop hasn't opened yet.

Still a chemist

No its on Allerton Road its a new photography place thats come down from London and it sounds quite helpful cause the shop hasn't taken off yet.

Oh, yes because you liked the chemist job to start with didn't you?

Yes, I would still like it you know if it was more busy.

Right well lets have a look at your throat first.
Yes it does look quite nasty, how long has it been bad?

For about the past 6 days now

And you feel its getting worse?
How long is it since you've had an anti-biotic?
Beginning of October

Yes

I think you need another one really I don't want you to have another bad attack.
Youv'e never been right since that attack of glandular fever really have you?

Hepatitus, no I've since then I have been very very depressed, terrible, I said I wasn't going to do this today

Is that because of things at home or is it to do with the job?

I think it is a bit of both

really

Well lets have a look at your record, I don't think you've been right since you had that attack of hepatitus, it often takes a long time to get over you see the social thing of glandular fever too yes bacause the two things of very similar really.

Right

And it is itchy? Have you got it anywhere else?

No

Are you doing a lot of scratching?

No not really its just when I get out of the bath really when its warm

Can I just check your armpits? Because it looks like a rash that could effect other areas. Yes you have got a little bit on your back as well in fact. O.K. do sit down, so its worse when you get out of the bath

Yes or in the mornings when I get out of bed when I'm hot.

And it was a Gestatin was it?

Thats right

Well I agree with you it looks a bit like a fungus rash bit like athletes foot sort of thing so it should really have responded

Well I've got none left now I've finished the tube.

Well I don't think it can be a fungi rash then or it would have cleared so we'll have to try you with a different form of treatment. Would you say it has spread since you were using the cream.

No it hasn't spread no.

Well there is just one other thing I think we should try and

if that doesn't get rid of it well send you back to the skin clinic you've been there before so it shouldn't take too long to get you seen. Right and what about the depression.

Its been all of a sudden, about 3 weeks now the slightest thing starts me off, and my mum doesn't understand me at all and I started off last Sunday we were at the dinner table and me mum uses the salt and pepper and puts them back into the middle of the table and so I asked her to pass the salt and then she didn't hear so I had to ask her about three times in the end I just burst into tears, I don't know what was wrong with me so I stormed up stairs and me mum said whats wrong with you, I said don't put the salt in the middle of the table, but it wasn't that at all, its just the slightest thing sparks me off.

What hospital have you been to will you tell me because I was surprised to see that your'd moved and then come back.

Yes well we were surposed to move and then the house fell through so we stayed were we we are. I got to change to see a Doctor without a signature at all my dad changed it for me, my dad and I don't get on at all hes my step-dad and Melanie and me mum are very close, so I'm the odd one out.

But you and your mum are very close

No

No is that recent because I always thought you were or are you putting on a good act.

I think we do or I do

What about your Grandma are you closer to her?

Yes, because I was with her as a child you see. Looking back I can't remember much I was about 3 or 4 but she was always out at work and I was with my Nan.

Is that because she was a single parent?

Yes

I've always felt that you were close to your Grandma.

I am very close to my Grandma but I can't talk to her because I can't talk to my Grandma, she loves a bit of gossip so I don't really tell her anything.

Well was she there when you argued with your mum?

Oh yes

And how did she feel, I mean in that sort of situation would she just sort of stay out of it or would she try and....

No she didn't say anything till mum and dad went out that evening and she said to me are you alright Thelma, I said Yes I'm fine thank you, she oh you had me worried there I thought you were going to walk out. I nearly did do two weeks ago, because they almost drive me mad, it started light hearted she said she like to give to adoptive charities because she thinks its aweful children in homes, so erh me dad said I've already done it once, I knew

what he meant so me mum said well whose that and he just looked at me and said her I stood up ready to shout at him and again the tears got there first and I sobbed my heart out

And does he see that it upsets you?

Yes

How does he react?
Have you looked into leaving home seriously I mean do you think that you could?

Not leaving home but just walking out but I'd probably turn up again in a few days time. I just need a break from them maybe I could appreciate them then. I would not do it.

Well its a very big undertaking to leave home, just thinking of the finances of it. Is this situation at home getting worse do you feel?

It is because nobody realises what they are doing, nobody realises I'm upset because I don't tell them, believe it or not my mum thinks I'm very hard, I think its because I've never told anybody I love them and me mum and even me dad he resents that so I have never shown him any affection and I find it very hard to do that.

Well if you say that to somebody you are leaving yourself in a very vulnerable position aren't you, you are exposing yourself.

Thats right.

And if you have the feeling that you worse likely on sufferance then its understandable, then

perhaps you don't feel as if you are prepared to take that risk. Oh I'm sorry to hear that it is so difficult. And your stuck in this job thats so boring and your not using your brain enough.

I know, and as I say I only have the Wednesday off and its 9 -6 and then I don't get home till about 10 to 7 because of the buses

When will you know about the Photography thing?

Erm it should be before Xmas I hope.

Cause that will be something your more interested in. I don't think any pills I could give you would help.

No

I think that probably the most helpful thing will be when you can be independant.

We are all on top of each other at the moment, I meanIhaven't got a room

Are you sharing with your Grandmother

Yes, nobody knows that I mean my boyfriend doesn't know that

Can you talk to him about things?

Yes I can, but hes one of those people nothing bothers him at all, he shrugs everything off and he can't understand why I get so upset, so really I just keep it all to myself.

You need to talk about it really don't you.

This is why I cry for a while and then everything builds up inside because I can't talk to anybody and I just explode.

Thats right thats what the

tears are. You shouldn't try and keep it all bottled up and you used to laugh didn't you and thats another way of releasing tension.

I know, I used to be shouted at for that as well, if someone fell over I'd burst into tears. In fact I still am very unsympathetic in the Chemist some of the things people come in with I off.

I shall have to let you go now, I'd like you to come back in about 3 weeks and lets have a look at the rash.

Erm there is something else, I'm taking the pill at the moment.

Oh you had a slight fright in May so since then.

Yes

Which one are you on?

Erm Ophranette, is it?

Well thats a good pill, whats the problem about that?

I need some more.

Oh well thats no problem. I'll just check your blood pressure. Which Chemist on Rose Lane is it, I'm just trying to think.

Wardan Humphries opposite Hargraeves Supermarket.

Emm its not the busiest part of Rose Lane is it.

No not at all.

Thats fine.

Thank you.

Is your boyfriend from a very stable sort of family.

Oh yes

So he hasn't got anything to make him insecure has he.

No hes got a lovely family and

a very good job. Hes doing well for himself.

I think you should try and share your anxieties with him. I am going to give you another 3 months of the pill and I think we ought to examine you then and perhaps do a smear test, alright its not too horrible honest come to me on a Wednesday, so I'd like to see you anyway in about 3 weeks.

Thats fine thanks

You'll have to take another days holiday or see if you can fit it into the Wednesday afternoon session when I do the smears.

All right thank you.
Are they on Anti-biotics on this

I'll give you the arithresee again Two twice a day and I think you should take them for a full week.

Thank you, bye bye

Bye see you in about 3 weeks.

APPENDIX C

Interaction Analysis Scoresheets, Stages 1 and 2

AGENDA (DR.)	PROCED. MODE	AGENDA (PT.)	PROCED. MODE	TIME	DUR.

AGENDA(DR.)			PCS.	PCD.	AGENDA(PT.)			PCS.	PCD.	TIME	DUR.
		I F R NF					I F R NF				
		I F R NF					I F R NF				
		I F R NF					I F R NF				
		I F R NF					I F R NF				
		I F R NF					I F R NF				
		I F R NF					I F R NF				
		I F R NF					I F R NF				
		I F R NF					I F R NF				
		I F R NF					I F R NF				
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		I F R NF					I F R NF				
		I F R NF					I F R NF				
		I F R NF					I F R NF				

Problem-Solving Scoresheets, Stages 1, 2 and 3

Agenda	Primary code	Secondary code	Focus	Agenda	Primary code	Secondary code	Focus

PREVIOUS FLOORHOLDING					CURRENT FLOORHOLDING					NEXT FLOORHOLDING					
Speaker	Agenda	Primary code	Secondary code	Locus of aut.	Speaker	Agenda	Primary code	Secondary code	Locus of aut.	Speaker	Agenda	Primary code	Secondary code	Locus of aut.	Foll N-F

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PREVIOUS FLOORHOLDING					CURRENT FLOORHOLDING						NEXT FLOORHOLDING						NEXT FLOORHOLDING					
Speaker	Agenda	Primary code	Secondary code	Locus of aut.	Speaker	Agenda	Primary code	Secondary code	Locus of aut.	Foll N-F	Speaker	Agenda	Primary code	Secondary code	Locus of aut.	Foll N-F	Speaker	Agenda	Primary code	Secondary code	Locus of aut.	Foll N-F

3.1 Identify and explore a) Problem
b) Associated events
c) Associated earlier events

OR	PT.

3.2 Identify options for action

3.3 Selection of option

3.4 Examine possible consequences

3.5 Monitor previous options

3.6 Identify or communicate with others

4.1 Cognitive Strategies

4.2 Behavioural Strategies

4.3 Offering Interpretation/ Hypotheses

4.4 Prescribing Drugs

4.5 Describing Resources

4.6 Referral to other agencies

OR	PT.

Number of Returns to

. . . . Agenda

OR
PT.

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APPENDIX D: RULEBOOK FOR CODING OF AGENDAS, PROCEDURES AND PROCESSES

In the following rulebook, three examples of each category are given. The examples are taken from the videotapes used in the study. The first two examples of each category represent clear illustrations of the category in question. The last example illustrates an instance when there may be a problem in making a judgement and as such represents a threshold occurrence of the category under discussion. For principal agendas, that is Physical, Emotional and Social, three clear examples are given and three threshold examples follow.

1. AGENDAS.

Definition: The explicit or implicit cause of concern of either party. They are the broad categories of topic addressed within the interview and as such are the focus of the problem solving process. The agenda is a category of problem which is used to code the topic under discussion - it is an inference made by the coder from the behaviour of doctor or patient, reflecting the coder's perception of the meaning of that behaviour. An agenda commences when there is evidence that the behaviour and speech of the doctor or patient may be coded by the rules for specific agendas. Both parties may be operating one or more agendas at the same time. An agenda once raised must always remain a possibility - an agenda can only be thought of as resting or pending. The only exception to this rule is the Open agenda which cannot be returned to: it can only be initiated or followed. There are ten different agenda types, these are:

a) Introduction.

b) Physical.

c) Emotional.

d) Social.

e) Open.

f) Historical Psychological

g) Video.

h) Conversation.

i) Uncertain.

j) Conclusion.

Agendas may be parallel when either party through their behaviour appears to be making reference to circumstances relating to different agenda topics. Any agenda may occur in parallel with any other agenda. Apart from **Introduction** and **Conclusion**, all other agendas are matters which may be considered as potential problems which may influence the problem solving procedure. These matters may not be problems actually addressed by doctor or patient: they may remain implicit but be available to be addressed. Three principal agendas are identified, **Physical, Social** and **Emotional**. Each time an agenda is raised by either party, it will be indicated whether the agenda is an **Initiation**, a **Following**, a **Non-Following** or a **Return**. (For definitions of these terms see below).

Exclusion criteria:

a) Agendas are differentiated from **Procedures** since the latter refer to actions performed by either party, whereas **Agendas** refer to a topic addressed by that action.

b) Agendas are to be differentiated from **Processes** in that the latter refer to the ways in which information is processed within the interview, whereas the **Agenda** refers to the content of the information processing.

1.1 INTRODUCTION. (I)

Definition: An agenda is an event in which a party recognises the presence of another and makes explicit their awareness of that circumstance. It occurs at the outset of the interview and is concerned with greeting. Once terminated **Introduction** will usually be revisited only for purposes of identification or if another relevant party enters during the course of the interview. General social chit- chat which occurs at the start of the interview will be coded as **Introduction**, whereas social chit-chat occurring elsewhere in the interview will be classified as **Conversation.**

Exclusion criteria:

a) **Introduction** is distinguished for **Conclusion** agenda in that the former occurs at the outset of the interview, whereas the latter typically occurs at the end of the interview.

b) Social chit-chat occurring at the start of the interview will be classified as **Introduction** but when it occurs elsewhere in the interview, it will be classified as **Conversation.** Social chit chat which occurs at the end of the interview will be classified as **Conclusion.**

Examples:

1. Interview 27, floorholding 1

Dr "Come in. Hello."

2. Interview 14, floorholding 2

Pt "Hello there."

3. Interview 27, floorholding 5

Dr "Are you about to move as well ?"

1.2 PHYSICAL. (P)

Definition:

Any verbal or non-verbal reference made by either party to what they take to be a bodily problem. Examples of non- verbal reference would include pointing at parts of the body, the physical examination of the patient etc. It may occur at any point in the interview, and in parallel with any other agenda. Separate Physical agendas will be recorded for those problems perceived by the patient to be separate (though they may in fact be related - see rules for coding).

Exclusion criteria:

a) Bodily problems are distinguished from **Emotional** agendas since the latter refers to a verbal statement of feeling accompanied by the non-verbal concomitants of such feelings, whereas bodily problems refer to bodily problems not necessarily with such non-verbal concomitants.

b) The distinction drawn with **Social** agendas is that **Social** agenda refers to the social impact of a problem.

Examples:

1. Interview 4, floorholding 6

Pt "She's got a problem with spots. Well a rash. Last year she came for this and it's gone there now, but you gave me some cream, a tube of cream and it went away"

2. Interview 6, floorholding 5

Dr "Has she been vaccinated ?"

3. Interview 7, floorholding 9

Dr "Have you had nosebleeds in the past ?"

4. Interview 36, floorholding 16

Pt "I have had terrible throbbing in my head all the time" (coded E and P parallel).

5. Interview 33, floorholding 52

Pt "Thank-you" (coded as accepting information - Physical).

6. Interview 77, floorholding 6

Pt "I'm not very keen on that"

(coded as discussing information about treatment - Physical).

1.3 EMOTIONAL. (E)

Definition: The instance(s) when feelings are being transmitted. Axiomatically an Emotional agenda will include 'emotional' statements and words, for example "It's *killing* me", "I'm shattered". Coding is initially carried out on the verbal content, but an Emotional agenda must demonstrate enough explicit reference, action or corroboration to indicate the presence of emotion. Where there is inadequate verbal and/or vocal presence there must be more than one non-verbal accompaniment, for example, vocal tone, pressure of talk, facial expression etc. Since laughing is, by this definition, emotional, 'laughing off' should be coded as **Emotional** agenda. 'Feeling' is defined as indicating feelings - the active expression of feeling together with the non-verbal accompaniments which commonly indicate that someone is feeling something; for example, changes in facial colour, changes in facial expression, changes in posture etc.

Exclusion criteria:

a) **Emotional** agendas are distinguished from **Physical** agendas since the latter refer to bodily problems, whereas **Emotional** agendas refer to verbal statements of feeling accompanied by the non-verbal concomitants of such feelings.

b) The distinction between **Emotional** agendas and **Social** agendas is that the latter refers to the social impact of a problem.

Examples:

1. Interview 2, floorholding 80

Pt "I'm just neurotic".

2. Interview 57, floorholding 10

Pt "All I did was gently touch it like this, and itwas like I was killing him".

3. Interview 37, floorholding 6

Pt "I'm at loggerheads with meself. I'm at loggerheads with the world er, I don't know what it is honestly, but I just feel as though I need something to take the edge off it".

4. Interview 12, floorholding 14

Pt "look for potatoes ? Like Daddy does ? "(laughs).

5. Interview 58, floorholding 23

Dr "You're giving me a smile too, aren't you ? Good".

6. Interview 29, floorholding 33

Dr "And seriously, I think you should be flat on your back, not walking around" (Facial expression and tone of voice expressive of concern).

1.4 SOCIAL. (S)

Definition: Social agendas are defined as those expressions made by one party with the express desire of making the other aware of the presence of circumstances relating to social impact. That is, the impact of social circumstances upon a problem; the impact of problems upon social circumstances; or a social problem itself. Legitimate Social agendas will include talk concerning the impact of family, housing conditions, employment and so on. They will also include the impact of physical problems on social circumstances: work, family, leisure etc. When a patient or doctor mentions the illness of another family member (not present at the consultation) this is coded as Social, not Physical.

Exclusion criteria:

a) **Social** agendas are distinguished from **Physical** agendas since the latter refer to the impact of bodily problems, while **Social** agendas refer to the social impact of circumstances (which may include the physical illness of other people).

b) **Social** agendas may be distinguished from **Emotional** agendas since the latter refer to verbal and non-verbal expressions of feeling.

Examples:

1. Interview 4, floorholding 17

Dr "Still humping that great big caravan of yours ?"

2. Interview 13, floorholding 29

Dr "What is your job ?"

3. Interview 19, floorholding 16

Pt "I know I have been trying to go through and see if there was anything. I have been away for a couple of days and done a lot of swimming so the chlorine may have exaggerated it".

4. Interview 32, floorholding 14

Pt "And he collapsed the hubby last Saturday".

5. Interview 34, floorholding 2

Pt "Hello it's me, long time no see. I've come for him, you know he wouldn't come

himself, it's his nerves. Only he missed his speech therapy appointment see".

6. Interview 59, floorholding 33

Dr "How's things at home now ?"

1.5 OPEN. (O)

Definition:

An Open agenda is defined as an agendaless question or statement from either party (for example "Is there anything else ?"). As an Open agenda cannot properly be the object of problem solving, technically this category does not form an agenda. However, for the purpose of this system of interaction analysis, open questions will be termed agendas. An Open agenda will include either party seeking undefined information, or responding in an undefined way to undefined information sought. This agenda will be used when either party addresses a problem defined by the coder, without specifying the exact nature of the problem. Typically, but not necessarily, an open agenda will take the form of an open question.

Exclusion criteria:

a) Any question asked which can be included in any other agenda, for example, questions which may be asked in the **Introduction** agenda.

b) The **Open** agenda will normally take precedence in coding over the **Uncertain** agenda, though where doubt exists as to which category is appropriate, then **Uncertain** should be used.

Examples:

1. Interview 2, floorholding 3

Dr "How do, how are you ?"

2. Interview 16, floorholding 7

Dr "Now then what can we do for Mrs Martin this morning ?"

3. Interview 16, floorholding 8

Pt "Well it's both of us actually, shall we deal with Phillip first ?".

(Responding in an undefined way to undefined information sought).

1.6 HISTORICAL PSYCHOLOGICAL. (HP)

Definition:

Any reference made by either party in the interview to an **Emotional** agenda (as defined above) which is no longer currently a topic of concern. It is used to cover instances when the doctor or patient makes direct or indirect reference to emotional problems which no longer have a bearing on current circumstances.

Exclusion criteria:

a) An **Emotional** agenda is differentiated from an **Historical Psychological** agenda, in that the former refers to a problem which is currently a matter of concern, whereas **Historical Psychological** agendas refer to matters which were previously of concern.

Examples:

1. Interview 64/65, floorholding 36

Pt "There is no way I want him to be like him" (refers to behaviour of elder child).

2. Interview 64/65, floorholding 37

Dr "Yeah, OK" (coded as Accepting Information about Historical Psychological).

1.7 VIDEO. (V)

Definition:

Any statement in which either party makes verbal or non-verbal reference to the presence of the video recording equipment. This agenda may occur at any point in the interview and in parallel with any other agenda. There are no exclusion criteria - any reference made to the presence of the video constitutes a **Video** agenda.

Examples:

1. Interview 2, floorholding 160

Pt "In front of the cameras too !".

2. Interview 14, floorholding 64

Pt "You've had all your TV people in, have you ?"

3. Interview 17, floorholding 48

Dr "Well I regret to say that next time you come, Mrs Shaw, I won't be able to supply the same amusement !".

1.8 CONVERSATION. (CV)

Definition:

The Conversation agenda is used whenever either party engages in small talk, social chit-chat and so on. It is delineated in order to distinguish discussion relating to the social impact of a problem, from talk which is by way of social interchange. It is coded for talk when its content does not allude to potential problems to be dealt with by doctor or patient.

Exclusion criteria:

a) **Conversation** is distinguished from **Social** in that the former relates to discussion about social circumstances without regard to the impact of such circumstances. **Social** agendas, in contrast, includes such impact.

b) **Conversation** will take precedence over coding of **Uncertain** agendas in that the former contains some recognisable reference to social conditions, whereas **Uncertain** is used where there are no readily recognisable reference to any concern.

Examples:

1. Interview 17, floorholding 37

Dr "Do you have many friends ?". (to child)

2. Interview 58, floorholding 13

Dr "Yes, good you're giving me a smile too, everybody is smiling at me today."

3. Interview 24, floorholding 42

Pt "Are you usually busy on a Friday night ?"

1.9 UNCERTAIN. (U)

Definition: An Uncertain agenda will be used to circumscribe a situation in which it is simply not possible to ascertain to which problem reference is being made, but it is clear that a problem agenda is being referred to. It should be used only when no other agenda is suitable.

Exclusion criteria:

a) Any expression which might legitimately be included under any other agenda.

Examples:

1. Interview 8, floorholding 44

Pt. "Erm ... I don't know".

2. Interview 10, floorholding 55

Dr "Pardon ?"

3. Interview 20, floorholding 31

Pt "By the way were the things that the boys took any good ?".

1.10 CONCLUSION. (C)

Definition: An agenda in which either party engages in those behaviours typical of closure of the interview. Usually this will occur at the end of the interview. One party may enter the Conclusion agenda while the other still has unfinished business on other agendas. When both parties have terminated the Conclusion agenda, it is unlikely that any further interaction will occur. The Conclusion agenda for all parties terminates when the patient(s) leave the room for the last time. Behaviours typically included in the Conclusion agenda include; saying "Bye Bye", rising from chair, and so on. Social chit chat that occurs in conjunction with these behaviours will be coded as Conclusion rather than as **Conversation.**

Exclusion criteria:

a) Behaviours common to **Conclusion** and **Introduction** which occur at the outset of the interview are coded as **Introduction.**

b) Where concluding is temporary, for example the patient leaving the room to provide a sample, then the **Conclusion** agenda will not be coded.

Examples:

1. Interview 21, floorholding 61

Dr "Bye, Mr Bohl".

2. Interview 9, Floorholding 54

Pt "OK" (as stands and prepares to leave).

3. Interview 2, floorholding 162

Pt "You've had a busy day too".

2. PROCEDURES.

Definition:

Within the **Agenda**, a procedure is a specific aspect of the content of the interview. It refers to the types of actions available in addressing agendas. The actions are coded according to their intended purpose or function within the setting of a problem-solving medical consultation in primary care. Seven procedures are distinguished as follows:

a) Introduction.

b) Treatment.

c) Referral.

d) Information Processing.

e) Physical Examination.

f) Investigation.

g) Conclusion.

These procedures may occur together with the **Processes** described below. Four of these procedures are specific to the Doctor-Patient interview; Treatment, Physical Examination, Investigation and Referral. They refer to procedures which occur within the consultation and are unlikely to occur in interviews of a different nature. In contrast the procedures of Introduction, Information Processing and Conclusion are more generally applicable to many interviews with a variety of purposes.

When a single floorholding moves through two or more procedures the procedures are said to be parallel since a procedure operates throughout a floorholding.

Exclusion criteria:

a) Procedure is distinguished from **Agenda** in that the latter refers to the topic addressed within the interview, whereas procedure concerns actions available in addressing those topics.

b) Procedure is differentiated from **Process** in that the latter is a subcategory of action (that is, types of behaviour) which are adopted within procedures.

2.1 INTRODUCTION. (I)

Description:

A Procedure in which either doctor or patient introduce themselves to one another, occurring predominantly at the start of the interview, before the commencement by either party, of the addressing of a problem.

A cluster of behaviours performed by one party upon each other, by way of greeting or introduction. Greeting concerns explicitly recognising the presence of another by non-verbal or verbal action at the outset of the interview. That is, those actions which are incidental social preliminaries to the business of problem solving. Either party will not usually return to Introduction unless for purposes of identification, such as if another party enters the room. The greeting cluster of behaviours includes:-

Shaking hands

saying "hello"

saying "Come in"

walking in

sitting down

Introduction commences when any of the above behaviours is first demonstrated within the interview. Introduction ends for any one party when they enter any other procedural mode.

Exclusion criteria:

a) Any gestures common to both **Introduction** and **Conclusion** occurring at the outset of the interview will be classified as Introduction.

b) Behaviours common to both **Introduction** and **Conclusion** which occur towards the end of the interview will be classified as Conclusion.

c) Instances where the patient re-enters the room after leaving (for example to provide sample) are not Introduction.

Examples:

1. Interview 8, floorholding 1

Dr "Hello, come in and sit yourself down. Right what can I do for you this morning ?".

2. Interview 31, floorholding 1

Dr "Hello" (picks up 'phone) "I think I buzzed twice, I've got Rachel with me. OK, thanks" (puts down 'phone).

3. Interview 32, floorholding 2

Pt "I'm getting lost here, going all round, all that way I was going Doctor".

2.2 TREATMENT. (T)

Definition:

A procedure in which either party makes reference through verbal or non-verbal behaviour to an aspect of treatment. It may occur in combination with any of the processes.

Treatment is taken to mean any intervention aimed at promoting the health of the individual (including advice regarding prevention). Treatment may be designed to assist any of the issues raised as an agenda within the interview.

The procedure commences with the onset of the behaviour constituting Treatment, and ends with the end of the floorholding in which such a behaviour occurs.

Examples:

1. Interview 16, floorholding 27

Dr "So there we are we'll give him some penicillin, two teaspoons right away, a teaspoon four times a day, that's breakfast time, dinner time, tea time and last thing at night, and I want to see him in five days, which will be Tuesday".

2. Interview 13, floorholding 27

Dr "Take the dog out for a walk".

3. Interview 74, floorholding 21

Doctor out of sight aspirating breast lump.

2.3 REFERRAL. (REF)

Definition: A procedure in which the doctor expresses through verbal or non-verbal behaviour, the intention to refer the patient to another person for further treatment relating to one or more of the agendas currently under discussion. Examples of such behaviours will include the verbal expression of such intent, the writing of a referral letter and so on. The procedure commences with the commencement of the verbal expression of the intention to refer. The procedure ends with the termination of the same statement and any associated actions. Treatment will be taken to refer to any intervention aimed at promoting the health of the individual, including advice regarding prevention.

Exclusion criteria:

a) Where **Referral** involves the writing of a referral letter, it is important to distinguish this from **Recording Information**. The latter will involve writing without the intention of involving another person in the treatment of the patient, whereas referral involves such intention.

Examples:

1. Interview 70, floorholding 2

Pt "Well, if you remember I came to see you a couple of months ago about this eye inflation and you sent me up to see Dr. Dunson".

2. Interview 13, floorholding 39

Dr "Do you have any preference to who you would like to see, or would you prefer to leave it to me ?".

3. Interview 38, floorholding 8

Pt "He sent me for a urine sample over at Broadgreen. We've had the results back and everything was OK".

2.4 INFORMATION PROCESSING.

Definition:

A procedure by which both doctor and patient convey information relevant to the **Agenda** currently under discussion. This procedure is not specific to the doctor- patient interview and will most likely occur in other interview settings. This procedure is divided into specific strategies of information processing which are characterised in the coding system as **Processes** (for definitions see below).

2.5 PHYSICAL EXAMINATION. (PE)

Definition:

This procedure includes any physical contact not included as an **Investigation** (see below for definition of investigations), such as taking the patient's pulse, taking patient's blood pressure.

Behaviours constituting the Physical Examination include:-

Either a) A verbal statement of intent which may or may not be followed by (but typically is so) physical contact between patient and doctor.

Or b) A verbal request made by the patient for the doctor to investigate symptomatic anatomical areas, typically followed by such examination.

The procedure commences either

1. when the doctor makes a verbal statement of intent or request for permission to conduct on the spot physical examinations, followed by such examinations. Or
2. when the patient makes a request for the doctor to conduct an examination as per 1.

The procedure continues throughout the following physical examination unless either party refuses to participate. The procedure ends either

1. when the doctor or patient declines the examination. Or
2. when the doctor ceases physical contact with the patient and removes him/herself to a distance more than an arm's length from the patient.

Exclusion criteria:

a) Physical contact by way of greeting or closure as part of the **Introduction** or **Conclusion**, for example a handshake.

Examples:

1. Interview 43, floorholding 17

Dr "Let me listen to your chest and then we'll decide what to do".

2. Interview 40, floorholding 13

Dr "Let's have a look then".

3. Interview 35, floorholding 3

Dr (looks at hand, without touching) "So what happened ?".

2.6 INVESTIGATION. (INV)

Definition: A procedure in which either party makes reference to investigations. This procedure may occur in conjunction with any of the processes. For example the doctor may give information about an investigation, or may prescribe (order) an investigation. An investigation we define as either a) Any analysis of the patient's body fluids carried out by the doctor present. Or b) Any physical, psychiatric or psychological assessment carried out by persons other than the doctor present.

Exclusion criteria:

a) **Investigation** is differentiated from **Physical Examination** in that the latter involves the doctor in physical contact with the patient, whereas **Investigation** involves the analysis of bodily fluids.

Examples:

1. Interview 44, floorholding 27

Pt "I go to see the specialist at the beginning of next week, Mr Williams. I think he took X-rays".

2. Interview 30, floorholding 15

Dr "And have you had a positive test ?".

3. Interview 2, floorholding 61

Dr "Would it be worthwhile sending a specimen off to the laboratory just to see if there's anything there ?".

2.7 CONCLUSION. (C)

Definition: A procedure in which a party terminates the problem solving procedure and hence the interview, through verbal and non-verbal behaviours. A set of gestures and verbal behaviours performed either by doctor or patient upon each other by way of closure and parting, and commencing in the final stages of the interview.

The behavioural clusters involved may include

shaking hands

saying "Goodbye"

saying "Thank-you"

Conclusion commences when any verbal statement or gesture of closure is made by either party. The conclusion ends when the patient leaves the room.

Exclusion criteria :

a) Any gestures which may be common to both **Introduction** procedure and **Conclusion**, which occur at the outset of the interview.

b) The patient leaving the room for any other reason that Conclusion, such as taking a urine sample, to be ill etc.

c) **Conclusion** and **Introduction** procedures cannot co-occur within an individual at the same time.

Examples:

1. Interview 10, floorholding 66

Pt "Thanks Doctor". (Stands and picks up handbag).

2. Interview 8, floorholding 74

Pt "Right, teaching them how to handle things". (Stands and adjusts clothing).

3. Interview 51, floorholding 46

Pt (standing at door, with hand on door handle, turns to Dr)

"Am I OK to carry on driving ?".

3. PROCESSES.

Definition: A series of behaviours performed by either party which have in common the aim of fulfilling a specific purpose. The processes are concerned with the processing of information within the interview. As such they are common to all interview situations and not specific to the doctor-patient consultation. Processes are subcategories of action, that is, they refer to types of behaviour adopted within procedures. The point at which a process commences and ends will vary according to the process in question (for specific demarcation criteria see the definitions given). However, each process will be in effect for at least the duration of the floorholding in which it takes place, hence, processes operate throughout a floorholding. Both parties may operate more than one process at the same time. When one floorholding moves through two or more processes, the processes are said to be parallel. Six processes are distinguished:

a) Seeking Information (which may include consulting notes).

b) Recording Information.

c) Giving Information.

d) Discussing Information.

e) Accepting Information (which may include active listening).

f) Prescribing (Doing).

Exclusion criteria:

a) Process is distinguished from **Agenda** in that the latter refers to the topic addressed within the interview, whereas the process refers to a set of behaviours directed at the processing of information regarding that agenda.

b) Process is differentiated from **Procedure** since process reflects the handling of information within the interview, whereas **Procedure** refers to types of action available in addressing the **Agenda**.

3.1 SEEKING INFORMATION. (SI)

Definition: A process in which either party requests information from the other regarding an agenda or agendas which may be either one previously mentioned or a new agenda. Such behaviours may include verbal and non-verbal requests. This procedure may occur in conjunction with any of the **Procedures**. This process commences with the onset of the verbal or non-verbal statement of request for information within a floorholding, and ends with the same floorholding. Seeking Information may include consulting notes, where the doctor is observed (through eye contact or handling of notes) to be making reference to the notes. It includes those actions performed by the doctor characterised by the handling of the patient's notes and orientation of gaze towards notes. 'Notes' may also refer to non-paper records such as computerised patient information systems.

Examples:

1. Interview 32, floorholding 5

Dr "So were you sort of twisting awkwardly ?".

2. Interview 30, floorholding 9

Dr "When was your last period ?".

3. Interview 11, floorholding 54

Pt "Do you want me to ask the receptionist for a bottle ?".

3.2 RECORDING INFORMATION. (RI)

Definition:

An information processing action in which the doctor or patient is seen to be making a record of details acquired in the interview. It consists of a behavioural complex in which the doctor or patient records data. For example, writing notes, or entering information into a computer via a keyboard. Recording Information commences with the first action indicative of the process and ceases with the end of the floorholding.

Examples:

1. Interview 75, floorholding 2

While patient is talking Doctor is oriented towards the desk, holding a pen and writing in the notes.

2. Interview 41/42, floorholding 48

Dr "Just let me make a note about Neil and then we'll get on with it, Right ?" (doctor writes in notes).

3. Interview 73, floorholding 3

Dr "How long have you had the sore throat for ?" (At the same time writes in notes, gaze directed towards notes).

3.3 GIVING INFORMATION. (GI)

Definition:

In this process either party, through verbal or non- verbal behaviour, provides information regarding an agenda or procedure under discussion, or a new agenda/procedure not previously raised. Examples of non-verbal actions would include nodding, showing the other party some written information etc. Giving Information commences with the verbal or non-verbal statement which provides information within a floorholding, and ends with the end of the same floorholding. Giving Information implies the transfer, or attempted transfer, of information between the parties in the consultation.

Examples:

1. Interview 15, floorholding 3

Pt "He showed me the X-rays and he said something like diverticulitis isn't bad, it's a little blockage in, just about here, in what is it the colon ?".

2. Interview 13, floorholding 22

Pt "Well what I'm worried about is these blotches that come up, they become raised at the end of the day".

3. Interview 21, floorholding 15

Doctor draws a diagram to explain to patient what a stretched aorta looks like.

3.4 DISCUSSING INFORMATION. (DI)

Definition:

Verbal statements by either party in which reference is made to procedures or agendas. Discussing information involves elements of both **Seeking Information** and **Giving Information** within a single statement. Additionally this procedure may incorporate an element of proposing alternative procedures, evaluating differing options for action (procedures), or linking agendas not previously linked by the other party.

Exclusion criteria:

a) **Discussing Information** is distinguished from both **Seeking Information** and **Giving Information** both of which it is related to, since **Discussing Information** incorporates both within the same statement.

Examples:

1. Interview 49, floorholding 31

Dr "I mean presumably you want to be pregnant, so there's no big problem with it. I would say at this stage it's probably not necessary to do a water test. If you, for example, were wanting to have a termination then I think we would do a water test, but I think that if you want to be pregnant it's probably too early to do one for a start because if it came back negative it would probably not mean that you were pregnant. It would mean it was a wee bit too early, so our usual advice to you would be if you miss two periods then come back".

2. Interview 57, floorholding 15

Dr "Do you think it might be frustration causing that ?".

3. Interview 60, floorholding 15

Dr "Well if it's bad and its necessary that's fine. But it's a drug that's, its a very effective drug but it's difficult with wee ones and unless we're having great problems I would, you know, prefer not to use it. Is that how you feel about it yourself ?".

3.5 ACCEPTING INFORMATION. (AI)

Definition: A process in which either party, by means of verbal or non-verbal behaviour, displays an acceptance of information relating to a procedure or agenda. This process may include active listening - where one party is engaged in ongoing verbal behaviour (a floorholding) and the other makes a minimal verbal contribution but is observed to demonstrate actions indicative of accepting information. Active listening differs only from accepting information in that the former is assigned if the process occurs during the subjects own floorholding, active listening is coded if it occurs during the other party's floorholding. The process commences with the start of the verbal or non-verbal statement of acceptance within a floorholding, and ends with the cessation of the same floorholding.

Examples:

1. Interview 37, floorholding 4

Patient is talking, Doctor is directing gaze to Patient nods and says "Mm". (Active Listening).

2. Interview 14, floorholding 5

Dr "Right". (Accepting information from previous floorholding).

3. Interview 11, floorholding 37

Dr "Yes, difficult isn't it ?".

3.6 PRESCRIBING (DOING). (P)

Definition:

In the prescribing process, either party engages in verbal or non-verbal behaviour which performs actions within the procedure to which it refers. For example, the Doctor may prescribe **Treatment**, perform a **Physical Examination** and so on. The process commences with the onset of the verbal or non-verbal behaviour indicative of prescribing or doing. The process ends with the cessation of such actions or the end of the last floorholding within which the behaviour occurs.

Examples:

1. Interview 4, floorholding 47

Dr "Do you need some more of your tablets ?".

2. Interview 51/52, floorholding 41

Dr "So, I really think that *going away on holiday is going to be the best treatment for your* tension".

3. Interview 24, floorholding 37

Doctor 'phones receptionist to ask for vaccine "Could I have some polio vaccine please".

APPENDIX E: RULES FOR CODING AGENDAS, PROCEDURES AND PROCESSES.

1. The interviews will be coded both from audio tape and video transcript.
2. Coding will initially be carried out on verbal behaviour, but may be modified by non-verbal behaviour (paralinguistic or kinesic).
3. Each interview will be timed from 0 seconds.
4. Scoresheets will be used to code all interviews.
5. Where a third party is present in an interview, all persons will be coded separately. This will be done simply by adding a third column to the scoresheet.
6. Each party in an interview will be coded separately to avoid the possibility of introducing bias which may occur if parties were coded together.
7. Agendas, procedures and processes for all parties will be coded for each party within all floorholdings, according to the operational definitions outlined in the Rulebook.
8. The coding of agendas, procedures and processes will not be done with medical insight. Coding will assume a naive posture and will be according to surface understanding.
9. Physically related symptoms (for example vomiting, diarrhoea) and anatomically related parts (for example, bladder, kidney) will be coded as discrete physical agendas. However, if such agendas are perceived by the patient to be the broad subject under debate, then we will bracket together the agendas on the scoresheet. If the doctor later makes a diagnosis which includes the symptoms previously related, we will give the diagnosis a separate agenda number, but will bracket together the related agendas on the scoresheet.
10. When one floorholding moves through two or more agendas, the agendas are said to be parallel since an agenda operates throughout a floorholding.
11. When one floorholding moves through two or more procedures, the procedures are said to be parallel, since a procedure operates throughout a floorholding.

12. When a floorholding contains two or more processes, the processes are parallel, since a process operates throughout a floorholding.
13. The duration of a floorholding will be coded in seconds from the beginning of the speaker's speech to the beginning of the next floorholding. Silence is coded as the floorholding of the last person who spoke.
14. Where floorholdings occur in parallel, and there is overlapping speech, these will be coded on the scoresheet as being in parallel.
15. All agendas raised by both doctor and patient will be labelled according to their topics. Thus if the patient's Physical agenda is "warts on the bladder", we will label this "P bladder warts". If the patients' second Physical agenda is the result of a kidney X-ray, we will label this "P kidney X-ray" etc. The same applies to Social agendas, Emotional agendas and Historical Psychological agendas. 16. When a topic has been raised by a party, that topic will carry the same agenda and topic designation whenever it is referred to again by either party.
17. We will assume that a person is on the same agenda unless it is very clear that the agenda has changed. This rule also applies to procedures and processes.
18. A transition is defined as the point when new occurrences or re-occurrences take place, that is where there is a shift in agenda.

APPENDIX F: RULES FOR CODING ACUTE vs. CHRONIC

1. The classification of Acute versus Chronic is made post hoc.
2. The principal presenting agenda for each interview will be classified as Acute or Chronic, according to the operational definitions of Acute and Chronic agendas.
3. The principal presenting agenda is defined as the first agenda (of the physical, emotional or social domains) raised by the patient in the interview.
4. Where the patient makes a verbal statement of an agenda (either Physical or Social) which is accompanied by non-verbal expression of emotion, the presenting problem is taken as that agenda which is expressed verbally.
5. Where a third party is present in the interview, only one presenting problem will be coded. If a second party consults within the same consultation, the presenting problem for that interview will refer only to the presenting problem of the first patient to consult.
6. Chronic problems are defined as agendas of extended duration (over four weeks) which may have been present for a long time. Alternatively they may be agendas of relatively short duration but where the prognosis is of a prolonged duration. Typically, but not necessarily, Chronic problems are of insidious onset. Examples of Chronic problems would be a patient who attends the doctor for a longstanding back problem, or a patient who has recently developed symptoms of rheumatoid arthritis.
7. Acute problems are defined as agendas of short duration where the prognosis is one of rapid recovery or resolution. Where a problem is Chronic in nature but gives rise to a complication or symptom of short duration, then the complication or symptom will be defined as Acute. Acute problems will typically be of definite onset. Examples of Acute problems would be a patient attending for an influenza vaccination, or a patient with longstanding asthma who has suffered a severe attack.

APPENDIX G: RULES FOR CODING PROBLEM SOLVING

HANDLING FEELINGS

a) Exploration of Feelings:

1. Clarification and/or identification of the nature of the feeling(s) e.g. whether anxiety and/or depression and/or anger.

2. Investigation of associated events e.g. whether losses or relationship problems.

3. Elicitation of behaviour associated with feelings e.g. crying or sleep disturbances (this includes associated symptomatology).

4. Examination of the impact on function in so far as this is not covered in (3). E.g. impact on work and relationships.

5. Exploration of earlier relevant events, e.g. losses, adverse relationships and traumatic events.

6. Exploration of differently toned feelings, e.g. enjoyment or relaxation.

b) Facilitation of ventilation of feelings.

1. Acknowledgement of feelings.

2. Giving space for feelings of expression, e.g.sitting quietly and letting the patient cry.

3. Giving permission to express feelings, e.g. saying it's OK to cry.

4. Sympathetic statements.

5. Empathic statements.

6. Non-verbal encouragements.

c) Limitation of the expression of feelings.

1. Ignoring or not responding to the expression of feelings.

2. Reassurance about the basis of the feelings, e.g. saying everything will turn out alright.

3. Diminishing the significance of events contributing to the feelings.

4. Criticising the feelings e.g. "You don't want to let yourself get upset by ...".

5. Diminishing the severity and/or the extent of the feelings, e.g. "You are not feeling that bad".

6. Relabelling the feeling so as to diminish the implied severity.

d) Direct approaches to handling feelings and their expression.

i) Cognitive

1. Controlling, e.g. count to 10.

2. Mental distraction (this is a form of control).

3. Modifying how the feelings are perceived, e.g. establishing that they fluctuate. 4. Feedback, indicating that the feelings are appropriate to the events. This includes reassuring about the feelings being appropriate to the events.

5. Predicting future feelings. This like (4) is a method of modifying the way in which the feelings are perceived.

6. Self disclosure by the doctor that they experience comparable feelings. This is also a sub-set of (3) above - modifying the perception of feelings.

ii) Behavioural

1. Controlling the expression of feelings, e.g. going out of the room or time limiting, hand washing.

2. Directing the expression of feelings, e.g. walking around the block or kicking a football.

3. Setting up incentives for graded exposure to precipitants of feelings.

4. Avoidance of precipitants of feelings.

5. Confrontation with the precipitants of feeling.

6. Implementation of relaxation techniques including teaching and giving tapes.

iii) Interpretation

1. Identifying the patients feelings by statements when the patient has not yet identified themselves.

2. Making links between feelings and current events or relationships in a manner the

patient has not previously made.

3. Making links between feelings and past events or relationships in a manner in which the patient has not previously done.

iv) Prescribing drugs.

v) Identification of the feelings as the manifestation of a medical condition.

e) The use of social networks or relationships.

1. Exploration of the opportunities for support.

2. Encouragement to use such support.

3. Referral to professionals for support.

f) Problem solving with respect to the precipitants and/or associated factors (this like all others is not mutually exclusive).

i. Encouraging the patient to problem solve.

1. Exploration of feelings in order to identify them etc.

2. Exploration of options for action.

3. Proposed selection of an option.

4. Checking whether an option previously chosen has been employed.

5. Examination of the possible consequences of taking an option.

N.B. It would be necessary to distinguish the extent to which the doctor prescribes options or leaves choice open to the patient.

ii. Direct action on the problem, e.g. proposing a joint interview with a patient's partner, or writing to housing or social services, or referring the patient's child. Again it would be important to distinguish whether or not such action is taken and the manner in which it is done, e.g. the extent to which the patient is involved in decision making about whether this course of action is undertaken.

g) Advice without problem solving involving the patient.

1. Prescription of rest without linking it rationally to the emotional state.

2. Prescription of change of circumstances, e.g. going on holiday without linkingrationally to the emotional state or circumstances.

HANDLING SOCIAL INFORMATION

a) Exploration of Social agendas.

1. Discovering impact of problem on social circumstances.

2. Discovering impact of social circumstances on problem.

3. Discovering nature of social problem.

4. "Concretising" Social agenda.

b) Facilitation or limitation of expression of Social agenda.

1. Accepting, acknowledging.

2. Not accepting, not acknowledging.

3. Redefining Social agenda as Physical.

4. Redefining Social agenda as Emotional.

c) Analysing Social problems.

1. Hypothesising about problem.

2. Fragmenting into sub-agendas.

3. Listing options of action.

d) Problem solving.

1. Describing resources.

2. Prescribing drugs.

3. Referral of patient to other agency.

4. Communicating with (or offering to communicate with) relevant other (e.g. employer, authorities, medical certificate).

5. Giving advice without problem-solving involving patient.

6. Facilitating problem solving by patient:

i) Suggesting options

ii) Inviting choices.

iii) Confronting.

iv) Examining possible consequences of action.

In order to be more manageable, the above taxonomy was rationalised. The categorisation below forms the basis for analysing the 70 consultations in terms of doctor and patient problem solving behaviours. Although the initial taxonomy reflected ways in which the doctor may be likely to handle emotional and social information presented by the patient, the final categorisation represents problem solving behaviours available to either party. The categories identified in the taxonomy were simplified into a coding system as follows:

1. Facilitation of expression of the agenda.

1.1 Acknowledgement of the problem.

1.2 Showing sympathy/empathy.

1.3 Giving explicit space/permission to express the agenda.

2. Limitation of the expression of the agenda.

2.1 Ignore agenda.

2.2 Diminish the value of events/feelings.

2.3 Relabel the agenda.

2.4 Give reassurance

2.5 Criticise the agenda.

3. Problem solving.

3.1 Identification and exploration of:

a) Problem (including breaking down the problem into subagendas).

b) Associated events.

c) Associated earlier events.

3.2 Identification of options for action.

3.3 Selection of option.

3.4 Examining possible consequences of action.

3.5 Monitoring the outcome of previously selected options.

3.6 Identify or communicate with others.

4.1 Cognitive strategies.

4.2 Behavioural strategies.

4.3 Offering interpretation/hypotheses.

4.4 Prescribing drugs.

4.5 Describing resources.

4.6 Referral to other agencies.

C. RULES FOR CODING

Facilitation of Expression of the Agenda.

1.1 Acknowledging problem.

Any verbal statement of acceptance of the problem raised previously by the other party, indicating that the party has noted the other's concerns. Indication that the agenda is a valid topic of concern for the interview.

a) Contrasted with (1.3) Giving space/permission to express the agenda, since Acknowledgement of the problem does not incorporate any element of encouraging the other to speak immediately following (though it may encourage the other to speak).

1.2 Showing sympathy/empathy.

Verbal statements which specifically acknowledge theimpact of the Social or Emotional agenda under discussion.

1.3 Giving explicit space/permission to express an agenda.

Verbal statements that the other party can and should now discuss an agenda. These may include questions or statements inviting the other to speak. The verbal statements may be accompanied by non-verbal behaviour associated with listening. For example a change in posture; sitting forward, bringing the persons closer; sitting back in the chair; putting down notes, instruments etc. on the desk; not speaking.

a) Contrasted with (1.1) Acknowledgement of the problem, since Acknowledgement of the problem does not incorporate any element of encouraging the other to speak in the immediately following floorholding.

Limitation of the expression of the agenda.

2.1 Ignoring agenda.

Adoption of any agenda other than the Emotional or Social agenda which was previously the concern of the other party. No reference being made to the Emotional or Social Agenda.

2.2 Diminishing the value of events/feelings.

Verbal statements which either diminish the significance of events relating to the Emotional or Social agenda of concern, or diminish the severity and/or extent of the feelings associated with such agendas. That is, statements that the events or feelings are not of sufficient significance to be further consideredSimilarly, non-verbal behaviours may accompany such verbal statements. a) Distinguished from 2.5 Criticising the agenda, since the latter involves the implication that the agenda should never have been raised, whereas Diminishing the value of events/feelings implies that the agenda was valid but need not be further considered.

2.3 Relabelling the agenda.

Verbal statements which attempt to change the nature or severity of the agenda in such a way that the implied severity of the agenda is diminished. 2.4 Criticising the agenda.

Verbal statements that the agenda is not of a severity or a nature which makes it a suitable topic for the Doctor-Patient consultation, together with the implicit or explicit implication that the other party should not be discussing the agenda.

a) Distinguished from 2.1 Ignoring the agenda, since Diminishing the value of events/feelings implies that the agenda was valid but need not be further considered.

Problem Solving.

Categories 3.1 to 3.6 refer to the problem solving strategies outlined by the McMaster model of problem-solving (Epstein et al, 1978).

3.1 Identifying and Exploring

a) problem.

b) associated events.

c) associated earlier events.

Verbal statements identifying and discussing information describing the problem, associated events, or associated earlier events. These include attempts to break down the problem into smaller parts.

3.2 Identifying options for action.

Verbal statements which identify specific options of action with the focus of solving the Emotional or Social agenda previously identified.

a) Identifying options for action is differentiated from 3.1 Identifying and exploring by the focus on possible solutions to the problem, rather than the nature of the problem itself.

b) Differentiated from 4.1 Cognitive strategies, since the latter involves description of specific techniques, whereas identifying options for action involves only the identification of options.

c) Differentiated from 4.2 Behavioural strategies, since the latter involves description of specific techniques, whereas identifying options for action involves only the identification of options.

3.3 Selecting an option.

Verbal statements which specifically accepts or prescribes (depending on the party) one option of action.

3.4 Examining possible consequences.

Verbal statements exploring the possible consequences of various options for action identified by either party.

3.5 Monitoring of previous options.

Verbal statements which either seek to ascertain whether a problem-solving option previously identified has been employed, or to ascertain the effectiveness or otherwise of previous attempts at problem-solving (of any nature, such as behavioural, cognitive, pharmacological etc.)

3.6 Identifying or communicating with others.

Verbal statements which identify others who may be of assistance with, or implicated in the agenda, or the problem-solving process. The identification of, and exploration of the opportunities for support from social networks or relationships. For example family members, work associates etc. That is, the identification of persons other than those present in the interview, on whom the Emotional or Social agenda has impact, or the identification of non-professional persons other than those present in the interview who may be of assistance in the problem-solving process. Does not include referral to other agencies and describing resources available to either party, since these are covered in other categories (4.5 and 4.6). a) Differentiated from 4.6 Referral to other agencies by the nature of the party to whom the communication will be addressed, non-professionals versus professionals. b) Identifying or communicating with others is differentiated from 4.5 Describing resources, since the latter does not involve identifying individuals, but instead bodies, grants etc. which may be of assistance.

4.1 Cognitive strategies.

Verbal statements describing specific cognitive strategies which may be adopted in order to address the Emotional or Social agenda in question. These may include:

i) Controlling, for example counting to 10.

ii) Mental distraction and reassurance, trying to think of pleasant things when approaching a feared object.

iii) Modifying the perception of the problem, such as establishing that the severity of the agenda fluctuates.

iv) Providing feedback, such as indicating that the feelings are appropriate to the event.

v) Predicting the future impact of the agenda.

vi) Self-disclosure by the Doctor that she/he experiences similar problems.

4.2 Behavioural strategies.

Verbal statements describing specific behavioural strategies which may be adopted in order to address the Emotional or Social agenda in question. These may include:

i) Controlling the expression of agenda, e.g. leaving room.

ii) Directing the expression of the agenda into other activities.

iii) Setting up incentives for graded exposure to the precipitants of feelings (for Emotional agendas).

iv) Avoidance of the precipitants of the agenda.

v) Exposure to the precipitants of feelings.

vi) Implementation of relaxation techniques (including provisions of teaching, audio tapes etc.)

4.3 Offering interpretation/hypotheses.

Verbal statements identifying the patient's agenda in Emotional or Social terms when the patient has not previously identified that agenda in such terms. Making links between the agenda and current or past events or relationships, in a manner in which the patient previously has not done.

a) Offering interpretation is distinguished from 3.1 Identifying and exploring the problem, associated events or associated earlier events, since the emphasis in the former is placed upon identifying the agenda in terms which are new to either party.

4.4 Prescribing drugs.

Verbal statements, accompanied by non-verbal behaviour such as writing, in which the doctor prescribes or states an intention to prescribe medication for the problem. Alternatively a request from the patient that the doctor prescribe medication for the problem.

4.5 Describing resources.

Verbal statements describing resources available or sources of assistance for the agenda identified. Such sources of assistance include statutory bodies, grants, libraries etc.

a) Differentiated from 3.6 Identifying or communicating with others since the former involves identifying individuals within the social network, as opposed to statutory bodies etc.

b) Describing resources is differentiated from 4.6 Referral to other agencies, since the latter involves the doctor in making referral to a specific form of assistance e.g. an hospital consultant, as opposed to simply describing assistance which is available.

4.6 Referral to other agencies.

Verbal statements, which may be accompanied by non- verbal behaviours such as making telephone calls, writing letters etc., in which the doctor refers the patient to specialist sources of assistance, or the patient requests referral to such agencies.

a) Referral to other agencies is differentiated from 4.5 Describing resources, since it involves the doctor in making referral to a specific form of assistance e.g. an hospital consultant, as opposed to simply describing assistance which is available.

b) Usually it is only the Doctor who will make direct Referral to other agencies, but the patient may request referral and this will be classified as 4.6 Referral to other agencies.

Locus of Autonomy.

This variable seeks to describe the extent to which either patient or doctor has autonomy within the choice of strategy adopted. The variable takes two values - doctor or patient.

Doctor-Locus - this includes those situations in which the doctor prescribes options for the patient without offering the patient either the option to follow or not follow the prescribed course, or to choose between various options. Alternatively doctor-locus refers to situations where the patient makes explicit statements asking the doctor to make such choices on the patient's behalf.

Patient-Locus - this refers to the situation where the doctor offers the patient options for action, and where the patient expresses the intention of deciding between options himself. Locus of autonomy is not coded when the problem solving strategy has a primary code of 2. These are strategies for limiting the expression of an agenda and therefore do not invite autonomy of strategy use.