Doctor and new patient communication:
the influence of *a priori* assumptions

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June 2015

Abstract

Background

Doctor-patient communication is fundamental to the therapeutic relationship necessary to achieve mutual understanding of the implications and impact of illness, diagnostic and treatment decisions, and health outcomes. It is recognised that both patient *and* doctor come with their own perspectives, beliefs and agendas. This quasi-ethnographic study explores the influence of the doctor's own *a priori* assumptions on their communication with a new patient.

Methods

Cognitive interviewing was used prior to consultations to explore the doctor's thoughts triggered by the referral information. The relevant subsequent consultations were audio recorded, as were loosely structured interviews after the consultation, during which the doctor reflected on what had been said and why. All data was subjected to qualitative thematic analysis.

Conclusion

The source, content and format of referrals are significant and doctors approach the information about the patient with their own perspectives, beliefs and experiences. The existence of assumptions and stereotypes appear to be triggered when processing the information. Doctors begin to develop the communication with the patient, based on their expectations of themselves and of the patient, before the patient is seen. During the consultation, some *a priori* assumptions were observed to be significant. *A priori* assumptions are influential to the communication with the patient and can result in communication not anticipated by the clinician. The relationship achieved with the patient during the consultation can be understood in the context of the concepts of *recognition* and *presence*.

Key words: doctor-patient communication; new patient; stereotype; assumptions; recognition; presence.

Dedication

This thesis is dedicated to the most important people in my world.

My husband Steve for his love, laughter, belief and support over many years and through many, many ups and downs. My son Dan and my lovely daughter-in-law Mieko and my beautiful grand-daughters Hibiki and Hikali. My son Tom and his lovely partner Sophie.

Together they made it possible for me to succeed.

Acknowledgements

Firstly, I would like to thank my supervisors, Professor Peter Phillimore and Doctor Alison Steven. Your support, guidance, encouragement and good humour have helped me through the periods of doubt and crisis of confidence.

Thank you to Professor Janice McLaughlin for her valuable advice and support during the difficult final stages of my PhD journey.

Thank you to Dr Roger Searle, Head of School of Medical Sciences Education Development, and his predecessor Professor Geoff Hammond, for their support, without which I would not have been able to undertake such a challenge.

Thanks also to the many friends and colleagues for their help, advice and support, with a special 'thank you' to Sarah Rylance and to Professor John Spencer for his ongoing encouragement and support.

A very special 'thank you' also to Sue Vecsey for her friendship and invaluable help with the presentation of my thesis. I really could not have managed without her.

I would like to thank the participants of my study who gave their time so willingly and with such enthusiasm. Last, but certainly not least, I would like to thank the medical secretaries who, despite their own very busy jobs, found the time to set me on the right track.

Thank you.

When our efforts have been crowned with such great successes as they have in the past century, why be concerned if someone questions our assumptions? Indeed, we often behave as if they are not assumptions, but simply the way things are. (McWhinney, 2001:331-350)

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Chapter 1. Introduction and Background

Introduction

This qualitative, quasi-ethnographic study uses inductive reasoning to explore the influence of a doctor's own *a priori* assumptions and expectations on their communication with a new patient. It focuses on the perspectives, reflections and interpretations of the consultants regarding their communication: before, during and after the consultation.

This chapter describes the background and context of the study. It summarises the development of the research and explains the organisation of the thesis.

Background

Research indicates that doctors make judgements about patients based on their demographic characteristics. A relationship was identified between the patient's social class and the quality and quantity of the information provided by the doctor, with patients of a higher social class receiving more communication and also more information (Willems *et al.*, 2005). Studies have also examined influences on communication related to specific illnesses or symptoms (Aitken and Mardegan, 2000) and specific contexts such as primary care (Beck *et al.*, 2002). Their findings identified that gender and age were also influential on communication.

It is recognised that both patient *and* doctor come with their own perspectives, beliefs and agendas, and communication between a doctor and patient is fundamental to diagnostic and treatment decisions and the outcomes of consultations (Hawken, 2005). Communication is also a key factor in the patient's understanding about, and self-management of, their conditions and their concordance to treatment plans (Epstein *et al.*, 2005). It is also known that effective communication within the consultation leads to better health outcomes for the patient (Beck *et al.*, 2002).

In this study, the consultants had different views regarding the significance of the patient's gender on their communication. However, several studies explore the influence of gender on communication, either that of the doctor's or both

the doctor's and the patient's (Roter *et al.*, 1991; Hall *et al.*, 1994; Bertakis *et al.*, 1995; Hall and Roter, 1998; Elderkin–Thompson and Waitzkin, 1999; Roter and Hall, 2004). Sandhu *et al* (2009) offer a systematic review of the literature on the impact of gender dyads on doctor-patient communication. They concluded that doctor/patient gender dyads (male/male; male/female; female/male and female/female) made a difference in several aspects of the consultation with implications for the effectiveness of the communication during the consultation, and the consultation outcomes.

Other authors focused on communication adaptations by the doctor in response to the patient's action e.g. the doctor discusses the topic raised when a patient utters concerns about their illness or treatment (Street Jr, 1991; 2001) or asks questions or offers opinions (Greenfield *et al.*, 1985; Street Jr, 1991; 1992; Street Jr and Millay, 2001).

The focuses of the above papers and studies were to *retrospectively* explore thematic influencing factors on the communication whilst the patient was in the room.

Context and Setting

In order to explore the influence of *a priori* assumptions on doctor-patient communication, this study tracks the relationship and communication from *before* doctor and patient meet i.e. from the receipt of the referral information through to post-consultation reflections on their communication by the doctor. The decision to focus on communication with *new* patients was made because the information about the patient was limited to the referral information and the doctor's responses to it. It enabled the exploration of the doctor's potential *a priori* assumptions *triggered* by the referral information, whilst excluding any assumptions or opinions about the patient from a previous encounter. Also, communication between doctor and new patient had not been established during previous consultations.

The fieldwork took place in meeting rooms, offices and outpatient clinics of an NHS Hospital Trust in the UK. The participants were 8 consultants, six males and two females, all from the same specialty.

Origins of the study: personal viewpoint and professional context

Personal viewpoint

I began nursing in 1973 as a psychiatric nurse. I chose that field of nursing because of experiencing mental illness within my family, but also because of an interest in inter-personal communication with individuals who had communication challenges. I qualified in other nursing specialties including palliative care and as a Macmillan Clinical Nurse Specialist in Palliative Care, designed and delivered communication skills training to medical and non-medical staff. My current role is in medical education, specifically in teaching communication skills to undergraduate and postgraduate doctors and allied health professionals.

Whilst working in clinical practice, I was interested how staff referred to patients. Frequently, and without staff checking if the patient was happy with this familiarity, elderly patients were often called by their first name or referred to as 'gran' or 'pops' (for example). Younger patients were invariably addressed by their first name, or a nick-name created by the staff. Nurses rarely called patients with a profession by their first name, instead calling them Mr, Mrs, Miss etc. I speculated what prompted staff to do this: the age of the patient; the age of the nurse; the social status of the patient; social influences on the nurse? At ward handover (the passing of information from one shift to another) patients were described in judgemental phrases such as *'you'll love ... she's a lovely little old lady'* or *'good luck with ... he's a typical miserable old man'*. On hearing these descriptions, I anticipated what the patient may be like and was aware of preparing myself for meeting them. I became interested not only in the impact on myself and other staff of the 'labelling' and stereotyping of patients, but specifically what prompted nurses to make these judgements and whether they influenced their interactions with the patient. In a recent study exploring stigma during ward handovers, Doyle and Cruikshank (2012) found that attitudes and values can be passed on from one nurse to another and that stigma and stereotype can also be transferred to other staff by the person giving the handover.

Troubling situations regarding the communication of doctors concerned me throughout my professional career, one being particularly memorable. A consultant refused to believe a young male patient, admitted after a road accident, about his level of pain. The consultant expressed the opinion the patient was 'soft' and 'making a meal of it', insisting he was discharged from hospital. What was it about the patient that led the consultant to have such a negative attitude towards him? I later learned that because the young man had long hair, the consultant apparently extrapolated from that that the young man was homosexual and therefore 'soft' and not to be believed.

Professional context

The General Medical Council has stressed the need for good communication (1993a; 1998; 2001; 2009). However, a report from the Royal College of Physicians (1997) stated 'poor communication between professional staff has been identified as an underlying factor for failed communication with patients'. Following publication of 'Tomorrow's Doctors' (General Medical Council 1993a) communication skills teaching became an integral part of undergraduate medical education and the British Medical Association emphasised the importance of good communication skills, stating they 'are central elements in demonstrating appropriate attitudes and professional development' (British Medical Association, 2003). The in–patients' survey by The Healthcare Commission revealed that although the results were broadly positive, key areas such as provision of information to patients and communication with health professionals showed little improvement (Healthcare Commission, 2006). In 2011-2012 there were 150,859 complaints received by the NHS (Parliamentary and Health Service Ombudsman, 2012).

Health care professional bodies consider good interpersonal communication an essential attribute. Courses, books, videos, on-line training materials and other options abound, all focussing on health care communication and yet examples of problematic and poor communication between health professionals and patients are commonplace (Parliamentary and Health Service Ombudsman, 2012; Crawford, 2013; Health and Social Care Information Centre, 2013).

Wanting to encourage health professionals to explore *their own* potential influence on communication situations, I have used an exercise during communication skills teaching with both undergraduate and post graduate medics has been used. A professional roleplayer stands without speaking in front of a group who are asked to complete a list of statements based only on what they see (Appendix A). The participants are then asked to explore how their assumptions might influence their communication if the individual was a patient. To illustrate how the appearance of one roleplayer resulted in totally different assumptions, he has, depending on his dress, been described as a 'Sun-reading member of the BNP of low/average intelligence and unlikely to be interested in medical information' (he was dressed in casual clothing including work boots and carrying a copy of the Sun newspaper) to 'a university lecturer, of higher than average intelligence, likely to be well informed and wanting to be given clear, factual medical information' (he was wearing a suit and carrying a copy of the Guardian).

Some health professionals find this exercise difficult. One group of senior health professionals was very resistant to the idea they would make assumptions about any patient, insisting they never stereotype, never make judgements. A participant stated he was 'programmed' not to do so and 'always treated everybody the same'.

Development of the Research Idea

The following anecdotal evidence from medical students illustrates assumptions about, and stereotyping of, patients exist in clinical practice:

> *'Believe it or not, we are frequently being told by consultants across virtually all of the specialities how to catch out the 'lying' patient in clinical examinations ... we're being encouraged to be suspicious and mistrusting of patients'*

> *'An anaesthetist told us to bear in mind when taking histories that we were in the top such and such per cent of the population and that we'd undoubtedly be more intelligent than all of our patients'*

> *'A consultant said he calls all fat patients 'big' because they never accept they are obese and fat'...*

My curiosity grew about the 'gap' between theoretical communication, i.e. what the doctor anticipated saying or was expected to say, and the actual communication (good or bad) between a doctor and a patient. The research question, aim and objectives gradually emerged from this starting point (Table 1).

Research Title
Doctor and new patient communication: the influence of *a priori* assumptions
Research Aims
To expand our understanding of doctor–patient communication by focusing on *actual* information provided, together with information *created* by the doctor, before a first consultation.
To draw out the implicit assumptions, including social and clinical assumptions which doctors bring to the initial consultation with a new patient.
To study the significance to the receiving doctor of referral information regarding a new patient and how the information influences subsequent communication between the doctor and the new patient.
To assess whether the source of the information and not just the information itself also influences the subsequent communication.
Research Questions
How and when do doctors decide what to say, and what not to say, when consulting with a new patient?
How is the influence of *created* information or *actual* information about the patient evident in the actual communication?
What other factors, such as the doctors own *assumptions* and preconceptions influence their communication?
How readily do doctors adapt their communication when the initial consultation leads them to rethink their prior assumptions?

TABLE 1 OVERALL RESEARCH PLAN

a priori assumptions

This section explains the generic meaning of the concept '*a priori* assumption' and its meaning within the context of this study. *A priori* is used in a philosophical sense to describe the prior assumptions upon which an argument or conclusions rests. It is denoting reasoning or knowledge which proceeds from theoretical deduction, rather than from empirical observation or experience, and is accepted as true or certain to happen without the need to prove or

substantiate it. *A priori* assumptions are not just about people, but can be about incidents, situations or events.

a priori assumptions in the context of this study

A priori assumptions are those made by a doctor about themselves, a patient or patients – which emerged during all stages of the study. In this thesis the 'referral information' or 'information' refers to the actual written words in the referral letter. However, the doctor's *a priori* assumptions were not limited to the written words of the referral letter. During their mental processing of the information, the referral letter acted as a *trigger* from which the doctor extrapolated and embellished - through the thoughts they had, the tangents their thoughts took and the connections they made - that were not actually provided as part of the written words. An example of this could be the assumption that a person from a particular area may ask more questions during the consultation. Through this process the doctors provided themselves with additional material based on *a priori* assumptions as a consequence of pre-existing stereotypes. During the consultation, the doctor may or may not act on such *a priori* assumptions, or may act on additional assumptions not previously expressed.

Research Design and Methodology

A qualitative, quasi-ethnographic approach using deductive reasoning was adopted. The final design is covered in more detail in Chapter 3: Part 2 but briefly, the study took a staged approach (Table 2):

Stage One - Anticipated Communication
Doctors underwent a cognitive or think–aloud interview, as they processed referral information about a new patient. They were asked to talk out-loud their thoughts – specifically focusing on their communication with the patient to be seen. They also responded to loosely structured questions. This stage was audio recorded
Stage Two - Actual Communication
The subsequent consultations with the relevant patients from the previous stage were observed. This stage was audio recorded.
Stage Three - Reflections on Communication
The consultants reflected on their communication with the patient, e.g. what was or wasn't said; why were things said or omitted and how they felt the overall communication with the patient went in practice compared with their anticipations. This stage was also audio recorded.

TABLE 2: DESIGN STAGED APPROACH

Key Concepts and Conceptual influences

This study draws on three main bodies of writing: on the doctor-patient relationship, on stereotype, and on recognition and presence. Crucial to the overall framing of the study is Goffman's work on the *self*, the presentation of self, and the negotiation of social identities in interaction. His insights into stereotyping sit within his broader account of social identity and its everyday reproduction (Goffman, 1959; 1963b; 1963a; 1967). Bourdieu's (1977; 1979) and Robbins' (2008) trio of concepts, *field, capital* and *habitus*, link well with Goffman's (1963b) insights and have also been theoretically influential on this study. Bourdieu developed a more abstract depiction of the arenas in which social interaction takes place, with his concept of habitus providing a lens on processes which earlier generations of sociologists had approached through the notion of socialisation. Bourdieu, moreover, through his conceptualisation of the interplay between different forms of capital, opened the way to a sharper appreciation of class and power relations, with their attendant inequalities, than Goffman was able to provide. Both Goffman and Bourdieu in different ways address the challenge of inter-subjectivity in social interaction, with the communicative potential for mutuality offset by the equal possibility of misconstruing others' feelings or intentions. This attention to communication points towards recent writing on *recognition* (Ricouer, 2005) as well as to the related theme of *presence* (Egan, 1975; 2009). Within the literature on

recognition, much of which has a political focus (Taylor, 1994; Fraser, 1995; Honneth, 2003; Fraser and Bourdieu, 2007; McLaughlin *et al.*, 2011), it is Ricoeur's (2005) more personal focus on the cornerstones of sociality and the needs of the self which strikes a chord in the context of this study. Alongside Egan's writing on presence, this exploration of the implications of seeing – or not seeing – another person informs our understanding of the specific aspect of the doctor-patient encounter which is examined in this thesis. Moreover, this also leads us back to the work of Goffman (1959; 1963b; 1963a; 1967) and Bourdieu (1977; 1979) and Robbins (2008) from whence I started. The following represents the points at which the different conceptual influences played a part in this thesis (Table 3).

	GOFFMAN	BOURDIEU	EGAN	RICOUER
Conception and design				
Data collection Stages 1 - 3				
Data analysis Stages 1 - 3				

TABLE 3: STAGES OF THE STUDY AND CONCEPTUAL INFLUENCES

Alongside these conceptual influences, the thesis adopts a trio of terms; *Ideas, Concerns* and *Expectations* (ICE), which is used in the analytical Calgary-Cambridge Consultation Framework and deployed within clinical training and practice to promote 'patient-centred' consultations (Kurtz and Silverman, 1996; Kurtz *et al.*, 1998; Silverman *et al.*, 1998; Kurtz *et al.*, 2005; Silverman *et al.*, 2008).   In this thesis, the trio of terms making up ICE has been applied in a different context and used as an organising framework or heuristic device, as one of the main devices through which the findings of Stage 1 of this study are organised and presented. This is explained in more detail in Chapter 3: Part 3 Data Analysis (Table 14).

Thesis structure

After this introductory chapter, the structure is as follows:

Chapter 2 – Literature Review

This is organised around the distinction between two main categories of literature which have relevance to different aspects and stages of the study. Whilst acknowledging the quantity and quality of publications on doctor-patient communication in the medical and psychological sciences literature, this chapter contextualises the study primarily from the sociological and anthropological literature. To clarify what literature, theoretical influences and concepts were influential at what stages of the study, this chapter has been divided into two parts:

Part 1: Literature critical to the design and conduct of the study

This section covers the literature relevant to the initial development, design, and conduct of the study. It begins by looking at the key relationship between a doctor and a patient before exploring the academic literature around the referral process. There follows a section exploring the concepts of assumptions and stereotype and their impact. The section ends by identifying the significance of the work on field, capital and habitus (Bourdieu, 1977; Bourdieu and Passeron, 1979; Robbins, 2008).

Part 2: Literature central to the analysis

This section includes literature relevant to theoretical influences or concepts that informed analysis. It begins by exploring the literature focusing on the inter-personal communication and inter-action through the concepts of *recognition* and *presence* - both of which do not often appear in the medical literature although have been central to literature from other health related professions, such as nursing. Together with the conceptual influences identified in part one, recognition and presence provide a valuable perspective and potential for deeper understanding of the complexities of the doctor-patient relationship.

The literature on the use of Ideas, Concerns and Expectations (ICE), or analogous concepts, within the context of teaching and research, are then

explored. The literature predominantly focuses on doctor-patient interaction, but also on non-medical contexts. This literature shows these concepts are contextual and a useful framework with which to understand the individual's experience.

Chapter 3

This chapter is divided into four parts:

Part 1: Epistemology and Methodological Influences

This explains the design through the exploration of social constructionism, qualitative research and quasi-ethnographic influences. The importance of ensuring quality when undertaking qualitative studies, together with how this is achieved and made transparent, is also discussed.

Part 2: Practicalities of the research design and data collection methods

This describes the process undertaken before data collection i.e. designing the study, choosing the specialty and NHS Trust, before moving on to an exploration of the methods used. The stages of the study are described in detail and include explanation of the adaptation of ICE from the Calgary-Cambridge Consultation Framework as an analytical tool for Stage 1. The influence of Bourdieu's work on understanding what the consultants drew on during the process of articulating their thoughts about the patient, and the consultation, is also explained. The section ends by visiting the ways in which rigour and quality of this study were assured.

Part 3: Data analysis

This section captures the complexity of dealing with data from the staged design. It begins by exploring differing theoretical perspectives of analysis – before giving the rationale behind the thematic approach taken. However, the key features of this part of the chapter are the descriptions of analysis of each stage of the study, i.e. cognitive or think-aloud interviewing, observation of clinical consultations, and loosely structured reflective interviews and their relationships with each other. For each of these separate data collection events, the concepts, themes and coding are described. The section concludes with considerations regarding the representation of the data.

Part 4: Reflection on the research process

This final section explores my own positionality during the research process. Significantly, it also looks at the relationship between the 'general' and the 'specific' - particularly in the context of the consultants' dialogue which tended to weave between the two. Looking at assumptions is an intrinsically difficult methodological topic, where the danger of misleading inferences is a very real one. Reflection on and justification of the representation of the data brings the section and chapter to a close.

Chapter 4 – Pre-consultation ideas, concerns and expectations

This chapter and the following two are central to the thesis, presenting thematic analyses of the material collected. They are sequenced and titled to mirror Stages 1, 2 and 3 of the study design. As previously described, early analysis and broad categorization of data was facilitated using a key concept of the Calgary-Cambridge Consultation framework, Ideas, Concerns and Expectations (ICE) as a heuristic device.

Chapter 5 – Communication during the consultation

It presents a series of case-studies from Stage 2 'Actual communication' with examples of the dialogue and the analytical process. The interaction and narrative between the doctor and new patient is captured and retained in large sections for purposes of generalisation and abstract theorising.

Chapter 6 – Post-consultation reflections

This chapter explores the consultants' reflections on how their consultations went and what influenced the communication. Many of the comments made by the consultants indicated that the relationship with the patient underpinned how they felt the consultation had gone, and there are many issues identified as being significant influences on that relationship. Also explored is the consultants' awareness of adapting their communication and what influenced this process.

Chapter 7 – Conclusions

This chapter begins by describing the beginnings of the study, from the premise that little had been written about the prior assumptions (about patients), that

doctors may bring to their consultations and the question as to how this might be investigated empirically. The phenomena of assumptions is then explored, together with the challenges associated with researching this difficult topic. The significance and application of the design and process of the study, including further discussions regarding the use of the concept ICE follows. The third section reflects on the theoretical implications and key findings - in which the distinct strands of the conceptual framework ICE, together with theoretical underpinnings from Goffman, Bourdieu, Ricouer and Egan are drawn together. Consideration is then given to the insights, lessons and implications to emerge from this work. A section on the implications and potential applications of the study for medical education is then followed by the pen-ultimate section on further implications and applications for contexts out with the doctor-new patient situation and with other professional groups. The chapter is concluded with closing comments, in which the thesis is drawn together.

Chapter summary

This chapter has outlined the context and design of the thesis. The next chapter explores the literature relevant to the design and conduct of the study followed by the literature central to the analysis.

Chapter 2. Literature Review

Introduction

This literature review is organised around the distinction between two main categories of literature which have relevance to different aspects and stages of the study. Some literature was influential from the beginning and informed the study as a whole. Other literature provided more focussed and significant relevance to concepts or issues which emerged later in the study.

Part One: Literature critical to the design and conduct of the study

This begins by looking at the key relationship between a doctor and patient and how their roles within that relationship were perceived in society. This is followed by literature relevant to referrals, or referral letters and the referral process. Following this, the significance of Goffman (1959; 1963b; 1967) is introduced before exploring stereotyping and its potential impact on doctor-patient interaction. Consideration of the work by Bourdieu (1977) concludes Part 1 by providing a perspective on the influencing factors on 'self' and one's behaviour or practice.

The doctor-patient relationship

Parsons (1951) is an early example of a sociological study focusing on the doctor-patient relationship. It resonates strongly with the focus of this study, due to his elaboration of the then general view of institutional and social structures and how they related to the person. By studying the behaviours of doctor and patient, their expectations of each other, and their individual contributions to the relationship, Parsons described 'four aspects of the institutional expectation system relevant to the sick role' (Parsons, 1951:436). He also described a 'communication gap' (Parsons, 1951:441), resulting from the mutual expectations and limitations of the doctor and patient. His work is described as 'steering the construction, deconstruction and reconstruction of specific social roles related to health and illness'(Shilling, 2002:621). From the following examples, it's relevance to the doctor-patient relationship of today, and concepts drawn on for this study, are clearly seen. Parsons (1951:437) described the roles of patient and physician as becoming part of a

complementary role structure. He conceptualised the interaction between doctor and patient as structured by 'pattern variables' consisting of cultural values shaping particular role requirements (Parsons, 1951:456). Later, Goffman (1959) was a key influence in the shift theoretically from the fundamentalist emphasis on roles to the agency emphasis on identity. He argued that when performing a role, the individual 'conveys the personal qualities attributed by others to this role or title which is the basis for self-image and also the basis for the image others give him/her' (Lemert and Branaman, 1997:35).

Parsons' recognition of the challenges for doctors, with patients becoming more active in finding information about their health (Shilling, 2002:626), resonates with contemporary medicine. Although types and sources of information have changed, patients' use of the internet for health information indicates that challenges remain (McMullan, 2005). Parsons also anticipated that patients were becoming more involved in their care. This is relevant to contemporary health care as patient participation has been the focus of many research studies over the past few years and has also been 'prioritized in policy initiatives … and found expression in recommendations for professional practice' (Collins *et al*., 2007:4).

Parsons (1951:478) distinguished the idea of 'good' practice and appears to have raised an issue analogous to 'holistic care' in his comments 'all good practice is the general processes of coping successfully with the psychological consequences of experiencing strain in social relationships'. He was referring to the alienation of the ill person from their social roles, but nevertheless was making the point that assessing the psychosocial impact of illness should be part of the doctor's role.

The psychosocial impact of illness and the emphasis on holistic care has been the focus for many studies over several years (Shapiro *et al*., 2001; Kendall *et al*., 2006; Andrews *et al*., 2010; Goldsmith *et al*., 2010) and addressing patients' psychological needs is fundamental to patient centred care and good communication skills (Kurtz *et al*., 1998; Silverman *et al*., 2008).

Another influential piece of work was Strong's (1979) ethnographic study of over a thousand observations of face-to-face interactions between paediatricians and parents of children thought to be affected by neurological damage. Drawing on Goffman (1959; 1963a; 1967; 1970) and his analysis of everyday ritual, Strong established four types of the concept *role format* (Table 4):

Bureaucratic	the doctor controlled the agenda; universal idealisation of the medical competence and technical authority of the doctor
Charity	moral judgements made about the children's mothers
Clinical	discussions amongst professionals
Private	healthcare being available to buy in the market place

TABLE 4: FOUR TYPES OF ROLE FORMAT (STRONG 1979)

He identified how consultations were often determined by the general political, social and economic shape of society; medical management and knowledge, and maintenance and encouragement of dependency on the professional. He argued that consultants often followed the same form despite different individuals involved, and identified the more paternalistic and bureaucratic relationship 'involving formality, politeness, and control of emotions' (Heritage and Maynard, 2006:358).

Health care and patient expectations have changed considerably over the past couple of decades. There has been a significant shift not only in the role of patient but also that of doctor (Coulter, 1999; 2002). According to Heritage and Maynard (2006:359) ethnographers' findings suggest that 'patients' subjectivity resides, like an iceberg, mainly below the surface of talk'. Suppression of patient experience is thought to be due to many differences between patients and physicians including status and authority, socioeconomic, ethnic and gender (Zola, 1973; Fisher, 1984; Clair and Allman, 1993; Atkinson, 1995). Other studies found the doctor's interaction with the patient was influenced by patient demographic (Willems *et al.*, 2005; Siminoff *et al.*, 2006; Street Jr *et al.*, 2007; Bertakis, 2009; Sandhu *et al.*, 2009).

The literature cited illustrates the complexity of interaction within the consultation and also the potential for doctors to come to a consultation with

their own ideas and expectations of, and about, their own role and that of the patient. These ideas and expectations may be flexible and adaptive to the individual patient but the potential for them to be more fixed, resulting in a more general rather than individual approach to the patient, is also a possibility.

Before a new patient is seen in secondary care, the referral letter is a critical source of information and is usually the first knowledge of the new patient the receiving doctor has. From this, the receiving doctor may develop their own ideas and expectations of the patient. The referral process and the information provided and/or *created* by the consultant was fundamental to this study.

Referral letters

Medical referral letters from primary care physicians to secondary care consultants have been the subject of many reviews, studies and comments. Criticisms directed at aspects of the referral would appear to be an international problem, as illustrated by the following papers. Although some were more clearly defined than others, the focus of the studies can be loosely categorised as follows: reasons for referral to secondary care; type of referral; the content of the referral and rate of referrals. As they reflect similar categories identified by the consultants in this study, the literature on the first three categories is summarised. Rates of referral were less relevant and consequently, the literature for this is not included.

Reasons for referral to secondary care

Coulter, Noone *et al*. (1989) looked at 18,754 referrals from 127 General Practitioners (GPs) who were asked to record all referrals using an agreed protocol. Several reasons for referrals were identified e.g. reassurance for the GP and/or patient; taking over the patient's management, although there was often more than one reason. Most studies between the 1980s and the present identified that reasons for referral were often unsatisfactory or unclear (Foot *et al.*, 2010). In a questionnaire based study, Hodge *et al.,* (1992) explored whether the reason for the referral was being correctly interpreted by the consultant. Analysis of 297 consecutive referrals showed that many were not a true reflection of the patient's condition, current treatment or medication and

in a large proportion of cases, the reason for the referral was either not given or was unclear or ambiguous.

Content of the referral

In a later Australian study, Toleman and Barras (2007) focused on referral information regarding medication. They compared 50 patients' current medication regime with 50 referral letters and 533 hospital medication charts and although the number of referral letters was small, also concluded the information was not a true reflection of the patients' current medication regimen.

The theme of unsatisfactory referrals was also taken up by Dupont (2002) who assessed 600 referral letters to a specialist out-patient clinic comparing the information in them with that obtained from the patient at the clinic. He concluded that referral information was inadequate, as much of the information acquired at the clinic had not been included. This was later challenged by Jolobe (2002:1336) who felt the criticisms of primary care doctors was 'unjustifiably one-sided' and secondary care letters were 'devoid of structure'. Jiwa *et al., (2005)* observed that most criticisms about inadequate information came from secondary care. GPs were asked to refine a list of contents for an ideal referral letter and then reviewed letters of referral to a gastroenterology specialty, cross referencing against the list. Very few contained what had been considered essential components. In a Norwegian qualitative study, Thorsen, Hartveit *et al.,* (2012) used focus groups to explore GPs views of the referral process. They concluded that GPs felt hospital consultants regarded them as lower down the system and described the process as 'sometimes humiliating'.

Also exploring the content of the referrals, a Canadian systematic review (Berta *et al.,* 2008) established 24 essential components for referral to an asthma clinic. These included: patient demographics; the main problem prompting referral; a clear indication of what the referrer wanted from the consultant; past medical history, current medical condition, a full medication history and list of current treatments. In a Norwegian study, Hartveit *et al.,* (2013) also recommended content for referrals to mental health services, as they also

identified that information considered essential by the receiving consultant was often not included.

A New Zealand study (White *et al.*, 2013) focused on how the wording of the referral influenced the opening moments of a surgical consultation. They concluded the most effective consultations were ones that facilitated an 'alignment' regarding the reason for the referral within the opening dialogue between surgeon and patient. They suggested the dialogue is dependent on the referral information setting the agenda for the consultation, and the consultant should make reference to the referral letter, and the reason given for the referral, in their opening dialogue with the patient.

A recent study was one of few exploring the quality and accuracy of medical information in referrals from general dental practitioners (DeAngelis *et al.*, 2010). They concluded that in many instances, medical information was only partially accurate and 12 out of 54 referrals provided no medical history at all.

In 2010, the King's Fund commissioned two significant studies to look at the referral process. Foot *et al.*,(2010), focused on the quality of GP diagnosis and referral. Key points were that the referral process is extremely complex, with many considerations to be made regarding the reason for referral whilst also taking into account patients' wishes together with policies and procedures of specific health providers. The authors considered that 'in all of the dimensions of quality explored, there is evidence of scope for improvement. Distinct challenges exist within different specialties, and for different types of referral' (Foot *et al.*, 2010:49). The second study (Imison and Naylor, 2010), brought together a review of the evidence regarding GP referral management schemes which aim to influence and control patient referrals. This is outside the remit of this study, but the report reinforced what other studies had said – that 'a considerable number of referral letters lack the necessary information' (Imison and Naylor, 2010:12).

The type of referral

Studies exploring the *type* of referral were relevant to this thesis, as several consultants in this study expressed opinions about referral letters and computer generated pro-forma referrals. All the following studies concluded that pro-

forma or standard referrals were preferable to non-standard, 'open text' referrals. However, the use of the former did not necessarily result in a 'good' referral. Salathia and McIlwaine (1995:47-48) found that despite high use of a standard format, information provided in 104 referrals by GPs and 89 hospital doctors were considered 'poor' on a scale of 'poor', 'average', 'good' for pre-determined content. In a later study, Tattersall *et al.*,(2002) found a problem both with referrals *to* and replies *from* the consultant, even when a recommended pro-forma was used. An Australian study, concluded that standard letter format, both for referrals to and responses by the specialist, needed to be used (Piterman and Koritsas, 2005). In a Brazilian study, Navarro *et al.*, (2002) found the quality and quantity of information differed significantly between the two types of letters, standard letters being more complete and containing information commonly absent in the non-standard.

In addition to providing more accurate information, Ramanayake (2003) in a Sri Lankan study, and Patel *et al.,* (2011) in a UK study both concluded the use of standardised referrals saved time, improved communication and patients were seen and diagnosed more quickly.

The literature reviewed in this section focused on the referral from the perspective of its relevance and 'completeness' as a form of medical or clinical handover of care from one provider to another. The majority of the discussions were centred on whether referral information was adequate and sufficiently informative to enable the receiver to have a clear understanding of the patient's current situation, the reason for the referral and the referrer's expectations of the receiver.

Although this background literature is important in order to contextualise this study, the focus of this study was not the quality or appropriateness of referral information, but what 'information' the consultant gained - either from the actual information given or factors they deduced and/or added i.e. their own preconceptions, interpretations or assumptions, triggered by the information given.

In the following sections, the phenomena of assumptions and stereotype are clarified, as they may seem very similar concepts, and contextualised with the

work by Goffman (1959; 1963b). Literature which focuses on or includes their impact, specifically in relation to the delivery of health care, is then identified.

The significance of Goffman

This study initially drew on the ideas of Goffman, a leading analyst of human interaction and everyday ritual. Goffman (1963b) identified that we have anticipations or pre-conceptions about another's social identity, based on information we may or may not have, before actually seeing or knowing the individual. Based on *a priori* assumptions, of which we may not be aware, we transform these anticipations into 'normative expectations', from which we create a 'virtual social identity' or stereotype. Until the individual is before us, we do not know if our assumptions match the 'actual social identity' i.e. what we now see or know (Goffman, 1963b:12).

According to Goffman (1963b:12), if the individual is perceived to be less than the 'virtual social identity' he is 'thus reduced in our minds from a whole and usual person to a tainted, discounted one' but if the person's 'actual social identity' is perceived to be more than anticipated, we re–classify the individual 'upwards' . Of course, there is also the option to continue with the 'virtual social identity' by ignoring or disregarding the 'actual social identity'.

Assumptions and Stereotyping

a priori **assumptions**

Within the health care literature there are several examples when *a priori* assumptions are considered. Street Jr. (2002) explored gender differences in the health care provider-patient context, making the link between an individual's *a priori* assumptions, generated from their stereotypes and attitudes towards men and women - specifically their communication needs. Specific to the doctor–patient interaction within the field of mental illness, Wilson (2005) proposes that when patients do not fit the doctor's *a priori* assumptions of how patients should behave, the physician may become annoyed or irritated with the patient for their non-conformity. The resultant relationship and interactions between doctor and patient may become more complex and difficult.

Koenig, Back *et al* (2003) discuss the contribution qualitative research has made to the care of the dying patient. They note that many patients may be denied opportunities to take part in research because of *a priori* assumptions of others i.e. health professionals, patient's family and ethics boards, that these patients are too vulnerable. They conclude that the system of human subjects' protection, predominantly based on drug or treatment trials, is inadequate for qualitative palliative care studies. They make several recommendations including that research policies be guided by empirical research of the actual impact of being a participant rather than the *a priori* assumptions about patient vulnerability. 'Dying patients should not be excluded from research simply because they are near the end of life. Similarly, bereaved family members should not be defined *a priori* as vulnerable' (Koenig *et al*., 2003:S48). In a study exploring the views of patients and health care professionals regarding recent re-designing of primary care services, instead of *a priori* assumptions of patients and health care professionals being regarded as potentially negative, they were fundamental to identifying attitudes regarding various aspects of primary care service changes (Mayes, 2011).

Stereotype

The term 'stereotype' comes from the Greek words *stereos* (firm and solid) and *typos* (impression), hence 'solid impression'. It is defined as a fixed idea people have about what someone or something is like (Cambridge Dictionaries Online). A stereotype is generally an oversimplified image of a group of people based, for example, on their dress or appearance, occupation or address. Stereotypes can therefore be created before the person is seen, and based on minimal information. This is significant to this study, as the potential for, and existence of, stereotyping was identified during analysis of data from different stages of the study.

The sociological and psychological literature suggests that people make sense of each other in complex ways in that they draw upon strategies of impression formation, aspects of identity, stereotype, stigma and prejudice. Of these, only stereotyping is explored in more detail in the context of this thesis. Stigma was not identified in this study, but because of its relevance to the key concept of

stereotype, information regarding its presence in healthcare is provided in Appendix B.

Stereotyping appears infrequently in sociological literature but frequently in psychological explanations of human behaviour and attitudes. It is recognised as a way in which we simplify our social world by reducing the amount of processing or thinking we have to do, especially when meeting a new person. By stereotyping we infer that the person has a range of characteristics and abilities we assume all members of that social grouping have (McLeod, 2008). These generalizations stem from experiences we have had, read about, seen in the media or have had related to us by friends and family. It is well recognised that we rarely interact with others without some expectation, as described by (Goffman, 1959:249-55) . He used the metaphor of the stage and performance to develop his conceptual framework of social life as a drama, but contextualized this by stressing that his focus was on the structure of social encounters – 'the structure of those entities that come into being whenever an individual enters the immediate physical presence of another' (Goffman, 1959:246).

The expectations of the other person may be derived from beliefs about demographic information, such as age, gender, ethnicity, and more individual characteristics such as personality traits (Miller and Turnbull, 1986). Macrae and Bodenhausen (2000:94) refer to 'social categorization' i.e. the process by which an individual perceives the 'invariant features of their immediate worlds' in order to behave in a 'purposive manner'. As they succinctly put it, 'knowing what to expect and exactly where, when, and from whom to expect it, is information that renders the world a meaningful, orderly, and predictable place' (Macrae and Bodenhausen, 2000:94). In their review and synthesis of the cross-disciplinary literature on doctor-patient communication and cultural competency, Perloff *et al* (2005:838) reinforce this by describing doctors as 'natural categorizers' who 'seeking to reduce uncertainty, draw on demographic categories and meta theories i.e. stereotypes, to simplify all the information they may or may not have about an individual'. The consequence being that under pressure they are likely to rely on 'decision-making heuristics such as biased expectations or social stereotypes' (Perloff *et al.*, 2005:838).

Different aspects of stereotyping in health care have been the focus of studies for many years. In their study on female ill health and illness, analysing 336 recorded interactions between physicians and their patients, Wallen *et al* (1979) contend the stereotyping of patients was common in medical practice. Fisher (1979) associated stereotyping with poor patient outcomes, while Annendale (1989) drew extensively on medical literature to explore doctors' stereotypes of patients in the context of law suits and malpractice. Whilst acknowledging Wallen's (1979) work, she also described the implications of stereotyping 'suit-prone patients' in that there is the potential for discrimination and clinical management to be motivated by the avoidance of a malpractice suit (Annandale, 1989:14).

In their qualitative study, Raine *et al* (2004) looked at the perceptions and beliefs of 46 General Practitioners regarding chronic bowel syndrome compared with chronic fatigue syndrome. They found that patients with the latter were often stereotyped as having undesirable traits e.g. transgressing the work ethic, having a low symptom threshold and lacking in stoicism. This led to the illness ceasing to be seen as a discrete disorder and becoming the defining feature of the patient. As a consequence, the doctor failed to assess the patient as objectively as they did someone with chronic bowel disorder, regarding the patients with chronic fatigue syndrome as problematic.

Examining the delivery of health care to African and none African Americans, Moskowitz *et al* (2012:996), in their quantitative study, stated 'we found implicit stereotyping among physicians; faces they never consciously saw altered performance. This suggests that diagnoses and treatment of African American patients may be biased, even in the absence of the practitioner's intent or awareness'. Minnis *et al* (2001) explored the potential for racial stereotyping amongst UK psychiatrists, following up studies several years earlier that suggested they negatively stereotyped black patients as being more violent than white patients. Their findings also showed that although the negative stereotype regarding violence was no longer apparent, there was evidence to suggest that racial stereotyping of black patients still occurred. They were more likely to be asked about their social conditions or support and psychiatrists also

expressed the opinion that schizophrenia was more common in black men, although statistically this is not the case.

In their qualitative think-aloud study on potential diagnosis of patients described in case vignettes, involving fifteen general practitioners, Skånér, Backlund *et al* (2005:8) stated it is widely accepted that through experience, a doctor can learn the skill of illness scripts or pattern recognition – a short cut diagnostic strategy helping them make sense of the clinical situation. Describing a delay in physicians reaching a correct diagnosis, Sheikh *et al* (2001:150) question whether there is also a blurring between pattern recognition and stereotyping and warn that clinicians 'must be alert to the limitations of a diagnosis based on stereotypical pattern recognition'. In response to this, Kai (2001:152) acknowledges the dangers of stereotyping but reinforces the value of pattern-recognition as being 'aware of summary patterns' which can alert the physician to possible explanations. However, problems arise when doctors 'fail to respond to people as individuals and inappropriately assume these patterns apply' (Kai, 2001:152). Writing specifically about gender and its influence, Street Jnr (2002:205) notes that 'gender-based perceptions and stereotypes can play a prominent role in the medical encounter' and that *a priori* assumptions regarding the capabilities and needs of the patient may be based on the doctor's gender based stereotypes and attitudes.

In a review of behavioural studies, Wheeler and Petty (2001) explored the effects on the behaviour of the person being stereotyped, suggesting they may behave in a way consistent with the stereotype. Although they were not focused on the doctor-patient scenario, it is clearly of some significance that the behaviour and cognitive processes of a patient could potentially be influenced if they were being stereotyped. This links with the study by Pechmann (2001) who explored the potential of 'Stereotype Priming' i.e. utilising pre-existing social stereotypes to either reinforce healthy behaviour that is wanted, or to illustrate how and why certain people take health risks.

Within the literature on the doctor-patient encounter there are mixed views about the value or appropriateness of stereotyping or categorizing a patient. In their study, exploring the non-medical influences on medical decision-making, McKinlay *et al* (1996:769) state that 'despite the 'objective' medical

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training, physicians remain human actors, socially conditioned to engage in stereotyping, whether consciously or not'. More recently, Shah and Ogden (2006:136) wrote that 'General Practice epitomises the need for such strategies as it illustrates a situation where two (or more) people meet and need to develop an understanding of each other given a minimum amount of time and information as a means to facilitate communication'. This could also apply to the secondary care situation when the doctor is meeting the patient for the first time and has only the referral information to go on.

Stereotyping may not always be negative, but may consist of attributes perceived socially as positive e.g. all overweight people are jolly; all Welsh people are very musical and all black Kenyans are fantastic long distance runners. However, the consequence for the person being stereotyped is that crucially, as an *individual* they are not seen. They are instead part of a social grouping – whether or not they belong there. They are not *recognised* as the individual they are, their 'actual social identity', but are instead *misrecognised* as having an identity or characteristic, that is a 'virtual social identity' set by somebody else (Goffman, 1963b:12).

Clearly, maintaining and acting on a positive or negative stereotype has the potential for the person to be disadvantaged and, if a patient, emotionally or physically harmed. The patient becomes 'this sort/type of patient' or a 'typical' example of the illness, and fails to be recognised as 'this person' with this illness, issue, fear etc.

Field, capital and habitus: the relevance of Bourdieu

Facilitating further understanding of stereotyping was the work of Bourdieu (1977), and the theorising of the methodology was also influenced by his concepts of '*habitus*', '*field*' and '*capital*'. These link well with Goffman's insights by providing a more abstract perspective on the influencing factors on 'self', and the process of social interaction.

Together with fellow social theorist Passeron, Bourdieu developed the concepts of the inter-dependant and co-constructed trio *field*, *capital* and *habitus* (Bourdieu, 1977; Bourdieu and Passeron, 1979; Robbins, 2008). Bourdieu argued that for us to understand interactions between people, or to be able to explain

a significant event or phenomena, it isn't enough just to listen to what is said or observe what happens. It is essential to examine and understand the *social space* or *field* in which these interactions or events occur. The *social space* or *field* consists of positions occupied by social agents (people or institutions) such as the consultants, patients and the NHS context. What happens within the *social field* – referred to as '*practice*' by Bourdieu - has limits that are determined by the evolving *habituses* brought to the *field* by the social agents, and the unfolding of power games over a central stake. He refers to the resources used in these struggles as different forms of *capital*: economic, social, cultural and symbolic (Bourdieu, 1977; Maton, 2008).

Economic capital is perhaps most easily understood i.e. wealth equals power and status. However, social capital refers to personal connections and networks, whilst cultural capital is the value placed on attributes, skills and reward (Bourdieu, 2006). Within the field of medicine, which is very hierarchical, being a qualified doctor is a form of cultural capital, but some fields of medicine are more highly valued than others. Symbolic capital relates to reputation and prestige and its existence depends on the belief by others that an individual possesses such capital. Again, if we look at the field of medicine, a 'consultant' possesses symbolic capital which is dependent on their patients, junior medical staff, colleagues and nursing staff (for example) believing they possess such capital.

Fields are shaped differently according to the 'game' played on them e.g. an education field with tutor and pupils is different to the institutional field of the consultation between doctor and patient. Mapping the social space allows us to allocate individuals to classes or to group individuals who share a similar position (Bourdieu, 1984).

Habitus focuses on the individual and how the individual acts, feels, behaves etc. within the field they occupy. It captures how and what we are in the present but also how our present is shaped by our past (Bourdieu, 1977; Maton, 2008). Grenfell (2008:51) writes 'Bourdieu defines habitus as a 'property of social agents (whether individuals, groups or institutions)' that together make up 'structured and structuring structure' (Bourdieu, 1994 :170). It is 'structured' by one's past and present, family circumstances or upbringing, one's

educational background or experiences. The 'structuring' relates to one's habitus shaping one's present and future practices and the 'structure' 'comprises a system of dispositions which generate 'perceptions, appreciations and practices' (Bourdieu, 1990:53). According to Bourdieu, we don't just act in response to habitus – but as a result of the inextricably linked habitus, capital, field and practice (Grenfell, 2008:51) – as illustrated by the following equation:

[(habitus)(capital)] + field = practice

The consultants had a level of comfort where they had the skills and expertise to deal with what the patient brought to the consultation. This habitus-field match is described by Bourdieu (1977:214) as 'fish in water' in which the social agent (in this instance the consultant) feels at ease. However, although the habitus is constantly changing and evolving in response to new or additional situations or events, there may be situations the individual does not want to accommodate. For example, if the consultant needed to be more challenging towards the patient, they may feel more apprehensive as this is contradictory to their 'norm' of wanting to be helpful and collaborative with the patient.

There are also situations where the field changes more rapidly, or takes an unexpected direction, for example when the patient is not as expected e.g. challenging, emotional, too familiar. If unable to adjust and adapt to habitus-field i.e. becoming 'out of synch' (Grenfell, 2008:59), the practice of the consultant may also become out of synch or less confident, resulting in them feeling ill at ease, frustrated or irritated.

The consultants' expectations of their role e.g. levels of competence and confidence, may match the patient's expectations of them. However, drawing on Goffman (1959) and Grenfell (2008), if the patients' expectations do not match their own, or the consultants perceive this mismatch or misrecognition, they potentially experience added stress to, and challenge of, their position.

Bourdieu's concepts of field, capital and habitus (Bourdieu, 1977; Bourdieu and Passeron, 1979; Robbins, 2008), restates in a newer analytic language those of Parsons' (1951) and Strong's (1979) exploration of what each individual brings

to the consultation and on what they base their ideas and expectations of their roles.

The concept of *generational habitus* (Moffatt and Higgs, 2007) combines generation theory (Mannheim, 1928) with habitus (Bourdieu and Passeron, 1977; 1979; Robbins, 2008), based on the observation there exists a way of being, thinking, and doing for each generation. One's habitus still influences much behaviour, and in the context of this study, was significant regarding comments about patients' age.

All these concepts are significant to this study. It was accepted that the *field, capital* and *habitus* of both consultant and patient were potentially influential on the *practice* of the consultant. The comments by the consultants about patients in general and the patient they were due to see, were not just based on the actual information they had received, particularly when making assumptions about the patient's social or professional situation.

Part Two: Literature central to the analysis

Introduction

This second part of the chapter focuses on literature central to the analysis and which became significant and influential when themes were emerging at different times of the analysis process. To make sense of the material gathered, the themes emerging acted as a prompt to search other bodies of literature which were unfamiliar at the study design stage but which became fundamental to the later analytical stages of the study.

Firstly, the literature on the concepts of 'Recognition' (Taylor, 1994; Honneth, 1996; Honneth, 2001; Ricouer, 2005; Fraser and Bourdieu, 2007) and 'Presence' (Egan, 1975; Hauerwas, 1986), is explored as they were both influential in the analysis, particularly the consultation and reflective stages. The value of recognition and presence was that they allowed the data to be used to engage in conversations with other debates of wider significance.

Almost simultaneously with the above, the Calgary Cambridge Consultation framework (Kurtz and Silverman, 1996; Silverman *et al.*, 2008), provided a conceptual framework for organising the data and analysis and presentation of the findings for Stage 1 of this study.

Recognition

Fundamental to the therapeutic relationship a doctor has with a patient is being able to see them, not just as a repository of organs or a collection of symptoms, but also as an individual with a narrative to reveal and an identity and role in their society.

In 'A Fortunate Man: The Story of a Country Doctor' John Berger (1997) together with photographer Jean Mohr, records the life and work of Dr John Sassall, a country doctor in the UK, and his ability to recognise his patient's humanity when their circumstances, illness and fears have made them unrecognisable to themselves. Their own self may have been lost to them, as they became identified by their illness and symptoms. By presenting himself to his patients as 'a comparable man' i.e. 'the doctor's acceptance of what the patient tells him, and the accuracy of his appreciation as he suggests how different parts of

his life may fit together…'(Berger, 1997:76), Dr Sassall enables the patient's confidence to increase and subsequently, their ability to be recognised. Dr Sassall was described by his community as a good doctor. This was not just because of his ability to medically treat or cure his patients. It was because he met his patients with a sense of knowing, sharing, appreciation and knowledge i.e. he recognised them and they felt recognised.

The above text illustrates that the concept of recognition has contributed for many years to the understanding and perceptions of the complex process of doctor-patient interaction. An explanation of recognition in a general sense follows, but the relevance of it within the doctor-patient context will then be revisited.

According to Taylor (1994), the concept of recognition developed as political and cultural pressure grew for minority ethnic or social groups to be recognised in their own right (and respected by others), but also to be able to create and sustain their own identity. There have been many struggles over nationality, religion, gender and sexual preference, but with democracy has come the politics of equal recognition. Recognition - as in the projected image by one person onto another - plays an essential role in the growing ideal of identity and authenticity. It features profoundly in our understanding of objects and people, identity and ideas, 'in the heart of contests around citizenship rights, identity politics, claims for material redistribution and demands for past harms to be acknowledged and redressed' McLaughlin *et al* (2011:1).

The refusal of recognition, or misrecognition i.e. the projection of an inferior or demeaning image, can lead not only to the oppression of an individual but also to the image being internalized (Taylor, 1994). For example, the inferior and demeaning image of a drug-taking, criminal, lazy, work-shy individual to identify an unemployed person in a socially deprived area. Some in that environment may internalise that inferior image of themselves and behave/think/live as if they are a lesser member of society, whether indulging or not in the stereotypical behaviour. According to Taylor, group recognition is a key feature of justice and 'due recognition is not just a courtesy we owe people. It is a basic human need' (1994:26). More recent collaborative works have further explored the association between recognition, redistribution and

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justice (Fraser and Honneth, 2003; Fraser and Bourdieu, 2007) in which they linked the struggle for recognition with an ethic of caring.

Although the various existing contemporary theories and continuing debates on the 'politics of recognition' are outside the remit of this thesis, its relevance is apparent when exploring recognition in the context of the individual. In his final book, the French philosopher Ricoeur (2005) took up the themes of self-recognition and recognition by others. He describes the concept of *ipseity* (*ipse* or *'self'*) i.e. what a person stands for, their values and their actions, as central to their identity or self-recognition. The person's memories and commitments constitute the narrative of their life which in turn constitutes their identity in the sense of *ipseity*. However, he also explores our relationships with others, and to what extent our self-recognition and full sense of self, requires (and even depends upon) recognition of and by others. We recognise ourselves because of our recognition of others, where we are placed with those others, and the recognition given to us as ourselves by those others. Honneth (1996:66-91) describes the self-internalised recognition from others as a source of shared social understandings i.e. the '*me*' which then gives the '*I*' its own externally validated status.

Honneth (2003) regarded recognition as intersubjective and institutionalised in society in three spheres of life - 'love' (the central idea of intimate relationships i.e. the private sphere), the 'legal order' (equality in relation to the law i.e. the public sphere) and 'achievement' (gained when the subject is allowed to enjoy self-esteem from their abilities that are respected and valued by others). In all three domains, 'the establishment of one's understanding is inextricably dependent on recognition or affirmation on the part of others' with all three types of recognition leading to human beings enjoying dignity and integrity (Yar, 2001:59).

This was echoed by Ricouer (2005) who identified recognition of, and by, others as reciprocal or mutual. He described reciprocal recognition as having narrow contexts – something like a commercial exchange in which the individuals involved do not have to give of themselves but merely participate in the exchange. There is no need to know more about or acknowledge the individual beyond what is required to fulfil the exchange (Pellauer, 2007:131). However,

this doesn't have to be a hostile or unfriendly interaction - it could be perfectly amicable, but without wanting or needing to know the other individual in any more depth than is necessary.

Ricouer (2005) identifies mutual recognition on three levels: affective, judicial and social. Affective is the recognition from our family that we are part of them and they are part of us. The mutual love and trust contributes significantly to our self-confidence in who we are. Misrecognition at this level can significantly undermine our self-confidence. On the judicial, the emphasis is on respect of wider universal 'norms', but also regarding the individual – that they are their own person with personal rights and responsibilities and also equal to all others. Mutual recognition at this stage gives us our self-respect and 'enriches our sense of selfhood' (Ricouer, 2005:202). Clearly, misrecognition at this level would undermine our own self-respect, promoting feelings of unworthiness. The third level described is social in which mutual recognition is the sharing of values, even though these may vary over time, which provide the context for social esteem.

These different levels of mutual recognition are inextricably linked and one can see the consequence of misrecognition in any of them may result in the individual's self-identity, self-recognition, self-value and self-confidence being undermined (as similarly described by Taylor (1994)). Ricouer also argued that mutual recognition was not about *equality* of status, hierarchy or authority – mutual recognition on all levels is valuing and respecting and creating a social bond that makes life together possible (Pellauer, 2007). Mutual recognition comes without a struggle to be recognised. It is an act of giving – a gift that does not need to be returned.

Recognition in the context of health-care

Recognition within the health-care situation has also been the focus of several studies. Drawing predominantly on Honneth's work for her ethnographic study based in secondary care, Fisher (2008) interviewed parents of children with mental and physical disabilities. She explored parents' ability in their private sphere to construct their own wellbeing and become empowered consumers of health care through intersubjective recognition of their own (and their child's)

'self'. She found this to be frequently undermined by the absence of recognition or presence of misrecognition by the health system, which attributed deficient or damaged identities to the parents *and* their child i.e. that to have a disabled child leads to an impoverished life with a lack of empowerment.

Taylor (1994) had also raised concerns regarding the tension that exists within institutions between treating everybody the same and taking into account individual identities. There is also a tension between recognising individuals' identities alongside their more universally shared rights of equality as a citizen – and whether in fact our identities as men or women, Muslims or Christians, gay or straight should publicly matter. According to Fisher (2008:596) 'an openness to alterity – that is to difference and singularity – is integral to the rights of recognition' but which also must be recognised in the private *and* public domains of life (Honneth, 2001; 2003).

Fisher and Owen (2008) also explored recognition and misrecognition within the context of empowering interventions in health and social care. They considered the findings of two studies on government interventions relating to family and health - teenage motherhood and healthy eating. Deficiencies or problems, in the eyes of the 'experts', equated to poor parenting or citizenship. This meant that no matter how well a young mother was coping, or how hard a family tried to be healthy, if they did not have the requisite knowledge or skills as defined by government schemes, they were perceived as having, or being, a problem. Fisher and Owen (2008) describe the 'ecologies of practice' of practitioners i.e. their openness to the diversity of others. A holistic and empowering relationship was created, through mutual recognition, by drawing on experiences from their own private and public spheres as well as those of the clients. Practitioners, being of similar 'profiles' as their clients, i.e. female, from working class origins and married or single with children, was significant in the process of mutual recognition. They also felt the distinctions between the 'spheres' as identified by Honneth (1996; 2001; 2003) was problematic and that neither 'private' or 'public' took precedence but were inextricably dovetailed, one influencing the other and *vice versa*.

A further example, based on the moving memoir by Lucy Grealy (1994) - a young woman with extensive and disfiguring cancer of the jaw - Shannon (2012) also

explores the vital role of mutual recognition in creating an empathic doctor-patient relationship. The mutual recognition sought by Grealy (1994) was often entirely thwarted by the doctor's need to maintain a 'professional distance'. Because of the uniqueness of the relationship between doctor and patient, there is a level of emotional and physical intimacy not found outside of a romantic relationship. The vulnerability of the patient, particularly when undergoing intimate and invasive examinations and/or investigations, is often not taken into account by the physician and herein lies the paradox of 'intimacy without intimacy' (Shannon, 2012:329).

In a qualitative study based in primary care in Denmark, Frederiksen *et al* (2009) explored the value of *continuity* of care. They interviewed 22 patients who had either been seen by their regular doctor or by one they had not met before. Their analysis explored patients' perceptions of their meeting and concluded that whether the patient knew the doctor or not, the added value of continuity of care *had* to be combined with recognition. Frederiksen *et al* (2009) defined recognition as a relationship context – or as described by Honneth (1996) an attitude expressed through interaction. In order to be recognised by the doctor, the patient had to feel they had not only been 'seen' but also their individual perspective on their illness and its impact on them had been respected. They identified the importance of recognition applies to all types of patients, not just those with a chronic illness or those who regularly saw the same doctor. Frederiksen *et al* (2009) also described the opposite of recognition as *humiliation*. They did not appear to substantiate this from their observation data but drew from retrospective narratives from the patients about previous consultations. An interpretation of their point is that when a patient is not fully recognised by a doctor, this is in effect *mis*recognition – the consequence of that is the patient being left feeling humiliated.

Stern (2010) explored the potential for promoting (self) recognition and combating stigma for people living with HIV/AIDS in South Africa. By giving members of the Treatment Action Campaign (TAC) i.e. those with HIV/AIDS, the opportunity to relate to themselves by applying Honneth's (1996; 2001; 2003) recognition criteria, individuals felt their self-esteem, self-confidence and self-acceptance had increased. As a result, they felt more prepared and

able to challenge the stigmatising representation of having AIDS or being HIV positive (Stern, 2010).

The above studies and papers focused on the recognition/misrecognition of the individual within the social relationship of health care, whether as a patient seeing a doctor or participating in health-promotion programmes. Of course, communication was fundamental to any of the situations, but it was the way in which the individuals were regarded by others and themselves that were the main foci of the studies. In their recent study, (Steihaug *et al.*, 2012) used the theory of recognition or 'recognising behaviours' (a basic respect for the other person as a subject and an authority in their own experiences), as developed by the psychologist Schibbye (1993) to explore how the existence of these behaviours was manifested in doctor-patient communication. They concluded that even when there was the potential for disagreement, 'recognising behaviours' could hinder escalation of potential conflict. The criteria of recognition described by Schibbye (1993) mirror very closely those of Honneth (1996; 2001; 2003) and although from the field of psychology, have been included to further contextualise the concept of recognition in the doctor-patient relationship.

There is much evidence to support the need for a doctor to recognise the patient. When 'recognising' another person, we are acknowledging their uniqueness and individuality in all aspects of their life. Patients may share the same named illness or experience the same described symptoms, but the impact on them will always be unique. It is of course possible to provide efficient and effective medical treatment without engaging with the patient or having an awareness of what the patient is going through. This style of medicine – one that achieves merely a technical goal - has been described by Charon (2006:5) as 'empty or at best, half medicine'. In the context of his own life limiting illness, Broyard (1992:45) wrote, 'I'd like my doctor to scan me, to grope for my spirit as well as my prostate. Without some such recognition, I am nothing but my illness'.

The above studies illustrate the need to be able to reach beyond the self, towards the other in an act of recognition ... 'for it is through this mirror of the other we come to know the self' (Shannon, 2012:333).

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Presence

Presence is a complex concept that remains rather vague and poorly defined. Initially, it was considered a liturgical concept, that is the spiritual presence of a supreme being (Harper, 1991), or a particular set of words, music and actions used in some religious ceremonies, especially Christian ones. However, it has also been identified by Egan (1975; 2009) to describe different degrees of commitment within an interpersonal interaction i.e. physical presence (self-focused energy), partial presence (energy focused on a task), full presence (energy focused interpersonally), and transcendent presence, the combination of physical, psychosocial and spiritual presence in a relationship that is transforming of the other. Presence became linked to healthcare communication, specifically in the care of the terminally ill where it was defined as 'A commitment to the sick and suffering - to alleviating suffering' (Hauerwas, 1986:5). In nursing, presence was considered a central concept in the relationship as an interpersonal process characterized by sensitivity, holism, intimacy, vulnerability and adaptation to unique circumstances (Paterson and Zderad, 1976).

Several definitions of presence have been offered. Brannigan (2009) suggested: 'being-there, being-with, being-for, being in relationship, and being- in – transcendence'. My own suggestion: 'together in the moment' encapsulates interactions with patients other than those approaching the end of their life (Dales, 2009). Shannon (2012:333) describes the simple act of listening as being 'present with another' but defines listening as not just 'hearing the words spoken but also hearing the spaces between the words – what is being told through gestures, gaze, form and function'.

Presence and mutual recognition reflect the mutual receptiveness and investment required to achieve more than meaningful interactions. Clearly, all human social interactions may be considered meaningful - they are performed with a communicative purpose or intentionality. In the tradition pioneered by Goffman (1959), interaction is considered the resource in which individuals organize their every-day life actions and make sense of their social order. Although the context in which it was used was care of the dying, the following description of presence reflects the importance of recognising the value of

every individual: 'the ability to create a relationship where each person mirrors and reciprocates the patient's worth as a human being and responding by acknowledging that person's intrinsic dignity' (Delbene, 2011:7) .

Whilst working in Palliative Care, presence was a familiar concept, experienced when having the profound privilege of being 'Present' with many people at different times of their illness, including the end of their lives. The atmosphere created in these situations was palpable, to the extent of being aware of one's own breathing. Taken out of that context, presence has also been observed between a dentist and an elderly patient, and doctors and their patients in many different settings.

Presence in the healthcare situation is inextricably linked to the doctor being non-judgemental, receptive, and having the ability to access personal experience and knowledge in order to form a unique interactive relationship with the patient. The doctor drops any preconceptions they may have about the patient, and does not allow the process of intellectualizing to interrupt the emerging experience. This is reinforced by Fingfeld-Connett (2006) in their meta-analysis of presence in nursing, for which four linguistic concept analyses and fourteen qualitative studies of presence were used. They described presence as characterized by sensitivity, holism, intimacy, vulnerability and adaptation to unique circumstances.

The concept of presence has certainly been given more attention within the nursing literature than in the medical field. This is exemplified by Godkin (2001), who explored the concept and its potential for influencing the satisfaction and (potential) healing of the patient, and Schmidt Bunkers (2010) in her description of 'living true presence'. In addition, presence is a concept with which many very experienced doctor colleagues are unfamiliar. The reason for this is not easy to establish from the literature, but a possible explanation is the difference in the professional-patient relationship and their approach to care. In his ethnographic study, Robertson (1996:297) described the differences in 'prime professional goals' of the nurses and doctors – the former being to provide daily care to enable the patient to live as normally and independently as possible through 'ongoing relationships whose sustenance demanded the demonstration of character virtues' the latter being 'systematic problem

solving, improving organic function, and research'. They both have the interest of the patient as a prime focus, but nurses take the route of wellness and patient autonomy to establish a relationship which addresses the physical and psychosocial needs of the patient in order to achieve 'normality' and independence. Their relationship may exist over a short or long period of time, but the opportunity to establish a depth that facilitates 'presence' is there. Doctors may take the route of ill-health, physical 'malfunction' and beneficence (along with respect for the patient's autonomy) to establish a relationship based on 'fixing' or 'solving'. These are of course generalisations, but the depth of relationship required by the nurse, who has more contact and opportunity to engage with the patient is very different from that of the doctor who has short periods of time in which to establish a relationship with the patient. The 'caring' aspect of the doctors relationship is perhaps more 'functional' in order to maximise the potential for building a patient centred relationship within a short contact time. As such, the need or opportunity to reach the depth of relationship required to establish 'presence' may be absent.

However, although he does not specifically write about them, the editorial by Chochinov (2007) clearly illustrates the inextricable link between 'Stereotyping', 'Recognition' (of the individual) and 'Presence' as his words encapsulate this aspect of the doctor-patient relationship. He describes the essence of medicine as being the conservation of the patient's dignity through the 'attitude', 'behaviour' and 'compassion' of the health professional. Whilst all of these are significant, perhaps the most relevant to the concepts of 'Stereotyping', 'Recognition' and 'Presence' is the '*attitude*' – about which Chochinov (2007) writes 'the healthcare provider needs to examine their attitudes and assumptions about a patient. The perceptions on which attitudes are based may or may not reflect the patient's reality' (Chochinov, 2007:185). The attitudes and assumptions may also influence the way in which patients are dealt with, as expressed by Remen (2001:353) in a autobiographical account of her own experience as a patient with a chronic illness: 'what they believe about patients and their potential may affect them profoundly. The attitude of an expert is contagious and can become limiting'. According to Chochinov (2007:185), patients seek their continued sense of value, and a positive image

of themselves, from the doctor as a 'mirror' who in turn needs to be aware that 'their attitudes and assumptions will shape those all-important reflections'.

Recognition, Presence and Empathy – is there a difference?

Recognition and/or Presence may seem indistinguishable from Empathy. However, in this study they are considered to be different aspects of an interpersonal interaction. Firstly, it should be acknowledged that the literature on all three exists. They are recognised as entities in their own right, differing from each other but part of the complexity of interpersonal interaction. They come from different traditions in writing, with empathy and to some degree presence closer to psychological usage, whilst recognition is used in a societal context.

Whilst empathy and presence have the focus on the illness or distress of another, recognition is about the person as a social member, whether or not illness or distress is present. The following offers an explanation as to how the concepts are perceived and their use and context within this study. Empathy is *from* the doctor *to* the patient. It is not a two-way process and is often described by the patient as being an attribute of the doctor's attitude and communication. It is often indicated through dialogue, although may also be communicated non-verbally. Empathy can exist without Recognition or Presence. Recognition is the seeing of another person within and outside of the context in which the interaction takes place. It can exist within, and external to, a context of illness or distress, and requires a level of vulnerability, transparency and acknowledgement of the other person as a member of society. Presence is an additional layer of human understanding of, and compassion for, the other person as a human being which may develop from a position of empathy. It is almost invariably the result of a general atmosphere, felt by both patient and the other person, which may be quite intense, often to the exclusion of one's surroundings, rather than any specific verbal or non-verbal exchange.

The Calgary Cambridge Framework

Traditionally, the doctor-patient relationship has been one of paternalism - the doctor taking control and the patient taking a passive role. Over recent

decades, this consultation style has been considered increasingly less appropriate and emphasis has been on a more collaborative approach including empowerment of the patient and patient choice.

The potential for consultations being more patient-centred was raised by McWhinney (1969:15), stating that 'many of the situations presented to the family doctor have physical emotional and social dimensions' and that in order to understand them a doctor needs to not only use their medical expertise but also needs to have an insight into human behaviour - 'he needs to understand how a patient's cultural level, social class and family background can influence the type of illnesses he develops … and the way he responds to illness'. Over subsequent years, the patient-centred consultation was further developed. Levenstein (1983) described the need for doctors to attempt to enter the patient's world in order to understand the meaning of the illness from the patient's view. He concluded the way to do this was to establish from the patient what their 'expectations', 'feelings' and 'fears' were regarding their illness and their situation. Levenstein, McCracken *et al*. (1986:24) further developed the method by stressing the significance of the presence of two agendas in any consultation; the patient's, in which the key factors are the 'expectations', 'feelings' and 'fears' but also that of the physician, which focuses on the medical explanation of the illness in terms of a 'taxonomy of disease'. The concept of exploring the two parallel agendas, whilst originating from the above works, was later operationalized into behaviours and skills in the Calgary Cambridge Framework or Guide which was originally published in 1996 (Kurtz and Silverman). It supported a much more evenly balanced, collaborative style by promoting the patient-centred or relationship-centred approach.

Over the years, the Calgary Cambridge framework has been adapted and refined to meet many different clinical contexts and is now used nationally and internationally across a wide range of health specialties to inform communication in practice. It underpins numerous medical undergraduate curriculum and postgraduate training, but although well established, it was difficult to establish if it was based on a particular theoretical framework. Jonathan Silverman, one of its authors, made the following comment:

> *'The Calgary Cambridge guide was developed in a rather pragmatic fashion, trying to bring together both patient-centred medicine and the evidence for skills in a structure which seemed to represent the medical interview. The skills were identified to try to codify what happens in the medical interview. It's really a mixture of lots of things! Not very helpful, but the truth!* (Silverman, 2011.Pers.Comm)

The patient's perspective was now identified by their *Ideas* - what they think is going on; their thoughts about what is causing their situation/illness/symptoms; their *Concerns* - any particular concerns they have about their situation; and their *Expectations* - what they are hoping will be the outcome of the consultation; expectations of the doctor, of themselves or of the health system. The combination of these aspects of the patients experience is known by the acronym 'ICE'.

The concept of ICE was adapted for this study and specifically used as an organising framework or a framing device for the data and analysis (how this was done is explained in more detail in the following chapter). In this context it was a heuristic device i.e. 'a procedure which involves the use of an artificial construct to assist in the exploration of social phenomena' and therefore a form of 'preliminary analysis' (Scott and Marshall, 2009:307). Albeit at a relatively low level, the framework of ICE helped in the organisation of material for presentational and analytic purposes.

Although this concept is more commonly recognised as a means for establishing insight into a patient's lived experience, it is fundamentally just a framework which can be used in other contexts, as the following examples illustrate. In the studies, the origin of 'ideas, concerns and expectations' (or similar) are not attributed to anyone, but it is clear they have comparable purpose i.e. to identify the unique experience of the individual in a given context.

The concept of ICE as a teaching tool

In a medical education context, it is important to be aware of the 'emotional climate' (Kurtz *et al.*, 2005:145) created by the learners, both before and after an activity that may, for some, feel quite anxiety provoking. For example, a tutor of anatomy may use the concept of ICE to explore the ideas, concerns and expectations of the medical students who are about to be confronted by a

cadaver for the first time. Students have a range of significant emotional responses to dissection - not only is the feeling of being upset experienced across cultural and racial boundaries, but also students exhibit or express increased callousness and disgust (McLachlan *et al.*, 2004:420). In order to dispel any anxieties or concerns from the start of the session, it may be important for the tutor to understand students' *ideas* about the session, *concerns* about seeing a cadaver and their *expectations* of the tutor, the session or themselves. McLachlan, Bligh *et al.* (2004:419) in a paper exploring an alternative to the use of cadavers observed 'all health care professionals have ideas, concerns and expectations about their role and their practice that is made up from the experiences they undergo in life (personal knowledge) which need to be considered in the teaching and acquisition of anatomy knowledge'. Being aware of this would enable the tutor to appropriately 'pitch' the session to be as student focused as possible, whilst still achieving his/her own agenda regarding intended learning outcomes.

Still in the area of medical education, role-play is frequently used, particularly in communication skills teaching. However, it is also a method that raises anxieties for many learners (Delvaux *et al.*, 2005; Kurtz *et al.*, 2005; Laine and Rollnick, 2007) – often due to self-consciousness about 'performing', inability to improvise when necessary, and the artificiality of the situation' (Kurtz *et al.*, 2005:102). Thus it is important to establish learners' ideas about role-play, what their own personal concerns are about participation, how it may be used and the tutor's ability to keep them safe (Swink, 1993). Understanding their expectations of themselves and of the value of role-play may be fundamental to the success of the session. This view was reinforced by a colleague who stated he would 'never use roleplay without first checking out the ICE of the participants' (Spencer, 2013).

Health promotion is often perceived by practice nurses, particularly those new to the role as an 'add on' to the other skills required of them, concluded Warner (2010:25) after having heard 'the *ideas*, *concerns* and *expectations* of successive groups over a number of years'.

To reinforce its value and the concept of ICE, a framework based on the Calgary Cambridge Consultation Guide has been developed for veterinary students

(Radford *et al.*, 2006). Although having considerable overlaps with medical consultations, there are clearly many differences with veterinary consultations and the previously discussed papers and the development of the Guide to the Veterinary Consultation based on the Calgary-Cambridge Model (GVCCCM) are clear examples of the adaptability of the concept of ICE to educational situations and contexts.

The concept of ICE as a research tool

There are also examples of studies using the concept of ICE, or similar, as part of the research design and/or analysis process.

Within the field of palliative care, Rassmussen, Norgerg *et al* (1995) asked 19 hospice nurses to narrate their *reasons* (which is analogous with ideas), *expectations, concerns* (and *hopes*) about their future work in a newly opened hospice. Their stories were analysed using a phenomenological-hermeneutic approach and it was found the nurses expressed different hopes, expectations and concerns depending on their level of experience. The implications were discussed by the authors who identified tensions between endurance and enjoyment of being a hospice nurse.

In their Sri Lankan qualitative study Ranasinghe, Chan *et al.* (2012) investigated the perceptions of Health Managers (HMs) about their Regional Health Information Systems (HIS). The aim of the study was to establish what their *ideas, concerns and expectations* were in relation to their own HIS and the potential for reform. The study identified the managers' HIS expectations were not met and that health planning or interventions were not evidence based.

Still within the broad context of medicine or health related studies, the qualitative study by Bjerneld, Lindmark *et al.*(2006:53-54) used a similar framework to ICE, using *motivations*, *concerns* and *expectations* to understand the thoughts and concerns of 19 volunteer nurses and doctors during recruitment for assignments carried out by International Non-Governmental Organisations (NGOs). The authors reported that previous studies had explored management of volunteers but had disclosed little information about the volunteers themselves. By focusing their study on volunteers thoughts and

feelings, Bjerneld, Lindmark *et al.* (2006) highlighted implications for those involved in recruitment for humanitarian work.

The responsibility of marking assignments can be daunting, and in their qualitative study, Hawthorne, Wood *et al.* (2006) used semi-structured interviews to elicit *ideas, concerns and expectations* of seven GP Tutors in preparation and actually marking assignments by undergraduate medical students. They explored the more contextual issues of marking to provide insights into decision making and 'internal negotiating strategies'. Using the ICE framework, the authors coded sections of data according to the main themes which were then refined into narrower categories.

Several medical schools in the UK offer a Graduate Entry course for students who may have diverse academic backgrounds and whose first degree is not associated with science or medicine. In their qualitative study, (Rapport *et al.*, 2009:e582) explored the *ideas, concerns and expectations* of 44 Graduate Entry medical students with either an arts or science degree, using an interview schedule focusing on 'life before medicine', their 'current experience' and their 'future plans'. The students were not specifically asked for their ideas, concerns and expectations but these concepts underpinned the thematic headings used in the analysis. The authors comment that concerns about their future was complicated by students' change in ideas, concerns and expectations regarding their intended specialty and maintaining their work-life balance (Rapport *et al.*, 2009:e584).

An example of ICE or similar being used in a non-medical educational setting is the study by Hespe (2011) who explored the complexity of issues surrounding school diversity. Following structured interviews, he incorporated the *expectations, concerns, values and ideas* expressed by students, parents, educationalists and policymakers into initiatives aimed at achieving and valuing diversity. The concept of ideas, concerns and expectations was fundamental not only to developing recommendations, but also to crafting acceptable policies.

As illustrated by the previous studies, exploring the *ideas, concerns and expectations* of individuals or groups offers the opportunity to understand personal perspectives and views.

Chapter summary

There has been considerable interest in the doctor-patient relationship for many years. It has been the focus of international studies exploring different contexts e.g. primary and secondary care, including specific doctor-patient demographics within different specialties. Specifically, doctor-patient communication has been intently studied and it is well established that socio-political changes have had a significant influence on the expectations of patients and doctors, on themselves and on each other.

The most common method for a patient to be seen by a secondary care clinician is a referral from another health professional, usually a secondary care clinician or a General Practitioner in primary care. This system would seem to be fraught with problems, particularly regarding the accuracy and substance of the information provided, with many studies attempting to identify and address these issues.

What doesn't appear to have been the focus of any studies is what thought processes the receiving clinician has, in addition to the expected medical interpretation of the patient's condition or situation, when assimilating the referral information. Although there are many studies exploring the existence of stereotyping and assumptions by doctors, it would seem that none have focused on the referral information being a catalyst for their emergence or expression, nor the impact of their existence on the subsequent communication with a patient.

Both Goffman (1959; 1963b; 1963a; 1970) and Bourdieu (1977; 1990; 2006) in different ways address the challenge of inter-subjectivity in social interaction and their insights facilitate deeper understanding of the complexities of doctor-patient communication.   Goffman's insights in particular provided the foundation for this study design.

The concept of *ipseity* (*ipse* or *'self'*) (Ricouer, 2005) has opened up the conversation with other debates regarding doctor-patient communication. It represents a person's values and actions as central to their identity or self-recognition but also to their relationships with others. To what extent our self-recognition and full sense of self, requires (and even depends upon) recognition of, and by, others is key to being 'seen' by others. Assumptions and stereotyping are facets of not seeing or recognising the 'other' – something of an anathema in contemporary medicine – and understanding this specific aspect of the doctor-patient encounter is what this thesis aims to examine.

Despite their value in underpinning the analysis for this thesis, recognition and presence (Egan, 1975; Egan, 2009), a concept central to interpersonal interaction based on caring, are rarely acknowledged in the medical literature.

Although the use of *Ideas, Concerns* and *Expectations* as a research tool is not unique, there was no evidence found to indicate that it had been used to categorise the thoughts and experiences of *doctors* in their consulting role with a new patient. This thesis offers an opportunity to gain insight into the views and thoughts of a doctor in this context.

Chapter 3. Epistemology, methodology and methods

Introduction

This Chapter is divided into four parts:

Part 1 explores the epistemological and methodological influences on the study, and why the study took the shape that it did.

Part 2 explores the practicalities of the design and data collection methods, identifying problems and pitfalls encountered along the way. The three staged approach to the study and the data collection methods are described before identifying how rigour and quality of the study were assured.

Part 3 describes the data analysis process with a clear explanation why and how the concept of ICE was used.

Part 4 reflects on the research process, my own reflexivity and positioning, before exploring the relationship between the *generalised* and the *specific*. The chapter concludes by exploring the representation of the data and issues around keeping true to the participants.

Part 1: Epistemological and Methodological Influences

Social Constructionism

This study takes a constructionist approach to understanding the communication between a doctor and a new patient - specifically exploring the potential influences of *a priori* assumptions on that communication.

Constructionism originated as individuals attempted to clarify the processes by which people describe, explain or account for the world in which they live. It has been closely associated with features of the post-modern era in qualitative research. It stands in contrast to positivist perspectives, which seek to measure social reality, or realist and politico-economic perspectives, which give prominence to causal relationships. Central to constructionism is how social phenomena are constructed as *meaningful* in social contexts and social reality

is built up of multiple meanings. The compatibility or incompatibility of these meanings is negotiated in daily life. Constructionism is therefore about the construction of knowledge and understanding: how it emerges, is understood, and how it develops a significance for society (Berger and Luckmann, 1991; Schwandt, 2003).

Constructionists view knowledge and truth as created, not discovered by the mind. Socially constructed reality is seen as an ongoing, dynamic process - meanings are created inter-subjectively, negotiated, learned and modified (Schwandt, 2003). Proponents share the goal of understanding the world of lived experience from the perspective of those who live in it.

There are different perspectives of constructionism – 'micro' and 'macro' (Burr, 2003:21-2) and 'weak' and 'strong.' The latter would seem from the literature to be the most commonly described differentiation. Weak social constructionism is the theory that social constructs are constructed rather than discovered, yet correspond to something real in the world e.g. money (Pinker, 2002:202). Reality is socially defined by individuals or groups, but this reality refers to the subjective experience of everyday life, how the world is understood rather than to the objective reality of the natural world (Berger and Luckmann, 1991).

Strong constructionism is often criticised as putting forward the argument that all of reality is a social concept and there is no actual reality. However, strong constructionism does not deny reality but our relationships with others determines how we make sense of that reality (Sayer, 2000). For example, the reality of history would not be denied, because it has happened, but our beliefs and understanding about history depend on our narratives and interactions with others 'when people talk about reality, they are speaking from a particular standpoint' (Gergen, 2009:4).

Constructionism focuses on uncovering the ways individuals and groups participate and contribute to the construction of their own perceived reality (Harris, 2010). It is acknowledged that meaning placed on this research will not be the discovery of an existing truth but rather the meaning will be

constructed according to the interactions, data and context in which it was obtained.

As the concept of 'Actual' belongs within a more realist tradition, the title 'Actual Communication' for Stage 2, where the consultant sees the patient, may seem contradictory to the study's constructionist approach. However, the word 'actual' was used pragmatically to distinguish between 'before the consultation' (anticipated communication), 'when the patient was seen' (actual communication), and the 'post-consultation reflections' (reflections on communication).

Qualitative research

Qualitative methods have a long history in anthropology, sociology and education (Britten *et al.*, 1995), and are recognised as contributing significantly to our understanding of health and healthcare. It is often described as seeking out the 'why' rather than the 'how' of its topic through analysis of a variety of empirical materials e.g. interview transcripts; cultural and historical artefacts 'that describe normal as well as problematic moments and meanings in individuals' lives' (Denzil and Lincoln, 2005:3). Qualitative methods are used to gain insight into many facets of human thinking and behaviour such as culture and lifestyles, attitudes, beliefs, value systems, concerns and motivations.

A qualitative constructionist approach was considered the most appropriate for this study; promoting greater insight and understanding into a specific aspect of the out-patient world of the clinicians and for exploring problems, issues or phenomena which quantitative methods could not have uncovered.

Ethnographic influences

This study was a *quasi*-ethnographic study because although *influenced* by ethnographic methodology, it could not claim to be ethnographic as the key to ethnography is the 'being there' and sharing. An interview based study would not achieve this.

Ethnography is predicated on the principle that social life is meaningful. We learn about people's lives as they engage with each other, and the world around them, according to their own lived experiences, interpretations and

understandings of actions, objects and communications. Ethnographic methods include the asking of questions, i.e. interviews, questionnaires or surveys, but also observation and participation in the lives of individuals, and questioning what has been observed or experienced. The aim was to witness the human events significant to the doctor's understanding of doctor/patient communication in an environment familiar to the doctor i.e. their own office and clinical consultations with patients.

Within the institutional setting of a hospital, interactions between the doctors, their secretaries, the patients and other health professionals are influenced by the cultural 'norms' of this environment i.e. 'hospitals both reflect and reinforce dominant social and cultural processes of their societies' (van der Geest and Finkler, 2004:1995). Ethnography is not a single research method and can involve a full range of research methods and 'cannot but be the best way' to learn about social phenomena and culture, whilst also being 'scientifically rigorous and systematic' (O'Reilly, 2005:1).

The present study design also included a variety of methods; observation, cognitive interviewing, loosely structured interviews, note-taking and audio recordings. Why these methods were chosen and how they were actually employed is described in more detail later in this chapter. Although the methods matched an ethnographic approach, carrying out the cognitive interviews, for example, created an environment and process that was not a reflection of the doctors' usual routine and therefore deviated from traditional ethnography. One could argue that observing consultations and attending specialty meetings did offer a certain amount of immersion in the setting and culture and the study remained significantly influenced by ethnographic methods including the ethnography of communication, described by Wardhaugh (2002:246) as 'a description of all the factors that are relevant in understanding how that particular communication event achieves its objectives'.

Quality and qualitative methods

Qualitative research has the purpose of 'generating understanding' (Stenbacka, 2001:551) and reliability is considered by many to be an inappropriate concept and several authors have offered an alternative to reliability. Lincoln and Guba

(1985:300) use '*dependability*', which closely corresponds to the notion of reliability and offer several other criteria that can be used to ensure quality: *Credibility, Neutrality* or *Confirmability, Consistency* or *Dependability* and *Applicability* or *Transferability.*

Seale (1999:266) suggests *trustworthiness* 'lies at the heart of issues conventionally discussed as validity and reliability'. Lincoln and Guba (1985:317) also emphasize '*inquiry audit*' as a process to ensure consistency in all aspects of the study: the design, analysis and writing up of findings and conclusion, and therefore contributing to the quality of the study. According to Stenbacka (2001:552) 'the concept of reliability is even misleading in qualitative research. If a qualitative study is discussed with reliability as a criterion, the consequence is rather the study is no good'.

It is clearly essential there needs to be some kind of qualifying check or measure for this research paradigm. As a result, many researchers have developed their own concepts of validity - generating or adopting what they consider to be more appropriate alternative concepts: *quality, rigor* and *trustworthiness* (Lincoln and Guba, 1985; Stenbacka, 2001; Davies and Dodd, 2002; Seale, 2004).

The rigour and quality of this study are covered later in this chapter.

Part 2: Practicalities of the research design and data collection methods

Introduction

This part of the thesis describes the process undertaken before data collection: designing the study; choosing the specialty and NHS Trust; moving on to an exploration of the methods used. The reason why secondary care and the specific specialty were used is given in Appendix C. Adaptations made to the study design and the data collection process is also explained. The section ends by visiting the ways in which rigour and quality were assured.

Number of data collection events

The following gives a strong affirmation of the empirical foundation of this work (Table 5). More detailed information is on page 80.

Data collection events in total = 84
Stage 1 – *Anticipated communication* **= 29 data collection events**
Stage 2 – *Actual communication* **= 25 data collection events**
Stage 3 – *Reflection on communication* **= 25 data collection events**
Additional material: **= 5 additional data collection events**

TABLE 5 : NUMBER OF DATA COLLECTION EVENTS

Ethics

As the study took place in an NHS environment, and patients were involved peripherally, Trust and Regional ethical approval had to be obtained. The following diagram (Figure 1) shows the stages and length of the process which is explained in detail in Appendices D; E & F.
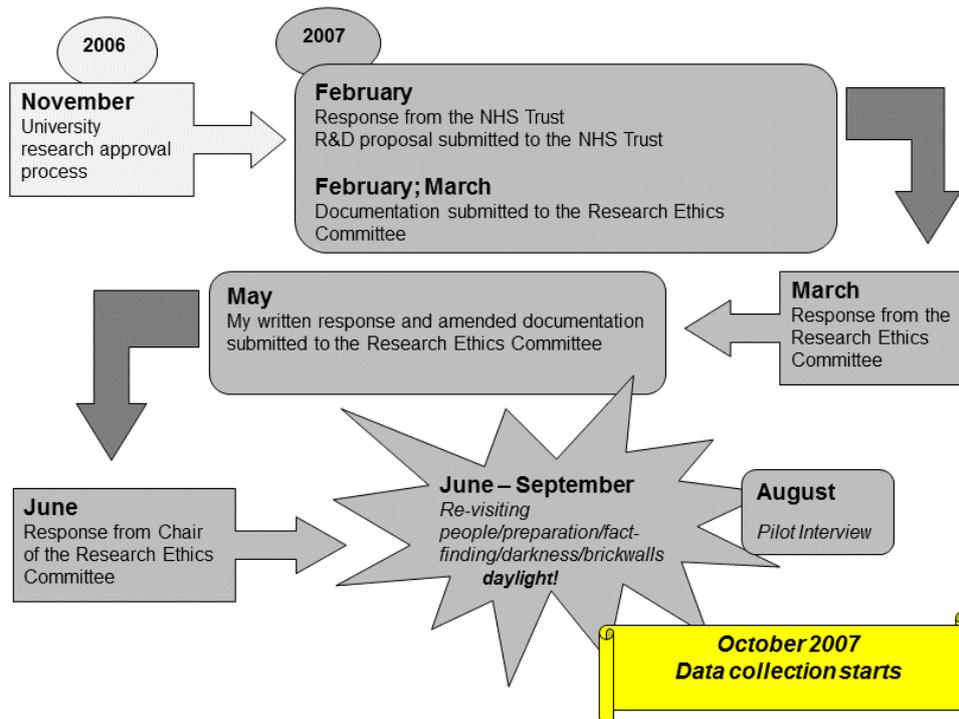
Choosing the specialty

To ensure a broad view of both male and female patients of a variety of ages, and to capture a variety of communication opportunities, a specialty that would not be age or gender specific was considered the most appropriate. A specialty with a team of ten consultants working across five hospitals within the same NHS Trust were approached to explain provisional plans regarding the study and gauge their willingness to participate. During these exploratory meetings, several issues emerged regarding the data collection (Table 6):

When referrals were received – some days there may be several, other days none
The problem of collating several referrals without consultants actually reading them before the cognitive interview
How to avoid a delay in urgent referrals being seen, picked up and actioned
How to 'track' when the patient would be seen in clinic and my own availability to attend and observe
Opportunities to observe a team meeting
The imposition the research may have on the consultants' secretaries and/or clinics' nursing and administration teams
How being involved in the study would impact on the doctors - if it was very time consuming they may be reluctant to participate
The study must not cause delays to clinics. Making any patient wait for the benefit of the research was clearly not ethical or acceptable
Any time set aside for interviews would be out with the doctors' normal commitments and they would have to find this time in an already busy schedule

TABLE 6: DATA COLLECTION ISSUES

Further information regarding the role of the secretaries and meeting the consultants is given in Appendix G.

The sample

Because of the focus and intended design, probability sampling (e.g. random sampling) or proportional representation were not appropriate. The sample was therefore purposive i.e. selected with a purpose in mind. The inclusion criteria were the doctor was part of the chosen specialty team within the NHS Trust with whom the study had been discussed. They also had to have the opportunity not only to read and assimilate the information about *new* patients but also be the physician who actually saw the patient. The principal exclusion criteria were physicians who did not fulfil the inclusion criteria.

It was an opportunistic sample, the nature of which resulted in a heterogeneous sample as opposed to a single gender, single culture sample, which may have given more narrowly focused data. It was also expert sampling, having gathered together individuals who were known to have demonstrable consultation skills.

The sample was selected in a non-random fashion. Eight consultants - two females and six males – were recruited from the team of ten. Four had been consultants for several years; two were significantly younger, having been consultants for a shorter period. One consultant came from an ethnic minority.

Although the study subjects were the consultants, for each consultant it was hoped to discuss and observe between three and six consultations with new patients, who by 'default' would be part of the study but not part of the study sample.

Consent

All consultants who agreed to participate in the study were provided with the information sheet (Appendix H) and consent to participate in the study (Appendix I) was obtained from the consultants before commencing Stage 1. All agreed for an invitation letter (Appendix J) to be sent to the patients whose consultations would contribute to Stages 2 and 3 of the study, together with an information leaflet (Appendix K) about the study. These were sent out by the individual secretaries. Before the consultation, consent was obtained from the patients for their consultations to be observed and discussed for Stages 2 & 3 (Appendix L). If a consultation could not be observed for any reason, data obtained during Stage 1 for the relevant patient would not be included in analysis.

To contextualise and supplement understanding of the issues relevant to this specialty, two multi-disciplinary meetings were attended, for which consent was required (Appendices M & N). These did not however contribute to the data or analysis.

Data collection methods

Interviews

This study was, methodologically, predominantly qualitative interview based – this being a pragmatic decision appropriate for the exploration of potential influences on the consultant's prospective communication with a new patient

and for retrospectively exploring the communication that took place (Silverman, 2010).

Rapley (2004:15) described the qualitative interview as 'a story that describes how two people, often relative strangers, sit down and talk about a specific topic'. They are 'social encounters where speakers collaborate in producing retrospective (and prospective) accounts of versions of their past (or future) actions, experiences, feelings and thoughts'. It is the interviewer who usually controls the exchange of information and defines the focus of the interview by leading the dialogue through questions. The respondent is in the more passive role of answering questions and providing information. As such, an interview goes beyond the exchange of views that contribute to everyday conversations. Significantly, in a research interview, the interviewer follows up on the respondent's answers to their questions.

Loosely structured interviewing

Interviews can vary from structured, where the interviewer asks each respondent the same series of questions which are standardised and consistent, to semi-structured, where the interviewees are asked the same open questions and once the topic focus has been established, their responses are free and unstructured and often uninterrupted. A sub-type of unstructured interviews are described by Rubin and Rubin (2005) as *guided interviews* or *guided conversations* during which the interviewee is encouraged to tell their story with minimal interruptions from the interviewer but who still maintains some order to the interview through half a dozen prepared questions.

These interview structures felt inappropriate for this study. A list of questions, whether formal or informal, was considered to be potentially distracting from being responsive to what the interviewee or participant said. Instead, loosely structured interviews were used, based on the system described by Rubin and Rubin (2005:148) incorporating notes or 'jottings'. Loosely structured interviews have been frequently used in research (Jackson, 2010; Alvesson, 2011; Hall, 2011; Giles, 2013) and serve to avoid imposing unwanted or inappropriate structure on the data - although as identified by Gomm *et al.*, (2000:255) inevitably some structure is necessary.

Cognitive/Think-aloud Interviewing

The term 'cognitive interview' has been used for several years to describe a method of data collection in different contexts - predominantly in memory retrieval in crime detection and information gathering in questionnaire design and evaluation.

In the 1980s Cognitive Interviewing was introduced for use by the police as a witness interviewing technique (Geiselman *et al.*, 1984) which involved the eyewitness learning several memory-retrieval mnemonics (Fisher and Geiselman, 1992). Although called the same thing, but distinct from the process described above, Cognitive Interviewing has also been a major method used for the evaluation of questionnaires or survey questions (Beatty, 2004).

The interviewer's role has also adapted to two main methods of cognitive interviewing. Firstly, to facilitate with minimal interruption the participant's verbalization of their thought process. The only interjection being when the interviewee stops talking out loud. This method relies almost entirely on the think-aloud process. The second method is to allow the participant to verbalize their thoughts, but the interviewer would then follow up the interview with more probing questions (Beatty and Willis, 2007). The method used for this study was a combination of both. The participants spoke without interruption, but were then prompted to elaborate on what was said.

Fundamental to cognitive interviewing is the think-aloud process and the creation of verbal reports or protocols, the use and development of which are guided by the work of Ericsson and Simon (1993). In the literature the terms cognitive interviewing and think-aloud interviewing appear interchangeable although the term think-aloud seems favoured in much research in health care settings. Literature also suggests that think-aloud is beneficial as it links the thinking processes of the participant with concurrent perceptions - revealing information in a particular part of the memory (Lundgren-Laine and Salantera, 2010).

There are several examples of cognitive or think-aloud interviewing being used in health-care research (Schuwirth *et al.*, 2001; Ahmed *et al.*, 2009; Brown *et al.*, 2009; Damman *et al.*, 2009; Darker and French, 2009; Fortune-Greeley *et*

al., 2009). Several studies have also used think-aloud techniques developed from information processing theory for researching clinical reasoning and decision making (Newell and Simon, 1972). Haimes (1990), carried out retrospective interviews with fourteen members of the Warnock Committee, exploring the management of sensitive information. Aitken and Margedan (2000) used the think-aloud process in the 'Natural Setting' i.e. whilst participants were performing usual nursing duties although some circumstances they did not continue if the context was inappropriate. Aitken, Marshall *et al.,* (2008) explored the decision making of critical care nurses who were subsequently interviewed to gain explanations and insights into their expressed thoughts. Offredy and Meerabeau (2005) employed paper scenarios and think-aloud to explore decision making by GPs and nurse practitioners, identifying decision making errors. Desai and Bolus *et al.,* (2009) used cognitive interviews with dialysis personnel to elicit perceptions regarding best practice in dialysis care. The think-aloud method has also been used to explore patient participation in healthcare consultations (Entwhistle *et al.,* 2004).

Ericsson and Simon (1993) describe two types of verbal reports – concurrent or retrospective. The former when the cognitive processes are verbalized as they occur i.e. thinking aloud. The latter, retrospective, accesses memory retrieval, described by Newell and Simon (1972:184) as allowing more opportunity to mix current and past knowledge, making 'reliable inferences from the protocol difficult'. This was echoed by Ericsson and Simon (1993) who described retrospective think-aloud interviewing as being open to weakness as the memory retrieved could be something similar to, but not the actual event, under study. This study used concurrent verbal reports.

During the cognitive interviews for this study, notes were made, either as full sentences or just words, regarding comments by the doctor, or observations made. These jottings were used to inform later questions asked of the doctors. Questions were formed and prompted by what the consultant said – or did not say. Post-consultation interviews were structured around the concurrent 'jottings' during the cognitive interview, in combination with data from the observed consultations, to inform other questions. By following this system, all jottings were relevant and pertinent to the aims of this type of research. Bugge

et al (2006) using think-aloud, video and interview data, focused on situations where information relevant to decision making in the consultation was not exchanged, either by patient or health professional. During the think-aloud process, the participants, having watched selected video clips of the consultation, were encouraged to discuss what they remembered thinking at that time of the consultation, but also what their current views were.

As the Cognitive Interview was fundamental to the study, it was essential to establish whether it would work as a method of generating appropriate data. It was not possible to receive formal training in this method, so advice was sought from experienced researchers who used the method, including Leanne Aitken (Aitken and Mardegan, 2000; Aitken *et al.*, 2008). A range of literature was read, particularly health care related studies (Aitken and Mardegan, 2000; Beatty, 2004; Offredy and Meerabeau, 2005; Bugge *et al.*, 2006; Willis, 2006; Aitken *et al.*, 2008; Quirk *et al.*, 2008; Ahmed *et al.*, 2009; Fortune-Greeley *et al.*, 2009; Hoffman *et al.*, 2009). In addition, a pilot interview was designed and carried out in order to become familiarised with the techniques and methods required.

Audio vs video

Capturing the communication on video was potentially an option, but advice was that this would make the research more complicated, not only ethically but also practically. The consultations were not all taking place at the same site, making the setting up of equipment time consuming and potentially impractical or unlikely to be possible. Although the use of video is recognised as a valuable means of capturing doctor-patient interaction (Heath *et al.*, 2007) the presence of the camera may have an inhibiting effect on doctor and patient, although there is little evidence to support this (Coleman, 2000). There is evidence that some patients are less likely to give consent for the consultation to be observed if it was to be filmed, or if they intended to talk about mental health issues (Martin and Martin, 1984; Howe, 1997; Coleman, 2000; Heath *et al.*, 2007; Themessl-Huber *et al.*, 2008).

It was therefore decided that observing and audio recording the consultations and/or making notes would be less intrusive, more appropriate and more

practical. From the perspective of being the researcher, recording the interviews and the consultations meant that more of the verbal interaction was captured than if only taking notes. The existence of the recordings also gave the opportunity to replay the interactions, create transcripts and provide illustrations, examples and demonstrations of developing themes.

Potential influences

Although recording interviews is common practice, consideration was still made regarding the influence this may have on the interview. According to Rapley (2004:18), the answer to the question 'does the tape recorder influence the talk?' is 'yes' and 'no', but in his experience, significant issues for interviewees are the permanency of the recording, being identified, and trusting the interviewer that information will not be misused. None of the patients expressed any concern about the consultations being recorded and none of the consultants found the recorder inhibiting.

Rapley (2004:19) also describes 'off-tape' talk which takes place once the recorder has been switched off - the 'prior talk being the product of a specific interactional context (and a specific identity) but now the context (and identity) has shifted again'. In this study, his description of the change in context and role of the interviewee was apparent when the doctors who spoke 'off-tape' tended to pre-fix this talk with 'personally'.

Use of field notes

Field notes, however brief, were essential and together with the jottings informed the structure of interviews. Contemporaneously and retrospectively written jottings and field notes also provided an aide memoire when moving into the next stage of the study process. They provided the potential for back-up had the recording failed and also additional material to the recordings, which gave a broader account of the verbal/non-verbal (interview) or observed (consultations) interactions. They also provided observational and/or descriptive material about the environment in both situations as well as capturing some of my 'headnotes' (Emerson *et al.*, 2011) of details or impressions. Notes were made in various places: during the cognitive interview; the hospital setting, including the out-patient waiting area; clinical rooms and

consulting rooms. Subsequent notes were made as soon as possible after the data collection event, sometimes in the car. Some notes remained as brief aide-memoires, whilst others were more detailed, depending on the timeframe between each stage of the study. A research diary, more reflective in content, was also kept.

Observation

In keeping with the ethnographic influence, the study design provided opportunities for observation. There were several opportunities to observe, and depending on the context, the purpose varied. The out-patient clinics provided the opportunity to gain insights into the professional culture and the general running of the clinics. Observing specific consultations provided an opportunity to observe the professional clinical context. The consultations, and the dynamic within this situation, were observed in order to gain a rich picture from which to develop an understanding of the communication process. Observation of the two inter-disciplinary meetings (Appendices M & N) provided an opportunity to broaden the context of the specialty including the use of specialty-specific terms.

According to the three different types of participant observation (Wolcott, 1988) observation for this study was by definition 'limited', but access to the consultants' secretaries and workplace was open and information was freely provided. This is explained in more detail in Appendix O.

The sample and data collection

Participant codes and anonymising data

It was essential the identities of the sample and the patients were anonymised. Codes were required for the following: the site where the consultant was based; the individual consultants; the data collection events or stages for each consultant and each patient. During writing, when making reference to individual consultants and specific patients, anonymising codes and pseudonyms have been used (Table 7).

Categories:			
➢ Site ➢ Consultants ➢ Patients ➢ Data collection events ➢ Other events			

Sites:	Patients:	Data collection events:	Other events:
X Y Z	P1-P5	**CI** – Cognitive Interview **M** – Consultation **MM** – Consultation repeat **RI** – Reflective Interview (post consultation immediate) **RD** - Reflective Interview (post consultation delayed)	**PTDNA** – patient did not attend **JDUTA** – researcher unable to attend **PTREF** – Patient refused consent

Consultants:	Consultant plus patient:							
➢ **X1 - Dr Padan** ➢ **Y1 - Dr Kings** ➢ **Y4 - Dr Mason** ➢ **Y5 - Dr Allen** ➢ **Z1 - Dr Shaw** ➢ **Z2 - Dr Workman** ➢ **Z3 - Dr Schofield** ➢ **Z4 - Dr Clarke**	X1P1 X1P2 X1P3 X1P4	Y1P1 Y1P2 Y1P3	Y4P1 Y4P2 Y4P3	Y5P1 Y5P2	Z1P1 Z1P2 Z1P3 Z1P4	Z2P1 Z2P2 Z2P3 Z2P4	Z3P1 Z3P2 Z3P3 Z3P4	Z4P1 Z4P2 Z4P3 Z4P4 Z4P5
Patient pseudonyms used in Chapters 4,5 & 6	**X1P3** John Williams	**Y1P1** Aden Winterton	**Y4P2** Barbara Clarke **Y4P3** Mary Brewer	**Y5P2** George Adams	**Z1P1** Jane Sanders **Z1P3** Violet Stokes	**Z2P2** Jack Ellis **Z2P3** Niki Ford	**Z3P3** Maria Alirdhi **Z3P4** Michael Rivers	**Z4P3** David Price **Z4P5** Harry Smith

TABLE 7: ANONYMISING THE DATA

For each data collection event, the appropriate code was allocated e.g. for Consultant X1 (Dr Padan) and the first patient, each stage would be coded i.e. X1P1CI; X1P1M or X1P1MM; X1P1RI or X1P1RD. This coding system was repeated for each consultant/patient combination and each stage of the data collection process. The age and gender of the patients was also noted, as was the gender of the consultants. All data collection events were recorded on an excel spread sheet.

Adapting the data collection process

The consultants' workload

Data collection had to fit around the consultants' workload, their diaries, their clinics, when referrals were made and when patients would be attending clinics. Although the fundamental research design was considered 'do-able' by each consultant, how the design would be implemented was negotiated with individual consultants (Table 8). This had not been anticipated and a detailed explanation is given in Appendix O.

In order for all three stages to be completed in one day, the respective secretaries had to do the following:

- Check consultant's availability
- Check availability of a clinic 'slot' in the out-patients department
- Book an extra clinic – liaising with the nurse in charge to ensure there would be appropriate nursing cover
- Choose the appropriate number of referral letters
- Contact relevant patients to advise them they were being offered a place in a 'research' clinic
- Explain what the research study was about and to what the patient was agreeing
- Ensure no patient had an unfair advantage or were disadvantaged by being offered places on the 'research' clinic.
- Ensure patients felt able to refuse to participate in the research
- Ensure an alternative appointment was available for the patient if they refused
- Liaise with the regional appointments centre to advise of the special clinic but also to arrange potential alternative appointments
- Send out invitation letters to patients together with the research information leaflet

ADAPTATIONS	CONSULTANT	STAGE 1	STAGE 2 (timescale after stage 1)	STAGE 3 (timescale after stage 2)
patients 'tracked' to different clinics	X1	4 PATIENTS 1P1-X1P4	X1P1 – N/A - JDUTA X1P2 – 9 DAYS X1P3 – 6 WEEKS X1P4 – N/A - PTDNA	X1P1 – N/A X1P2 – SAME DAY X1P3 – SAME DAY X1P4 – N/A
½ day special clinic to do all three stages	Y1	3 PATIENTS Y1P1-Y1P3	Y1P1-Y1P3 – SAME DAY	Y1P1-Y1P3 – SAME DAY
½ day special clinic to do all three stages	Y4	3 PATIENTS Y4P1-Y4P3	Y4P1-Y4P3 – SAME DAY	Y4P1-Y4P3 – SAME DAY
patients chosen from existing clinic	Y5	2 PATIENTS Y5P1-Y5P2	Y5P1-Y5P2 – NEXT DAY	Y5P1-Y5P2 – 3 DAYS LATER
all allocated appointments at existing clinic	Z1	4 PATIENTS Z1P1-Z1P4	Z1P1 - 10 DAYS Z1P2 - N/A - PTREF Z1P3 - 10 DAYS Z1P4 - N/A - PTDNA	Z1P1 - 2 DAYS Z1P2 – N/A Z1P3 – 2 DAYS Z1P4 – N/A
½ day special clinic to do all three stages	Z2	4 PATIENTS Z2P1-Z2P4	Z2P1-Z2P4 – 3 WEEKS	Z2P1-Z2P4 – SAME DAY
patients 'tracked' to different clinics	Z3	4 PATIENTS Z3P1-Z3P4	Z3P1 – 4WEEKS* Z3P2 – 6DAYS Z3P3 – 4WEEKS* Z3P4 – 4WEEKS* *same clinic	Z3P2 – SAME DAY Z3P1:Z3P3:Z3P4 – SAME DAY
full day special clinic to do all three stages	Z4	5 PATIENTS Z4P1-Z4P5	Z4P1-Z4P5 – SAME DAY	Z4P1-Z4P5 – SAME DAY

TABLE 8 : ADAPTATION OF DATA COLLECTION PROCESS

Total number of data collection events and data sets

What the data from the different stages of the study represented is shown in (Table 9):

Data collection events
Stage 1 – Anticipated Communication – (approx. ½hr per each referral read)   8 consultants ranging from 3-5 interviews each = 29 data collection events.
Stage 2 – *Actual communication* (approx. 45mins per observed consultation)   8 consultants ranging from 2-5 consultations = 25 data collection events
Stage 3 – *Reflection on communication* (approx. ½hr per interview per patient seen)   8 consultants ranging from 2 - 5 interviews = 25 data collection events
Additional material: General discussions following interviews (approx. 20mins each)   1 x 5 consultants = 5 additional data collection events
Total = 84 data collection events.

TABLE 9: DATA COLLECTION EVENTS

From the above events, the total number of data sets i.e. matched interviews for anticipated communication, observed and transcribed consultations (actual communication) and reflection interviews was twenty-five (Table 10):

Consultant	Complete sets	Total
Dr Padan (X1)	X1P1;X1P3	2
Dr Kings (Y1)	Y1P1;Y1P2;Y1P3	3
Dr Mason (Y4)	Y4P1;Y4P2;Y4P3	3
Dr Allen (Y5)	Y5P1;Y5P2	2
Dr Shaw (Z1)	Z1P1;Z1P3	2
Dr Workman (Z2)	Z2P1; Z2P2; Z2P3; Z2P4	4
Dr Schofield (Z3)	Z3P1; Z3P2; Z3P3; Z3P4	4
Dr Clarke (Z4)	Z4P1; Z4P2; Z4P3; Z4P4; Z4P5	5
	TOTAL: 25	

TABLE 10: TOTAL NUMBER OF DATA SETS

This represented a substantial amount of material, consisting of audio files; written transcripts of interviews, consultations and general discussions.

Data collection in action

The stages of the study

Stages 1, 2 and 3 aimed to allow for an iterative process for data collection as well as provisional analysis, in which the previous stage would influence the following one, and subsequent stages used to provide the basis for retrospective analysis of previous ones. The Cognitive Interviews (Stage 1 - Anticipated Communication) were carried out on selected referral information that had not previously been seen by the consultant. The focus of the interview was to hear the verbalisation of the consultant's thoughts i.e. what 'sense' the consultant was making of the information, what other factors were being deduced from the information and how they thought the information may influence their communication with the patient. These interviews were intended to be transcribed and provisionally thematically coded before observing the appropriate clinical consultation (Stage 2 - Actual Communication). It was anticipated that observations would occur over a period of time, depending on when the patients needed to be seen. Also anticipated was having time to transcribe, provisionally code and compare the Anticipated Communication with the Actual Communication before doing the post consultation interviews (Stage 3 - Reflection on Communication).The aim of this stage was to establish the consultant's views on the consultation communication; whether their anticipated communication reflected their actual communication and whether assumptions or stereotypes had influenced their communication.

Stage 1 - Anticipated communication

Introduction

All referral letters were seen first by the secretaries, who anticipated taking two to three days to set aside between three and six referrals for the study. As referrals were not read every day, this was considered to be near the usual waiting time for non-urgent referrals. The secretaries could recognise if the referral needed to be followed up urgently and these would not be included in the study. In cases where the secretaries were unsure, another consultant read

the referral to assess acceptability for inclusion in the study. The secretaries set aside referrals that would hopefully provide both male and female patients and a range of ages. This of course, could not be guaranteed.

As consultants were being asked to talk openly and frankly about their feelings, concerns or expectations, they were more likely to speak freely if given an appropriate space in which to do so. Interviews were carried out either in the doctor's own office or in the consulting room in the out-patient clinic. Both places were 'home territory' for the doctor and provided a confidential space, except when the clinic nurse was present.

The interview process

Before this interview, all consultants were provided with information about the study, its design and aims (Appendix H). They were asked if anything needed clarifying. Although they had given verbal consent, written consent from each consultant was obtained before starting the interview (Appendix I). The format of the cognitive interview was explained again to ensure each participant understood and was comfortable with the process. To enable the recording of all interviews, the participants were again asked for consent to record and issues of confidentiality and anonymity were addressed. The participant was asked if they were ready to start.

As one might anticipate, interviews varied and the following describes the different experiences encountered with different consultants.

As the interview began, participants were shown for the first time referral information about a new patient. They were then asked to 'read aloud' the information and to 'talk aloud' their thoughts as they processed it. Most interviews went without interruption, but a couple had to be suspended whilst the consultant dealt with queries from a colleague or phone calls.

All but one, who required prompting with *'you're not saying anything',* started reading the referral information out loud. The consultants were left to continue talking until they reached a point where they either stopped talking or indicated they wanted some contribution from me. As previously explained, a prepared list of questions was not used, but jottings and brief notes were used

to explore what they had said; the information they had read; the comments they had already made but also, about things they may not have mentioned, such as the patient's age, gender, address etc. Only when the cognitive or think-aloud process had finished was the consultant asked probing questions to elicit more information. For example, if they identified the patient's address was in a very rural area, the following question was 'does it make a difference if they are from..?' Such probing questions continued, following the content of what was said e.g. the name of the patient ('anything about their name?'), or what was omitted e.g. their age ('what difference does it make that he/she is...?')

Some questions may be perceived as leading rather than probing. There are two schools of thought regarding this. In a positivist tradition, emphasis is on the absolute standardisation of the whole process, arguing that the role of researcher is to remain neutral, (Weiss, 1994b). If it is perceived that questions at the beginning of the data collection are leading, or the researcher is not 'neutral', then the data could be judged as flawed (Ackroyd and Hughes, 1992; Weiss, 1994a).

However, being more interactive with the participants is advocated by Lundgren-Laine and Salantera (2010) in their study exploring clinical decision making using the think-aloud technique and alternatively to the positivist tradition, emphasis is on interviews being social occasions with the potential to build a rapport and create conversational possibilities in search of depth (Kvale and Brinkman, 2009). Social occasions do include leading questions, not by design or intent, nor even by carelessness, but as a by-product of the flow of conversation. The argument therefore, is that leading questions can be inevitable, or avoided only at the cost of creating a more stilted interaction. There is also the argument that through the media of information leaflets, recruitment discussions, consent forms and the meeting and greeting before the interview (where the project and the reason for the interview are unpacked) researchers implicitly and explicitly show the interviewees the kind of style, format and trajectory of talk in which they are interested (Rapley, 2012:549).

The interview continued until both myself and the interviewee felt the it had reached a natural conclusion. The next referral letter was then given to the consultant and the process was repeated.

Stage 2 – 'Actual' communication: observation of consultations

The aim of this element was to link the 'anticipated' communication with the 'actual' communication. The influence of ethnography was apparent as some consultations did represent an aspect of 'the context of their daily life and cultures' (O'Reilly, 2008:3) although others were specifically organised for the study. This altered the dynamic of the clinic, particularly time-wise, and although the observation was direct in all cases, unlike an ethnographic study, it was not sustained over a period of time and only provided a snapshot of their overall consulting practice. The post consultation interviews were also not a usual part of the consultant's daily life but were taking place specifically for the study.

Before attending clinics, patients should have received a letter explaining the research and inviting them to take part (Appendix J), together with an information leaflet (Appendix K). However, some did not, being telephoned instead by the secretary, who explained there would be a researcher present in the clinic. Clearly, these patients had not read about the study so they required more time to be spent with them before gaining their consent. The opportunity to discuss the study and gain consent was not as straightforward as hoped. All clinics took place in busy out-patient departments with some having several concurrent clinics. In the clinics specifically set up for the research, the nursing staff advised when the patient arrived. One hospital provided a room in which the research could be discussed in private with patients. In other clinics, where non-research patients were also seen, the staff knew nothing about the research and this felt very uncomfortable, as it seemed the study was obstructing the normal flow of events. It had been hoped that reception or nursing staff would say when the 'research' patient arrived, but instead it was necessary to stand near the reception to over-hear the patients' names as they reported in. If unable to create a 'space' in which to talk to the patient, there was no choice but to sit with them in a busy waiting area. As it was essential

the patient was seen before their consultation, a lot of negotiating with reception staff and clinic nursing staff took place to make this happen.

Further information was given to patients and any questions answered. If the patient agreed to their consultation being included in the study, written consent was obtained before their consultation (Appendix L). All patients were assured that whether they agreed to be involved in the study or not, their clinical care would not be influenced or compromised in any way. Data obtained during Stage 1 was withdrawn from the study for one patient who did not consent.

Having obtained written consent, the consultation was observed and audio recorded. The recorder was placed between the patient and the consultant except when the consultant physically examined the patient when, to maintain the patient's privacy, the recorder was held outside the door or curtain. Consultations lasted between twenty and forty-five minutes. No other contribution from me was required apart from acknowledging the patient when they arrived and thanking them when they left. Although clearly aware of another person's presence, patients did not appear to find it inhibiting. Depending on how the data collection had been arranged, other consultations were subsequently observed, or the process was repeated at another time.

Having become familiar with the concepts of habitus, capital and field (Bourdieu, 1977; Bourdieu and Passeron, 1979; Robbins, 2008) it was interesting to contextualise these concepts with observations of the consultants' different styles, not only from each other, but towards different patients. Some were more formal whilst others had more curiosity about the patient's personal life. The length of the consultations also varied.

Stage 3 - Reflection on communication: post consultation interview

The aim of this element was to explore with the consultants how they felt the consultation had gone. Without the patient present, the interviews focused on the consultant's reflections on their 'anticipated' and 'actual' communication with the patient. The interviews lasted approximately 15-20 minutes for each consultation and were audio recorded. When the study was designed, it was

anticipated that Stages 2 and 3 would be completed on different days. However, it became apparent that this data collection would have to be either on the day of the consultation or within a couple of days in order for the consultant to recall with any degree of accuracy or clarity how the consultation went – or as one of the consultants put it:

> **Dr Allen:** *'It needs to be close enough to enable us to be 'reflectful' and not 'forgetful'*

The intention was to ask each consultant to identify a 50% selection of Stage 2 consultations that were memorable for them for the communication that took place. However, as the consultants were keen to reflect on all of their consultations, 100% of the consultations were followed up by Stage 3 interviews.

The data collection stages provided a logical progression from the referral process, to the patient being seen, to reflections on the communication. Having listened to the information contained in the referral letters and the thoughts, ideas and comments of the doctor, and observed and listened to the interaction with the patients, it was apparent there were many influences on the doctor's communication, and the inter-linking of these could be seen throughout the stages. Extracts from Dr Shaw (Z1) and one patient (Z1P1) illustrate the narrative thread through the stages of the study (Table 11). To help facilitate maintaining the anonymity of the specialty, some terms have been removed.

> **Stage 1 – Anticipated communication**
>
> **Dr Shaw:** *'So (if) she comes expecting an (procedure) then (I'll) have to probably tell her that she doesn't need one. … I will not purposely raise the issue, but if she expects … thinks she needs one, at the end when I ask any questions and stuff and she says 'what about an (procedure)?'… then I would probably tell her I don't think she needs one'*
>
> **Stage 2 – Actual communication**
>
> **Dr Shaw:** *'We could do an (procedure) if you're dead keen … well, if you're set upon, if you think you need one. If you ask me why I think you need one, I think it would be normal'*
>
> **Z1P1:** *'Yeah, okay. So you don't think I need one?*
>
> **Dr Shaw:** *'So I could do one if you feel there's any worries in your mind that could this be anything sinister or serious and you want mind put at rest, if you feel that way, I'm happy enough to … '*
>
> **Z1P1:'** *… suppose that would … so that if subconsciously, I'm not aware that I am worrying about it … '*
>
> **Stage 2 – Reflection on communication**
>
> **Dr Shaw:** *'I don't think it went very well to be honest. Because at the end of it I got a feeling she still did not believe what I told her. And I feel [sighs], it's sort of … I think the agenda was having an (procedure) and I think she got the (procedure) she was after because I think she was worried she might have cancer. So she's, I think the agenda was getting the (procedure) done, so to that end I think she succeeded*
>
> **Jill Dales:** *'Why did you raise the subject of (procedure) when in the cognitive interview you said you would not do this?*
>
> **Dr Shaw:** *'Did I raise it after she expressed desire for it? No? I don't know why I did that then. I don't know why I did it then. It turns out that's really what she was after anyway, so That's the only way I could give her any more reassurance'* (i.e. offering the procedure)

TABLE 11: NARRATIVE THREAD THROUGH STAGES 1, 2 & 3

The consultants differed considerably in their ability to reflect and to acknowledge influences on their communication.

Following Stages 1 & 3, once the interviews were 'over' in the formal sense, five of the consultants engaged in further discussions, some of which was a continuation of their reflections but also more general exploration of how they communicate in the clinical setting and what influences it. This phenomenon of rich material occurring outside the formal data collection process and therefore not used has been described as 'lost gems' (Cohen *et al.*, 2007). However, with the consent of the consultants, these 'gems' were gathered - recording and transcribing as 'additional material'.

Part 3: Data analysis

Introduction

Theoretical perspectives

There are many terms or models used to describe the process from interviewing study participants to understanding the meaning and context of what was said, to finally producing a descriptive account that effectively communicates what the data tells us.

Wolcott (1994) describes analysis as a process of interacting with the data in order to identify key themes and relationships. He defines *interpretation* as the stepping back and consideration of what to make of the data, or its meaning and context, and *description* being the descriptive account achieved as a result of letting the data speak for itself. Murphy, Dingwall *et al* (1998) describe the process of analysing, interpreting and transforming (making sense of the data). Rubin and Rubin (2005) describe the process in two phases. The first phase includes the preparation of transcripts; finding, refining and elaborating on concepts, themes, and events. The second phase they describe as having several 'paths' to follow by comparing concepts and themes across interviews before drawing broader theoretical conclusions.

Acknowledging the potentially 'massive amounts of data' gathered in qualitative studies, Patton (2002:432) describes the process required of reduction, sifting and identifying relationships before communicating what the data is saying.

Silverman (2010:221) suggests there are key questions a researcher can ask themselves which will in turn identify an issue associated with the analytical process (Table 12).

Question	Issue
What are the main units in the data and how do they relate or fit together, (bearing in mind that meanings may cross several units).	articulation
Which categories are used by the research participants (these should be used from the outset of analysis)	definition
What are the contexts and consequences of the categories used?	'hows' and 'whats'
What are the difficulties encountered by doing the study?	the creative use of troubles

TABLE 12: KEY QUESTIONS AND ISSUES (SILVERMAN 2010:221)

The issue of 'troubles' as identified in the above table is particularly relevant to this study. In the different interviews, the consultants spoke from different perspectives i.e. anticipating the consultation and their communication, and reflecting on their communication after the consultation. They also spoke of their experiences which fed into their anticipations and assumptions regarding communication with patients generally but also with the patient to be seen. They linked their professional and personal identities when contextualising their thoughts and attitudes regarding their communication with patients. This 'speaking with several voices' (Silverman, 2010:226) is viewed in different ways, depending on whether a positivist or constructionist approach is taken. For the former, it is likely to be viewed as a problem requiring a solution, such as separating the voices into distinct categories e.g. what the consultants say about 'patients' and what the consultants say relevant to 'this' patient. The latter (constructionist) view the 'several voices' as support for their argument that 'identity' is never a fixed entity inside our heads but that, depending on the context, we will present different aspects of ourselves. According to Silverman (2010:226), rather than trying to get rid of these multiple voices, we should 'examine what voices people use, how they use them and with what consequences'. This approach is fundamental to the 'active interview' described by Holstein and Gubrium (1995:227):

> *'Constructed as active, the subject behind the respondent not only holds facts and details of experience, but, in the very process of offering them up for response, constructively adds to, takes away from, and transforms the facts and details. The respondent can hardly 'spoil' what he or she is, in effect, subjectively creating'*

This approach was taken for this study as all subject positions in the form of reflections, comments and assumptions made by the consultants - as they actively created meaning regarding their communication with patients/this patient - were viewed as findings rather than problems.

Analysing the data

Quantity of data

Before describing the analytical process, the following shows what data was available and approximately how much of it there was (Table 13):

	Recordings	Transcripts	Field notes approx. one page per data collection event	Total:
Anticipated Communication	25	25	25	75
Actual communication	25	25	25	75
Reflections on communication	21 (immediate) 4 (delayed)	21 (immediate) 4 (delayed)	21 4	63 12
General Discussions	7	7	7	21
Total:	84	84	84	**225**

TABLE 13: DATA_WHAT AND HOW MUCH

Transcriptions

The audio recordings were originally to be transcribed by a secretary. When this was not possible, they were sent to an external transcription company used by the University. With hindsight, because the secretary may have recognised the participants' voices, using the company increased the potential for maintaining the anonymity and confidentiality of the participants. Due to the circumstances and adapted study design, several data set recordings required transcribing. As a result, the iterative process intended i.e. Stage 1 data recording – transcription – analysis – Stage 2 data recording – transcription – analysis, did not happen quite as intended.

The transcription company was advised of the required transcription notation and formats which were in line with the study's aims and objectives.

Choosing a thematic approach

Having read several texts and studies regarding analysis strategies, an approach guided by Rubin and Rubin (2005), was chosen. They described a data analysis which interprets *meaning* from data content in order to 'reveal patterns or to stitch together descriptions … into a coherent narrative'. They also make the point that although analysis is based on the words, descriptions, stories presented by the interviewees, 'the interpretations are those of the researcher'. This reinforced the need to be honest and true to the data.

Moving from the raw interview data to analysis of the transcripts and the production of evidence-based interpretations was a complex and long process. Drawing on Rubin and Rubin (2005), the following sections describes the analysis process.

Analysis Process

All elements i.e. Cognitive interviews, Actual communication and Reflections on communication

Familiarisation and editing

- Once transcripts were received each consultant/patient set was colour coded by printing on coloured paper: White=Cognitive Interviews; Blue=Actual Communication; Green=Reflective Interviews. This facilitated identification of each part of the data.

- Whilst listening to the relevant recording, all transcriptions were read and edited for accuracy, not only for content but also for the attribution of dialogue.

- All transcripts were then up-loaded to the qualitative software programme, NVIVO 9 and labelled accordingly e.g. Y1P1CI.

- Transcripts from each individual consultant were read again to gain a general impression of what concepts and themes were present.

- The process was repeated but hand written annotations were made to highlight specific points or the focus of the comment (for example, about the referrer, the patient, medical information, apparent assumptions). Detail was added if anything occurred that might influence the interpretation, such as laughter.

Concepts, Themes and Coding

Attention was focused on dialogue that could be interpreted as stereotyping or an assumption as these were fundamental to the aim of the study.

- Initial codes were created in NVIVO 9 e.g. area/address of patient's home; not often seen by GP; patient's health beliefs.

- Synthesis of all the cognitive interviews for each individual consultant/patient pairing was made to aid understanding of the overall narrative.

- Some similar themes emerged. Additional codes were directly or indirectly revealed e.g. anticipated emotional state of the patient; mental image of patient.

- Synthesis of *all* consultants' cognitive interviews was undertaken to facilitate development of concepts and themes across the overall narrative of the eight consultants.

- Further codes were added until there appeared to be no further new or repeated concepts or themes.

- Annotations were made on NVIVO 9 as with the manual annotations

- Quotes were categorised into themes e.g. Patient; Consultant; Referral

At this point it was apparent that comments made by the consultants could be represented as expressions of their Ideas, Concerns and Expectations before seeing a new patient, and were categorised accordingly.

- Each category was also colour coded, so relevant transcribed dialogue was highlighted both manually and electronically as Ideas=blue; Concerns=green; Expectations=orange. This made them very easily identifiable when looking through quotes or full transcripts.

The concept of ICE was used as an *organising framework* or *heuristic device* for the cognitive interview analysis only (Table 14). This was fundamental in structuring the approach to, and the thematic categorization of, the data.

ICE	Anticipated Communication
IDEAS	Influence of the referrer or the referral information
	The patient or generalised comments on 'that type' of patient
	How they 'usually' communicate with their patients
	Influences including personal and cultural issues
	(Medical management)
CONCERNS	How the patient may present
	Difficult areas of communication
	How the consultation may go
EXPECTATIONS	Of themselves and of their communication
	Of the patient and their communication
	How they intend to communicate
	What they will communicate
	How the consultation will go

TABLE 14: ICE AS A HEURISTIC FRAMEWORK

Medical consultations

Concepts, themes and Coding

- The analysis aimed to create synthesis between the individual consultant's cognitive interview and communication with the respective patient i.e. how their anticipated communication and their actual communication were reflected in each other.

- Other themes or concepts e.g. use of humour or laughter; reassurance by the doctor; use of 'jargon'; collaborative language, were also drawn from the communication.

- Synthesis of *all* consultants' medical consultations was undertaken to facilitate development of concepts and themes across the overall narrative of the eight consultants.

Reflective interview*s*

Concepts, themes and Coding

- The analysis aimed to explore the influence of concepts, themes and codes identified through the cognitive and medical consultation.

- Specifically, the analytical focus was the influence of *a priori* assumptions expressed before the consultation or during this reflective interview.

In addition, memos were created in NVIVO 9 for each consultant/patient set to capture thoughts triggered by particular interviews; and cross referenced to other interviews. There was also a '*significant quotes*' folder created to capture quotes that indicated a theme.

Having coded the different interviews, patterns and connections were looked for. The coded data was sorted and compared for similar or differing aspects. Integration, continuous checks for accuracy and consistency continued as credible themes developed. Throughout this process, monthly meetings were held with my supervisors where the transcriptions were discussed, to provide confirmation from a neutral perspective, that themes were supported by the data.

As a result of this long and rather complex process, which is diagrammatically represented in Figure 2, all three stages addressed the study's aims and objective.
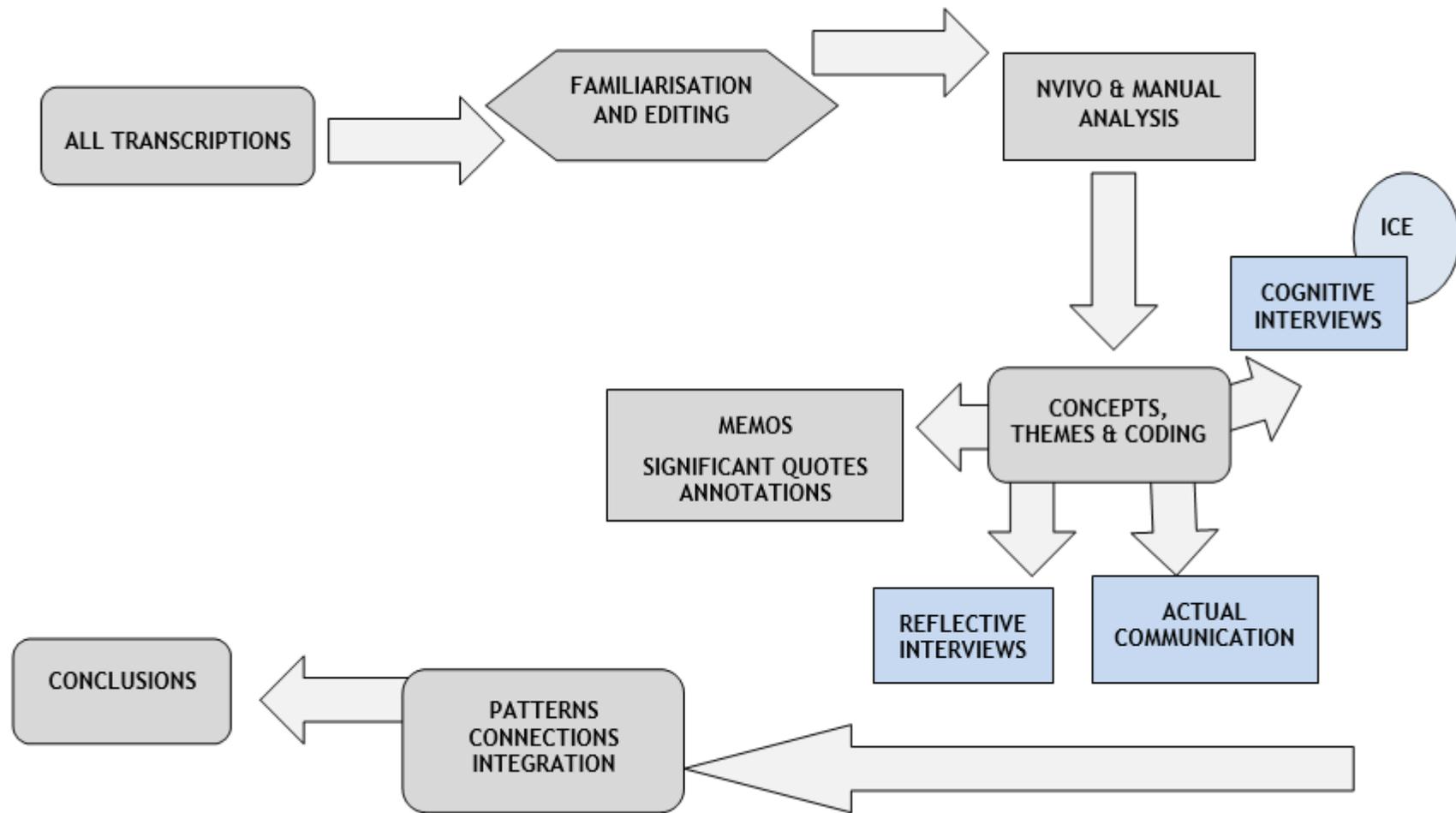
FIGURE 2: DIAGRAMMATIC REPRESENTATION OF DATA ANALYSIS PROCESS

The representation of data

Although Sperber (1985:11) referred specifically to anthropological research, his description of data representation was helpful when considering data in this study. Chapters 4-6 aim to provide *representations* - through *interpretation*, *description* or *reproduction* (as appropriate), of the comments, behaviours, characteristics and attitudes of the doctors through all three stages of the data collection process. The aim of the representations are to resemble as clearly and easily accessible as possible, the object, situation or event that it represents. When possible, representation is through reproduction of what was said or observed, but inevitably, sometimes it is through interpretation or description. According to Sperber (1985:16), 'it is dubious that what is achieved through interpretations could be achieved by any other means'. For example, representation of a doctor's demeanour may be through the interpretation or subjective understanding of a characteristic e.g. 'concern'. It may not be explicitly named by the doctor e.g. 'I am concerned'. The doctor may then be described in interpretive terms as 'sounding concerned' or 'having a concerned manner' as this characteristic is commonly perceived the same by those sharing a similar cultural understanding (Sperber, 1985). By synthesizing the representations, which do not necessarily emerge simultaneously but can develop progressively as a result of new data or further interpretations, the object of all the representations hopefully becomes clear.

Rigour and Quality of this study

Trustworthiness, subjectivity and bias were taken extremely seriously for this study. There may be concern that having a lone researcher may not ensure consistency and make the study material not available for others' scrutiny. It is axiomatic for a Social Science PhD undertaken at Newcastle University that the student is the sole analyst of their own data. Their developing analytical ideas are checked and discussed with, and defended to, their supervisors. To provide an affirmation of its quality and credibility, monthly face-to-face supervision with two supervisors took place. Through supervision, data were examined and initial and potential themes were identified. Subsequent meetings were used to test that analytical inferences were supported adequately by the data.

Feeling more comfortable with, and liking some participants more than others had the potential to influence observations, data analysis and the selection or exclusion of data. The reactions and feelings towards the participants did not remain unquestioned but were discussed with supervisors and thus raised as something to take particular notice of.

This did not just apply to the thesis, as any conference presentations representing all or part of the study were also seen and critiqued by the supervisors to ensure an accurate representation and unbiased view, supported by the data, was being put forward.

During attendance at a major international conference, as part of a mentoring system, a meeting took place with an experienced qualitative researcher, Dr Denise Baker-McClearn (2008). The focus of the study, methodology used and the preliminary data analysis process were discussed over a period of three days. After the conference, transcriptions of all interviews for one consultant/patient pairing were sent to the mentor, but to avoid imposing preconceptions or opinions, no analysis was included. The lengthy notated transcripts are not included but notes, brief analysis and comments were received back from the mentor and discussed in supervision. Several examples of narrative were identified by the mentor as reflecting the preliminary analysis and reinforcing the objectivity of the analysis thus far. The handwritten communication from Denise is Appendix P.

According to Bugge and Jones (2007:31), a lone researcher is also in a good position to 'see, hear and compare the various viewpoints (including the researcher perspective)'. Because of the staged approach, and the inextricable link between the data collection events, these sentiments fit with this study.

Whilst the data for this study was rich and descriptive, and potentially difficult to get through, *all* of it was read and considered. 'Outliers' or situations that deviated from the majority were not disregarded (Silverman, 2001). They were explored in order to try and identify or explain why these variations occurred and their significance.

The issue of quality or accuracy may be addressed by triangulation, in which the data or evidence is sought from different, independent sources using

different methods (Mays and Pope, 1995). Any method will be limited to the depth and breadth and perspective of information gathered, so combining methods can increase the potential for different issues and perspectives to be identified and for findings to be substantiated or reinforced. Because this process aims to reassure the *accuracy* of 'external reality' (e.g. facts, events) and 'internal experience' (e.g. feelings, meanings), it is described by Silverman (2010:225), as containing positivist elements. For this study, issues of trustworthiness and credibility were addressed through a form of data linkage, resembling triangulation e.g. a staged approach was taken; a variety of methods used including: different interview methods which were audio recorded; observation and audio recordings of the consultations; field notes; observation and note taking of meetings, but the intent was not to confirm *accuracy*. Taking a constructionist approach, the aim was to use varied opportunities or contexts in which to move through 'how' 'what' and 'why' questions in order to seek an understanding of the consultants' accounts of who and what they are as they drew on their experience. Also, the quasi-ethnographic elements of observation provided contextualised visual data.

Another criticism of qualitative research is whether it consists of just a collection of anecdotal and personal impressions (Silverman, 1987; Bryman, 1988; Silverman, 2000). Anecdotes are, however, very valid forms of passing information between people and the verbalised lived experience of any individual, including the participants of this study, should not be disregarded due to being unsupported by scientific 'fact'. Making the connection with the Calgary Cambridge framework, if a patient experiences pain and seeks medical advice from a doctor, whether the doctor can provide a scientific cause or reason for the pain does not invalidate it nor deny it from being experienced. The only 'evidence' to support the existence of the pain may be the anecdotal evidence of the patient, but in the context of the consultation, it has to be regarded as 'fact' or 'real' to the patient and therefore 'fact' or 'real' to the doctor.

Because the design, data collection and interpretation is often unique to the individual researcher, the issues arise of replication and falsifiability (described by Popper (1993) as refutability or testability). This is the possibility of another

researcher being able to reproduce not only the methods but also the conclusions. Although records of the data collection methods and events for this study were kept, showing how the data was categorised or filed, and documenting the process of analysis of data - described by Lincoln and Guba (1985:317) as 'inquiry audit' and Seale (2004:45) as 'audit trail' - the *methods* of this study may be replicated by another researcher but the analytic process and findings are unlikely to be the same, particularly if a different epistemological approach is taken. This issue of individuality, or 'human factor' (Patton, 2002:433) is regarded by some as a strength, but by others as a weakness, as it may result in the use of different terminology, the use and understanding of which may not be shared by more conformist researchers. It may also lead to a lack of a clear description of the analysis process itself (Patton, 2002; Silverman, 2010).

Part 4: Reflection on the research process

Introduction

The final section of this chapter begins by exploring my own 'positionality' during the research process. As is conventional, this section will be written in the first person.

As the consultants often wove between talking generally about their communication issues with 'patients' and specific communication issues with the patient about to be seen, the relationship between the 'general' and the 'specific' is explored. Because of this, the reflective process of how the data has been represented brings the section to an end.

Positioning & Reflexivity

My positionality

Regarding my positionality, or 'foregrounding lived experience and a changing cultural self' (Šikić-Mićanović, 2010:46), I am aware that I came to the study with a set of cultural, social and political values, perspectives and influences. I was very aware of my 'self-location' (Pillow, 2003:178) and how that could be perceived, or potentially influence situations. Everything about me: my age, gender, appearance, professional status and experience, role as a communication skills tutor, personal and professional values and beliefs, were inextricably linked with my role as researcher. The choice of topic to study was prompted by my professional experiences and personal interests. As acknowledged by Lillrank (2012:282), this is not unusual and for many researchers, the subject studied is of particular interest to them and something that touches both their personal and professional lives. Such is the connection between researcher and subject that Andrews (2007:27) stated *'Sometimes we might even feel that our questions choose us'*.

Being the means through which data was collected - referred to by Streubert and Carpenter (1995) as the 'researcher as instrument' – and the way in which I understood and described the social phenomena under study was inevitably influenced by my own theoretical orientations, academic training and my own ideas and concepts. Succinctly put by O'Reilly (2005:222): 'So, you are not just

experiencing and observing phenomena in their natural setting, you are interpreting, analysing, seeking, sorting and even affecting outcomes by your presence'.

Being aware of and paying attention to one's own position is achieved through the reflective process which in turn enables the researcher to demonstrate the trustworthiness or credibility of their research process and findings (Pillow, 2003). Reflexivity is recognised as a means by which the researcher, given their own positionality, can explore their representation of the participants in their study. It is described as a process of 'self-understanding and self-questioning' (Patton, 2002:64) but it's aim is not to prove or demonstrate objectivity on the part of the researcher, but to help the researcher understand 'the subjectivities through which our research materials are produced' (Pink, 2004:397). Two ways of bringing reflexivity to the forefront of qualitative research reporting is offered by Patton (2002). The first is the reflexive or first person voice which, by placing the researcher in the heart of the research, emphasises human factors and relationships as well as indicating honesty and mutuality. However, this is recognised by Patton (2002) as problematic for both the researcher and reader, depending on their perspective and expectations of academic writing. The second method offered is for the writer to provide a reflexive account integral to the writing process.

Throughout this study, aspects of reflexivity have been interwoven, and I have also reflected on whether my presence influenced the interaction with the patient. I am unable to know how much the doctors adapted their consultation style, but they all commented they were so used to having observers in their clinics e.g. medical students; other trainee health professionals; nurses; junior doctors; qualified doctors and health professionals that they were able to forget I was there. I have also reflected on how much my 'self' influenced *my* interpretation of events. I know I felt more comfortable with and positive towards some consultant's than others and have therefore had to question and reflect on whether I was in any way forming an opinion or placing a judgement on their practice and communication. Being aware of this led me to scrutinize more closely what was heard or observed, and whether my interpretation showed any degree of bias. This situation was discussed with supervisors and

my interpretations explored and challenged. Every recording of every consultation was listened to many times to be very clear of emotions, inferences, tone of voice, pauses etc. Every memo associated with a recording and transcript was read and re-read. Annotations written on transcripts and recorded in NVIVO were read in context of the spoken words.

The relationship between the general and the specific

Another potential challenge was the consultants weaving between specific and general assumptions e.g. relating directly to the information received in the referral letter and specific and general assumptions about their consultation style and 'patients'. The assumptions they expressed in the cognitive interview were not necessarily initially focused on the patient about whom the referral was written.

The following three chapters presenting the analysis are central to the study. Chapter 4 explores the comments made by the doctors as they processed the referral information which acted as a *trigger* or *catalyst* for the expression or 'uncovering' of prior assumptions and stereotypes. It is important to be clear what is being referred to with regard to the general and the specific, because there are separate issues here. Firstly, there are the assumptions. By their very nature, they do not occur in isolation. They are assumptions precisely because they are grounded in a context of previous encounters, previous assumptions, prior knowledge and experiences etc. So, in terms of the assumptions, the general can never be kept at bay. Epistemologically, it's probably an error to try and isolate the specific from general. So, in the analysis this 'problem' and its paradoxical features are recognised. However, I believe it has been possible to recognise when assumptions moved from general ones, triggered by the referral information, to more specific ones, which appeared to be the next 'stage' in the thought process being articulated.

Secondly, there is the doctor's consultation style, which could be described in general terms i.e. how they dealt with *patients*, or more specifically about *the patient* to be seen. Whilst the doctor's consulting style does play a part, they are not inseparable from the way the doctor forms assumptions about patients. When talking about how they would communicate with the patient, even if what

they said could be perceived to be their general consultation style, the reasoning behind it or the 'why' was inevitably based on an assumption. In everyday life, generalisations are drawn from personal experience, which by bringing a semblance of order and consistency to social interaction, make everyday life possible (Payne and Williams, 2005). As indicated in Chapter 2, some assumptions and generalisations may be without serious or harmful consequences, whilst others may have an opposite impact. Some assumptions are not always firmly held, and may be open to change.

Chapter summary

This comprehensive chapter has described, explored and provided rationale for the epistemological and theoretical approaches taken, as well as the study design and data collection methods used.

Social constructionism was considered an appropriate epistemological stance for this study because it places emphasis on everyday interactions between people, and how they use language to construct their perceived social reality. It regards the social practices people engage in as the focus of enquiry (Andrews, 2012), and involves looking at the ways social phenomena are created, institutionalized, and made into tradition by humans. Most of what is known and most of the knowing is concerned with trying to make sense of what it is to be human (Steedman, 2000).

Using a quasi-ethnographic approach, several complementary methods of data gathering were used. By way of a general definition, qualitative research 'locates the observer in the world' and through interpretative practices, 'makes the world visible' (Denzil and Lincoln, 2005:3). Fundamental to this study was the exploration of factors that had the potential to influence the construction and delivery of the doctor's communication with the patient. The aims of this study (Table 1 Chapter 1:7) therefore, are intrinsically qualitative and would not have been achieved using quantitative methods.

Two different types of interviews were used, the first being Cognitive interviewing or think-aloud. The originality of its use in this study is the focus on the influence of the referral information. The use of concurrent think-aloud

during the process of reading the referral information meant the participant was engaged in a 'real' task, rather than a hypothetical or simulated one, which would potentially make the verbal data less accurate and more difficult for the participants to provide. Using the think-aloud approach ensures the focus is on the participant's thoughts, which potentially means that data being obtained is 'most purposeful' for the research goal (Young, 2005:22). Using both think-aloud and reflective interviews raises questions how far it is appropriate to think that people attach a single meaning to their experiences and whether there may be multiple meanings Silverman (2010). In keeping with a constructionist approach, interview responses were treated as actively constructed narratives (Reissman, 2008; Gubrium and Holatein, 2009).

Observation is accepted as a valuable research method (Taylor *et al.*, 2006:112) and provided several strengths to this study, not least because is not just a single method - providing visual, auditory and other sensory information. Observation also provides an opportunity for spontaneous informal talk and potential unstructured interviews. This additional material allows inferences to be drawn from one data source and contrasted, corroborated or followed up by another (Mabweazara, 2013:109) which this study design facilitated.

There are a number of descriptions of different data analysis strategies. Many describe content analysis to create themes, concepts, events, patterns or units (Silverman, 2001; Patton, 2002; Rubin and Rubin, 2005) whilst others refer to a more theory development approach e.g. Grounded Theory Analysis. The way in which the data was analysed is set out clearly and the decision to use a thematic approach was pragmatic, given the study was exploring links between different contexts of doctor-patient interaction as well as the existence, significance and potential influence of doctors' assumptions.

Rigour and quality issues are also discussed and the chapter ends with a consideration of the representation of the data and of researcher positionality.

Chapter 4. Pre-consultation ideas, concerns and expectations

Introduction

This chapter seeks to do four things: Firstly to represent the method and design in action of the first stage of the study, in which *a priori* assumptions are key. Secondly, to present the uttered thoughts and other comments of consultants as they processed the referral information regarding a new patient. These underpinned the observations for subsequent consultations. It then seeks to demonstrate the use of the concept Ideas, Concerns and Expectations to capture and categorise what was said by the consultant and finally, to conclude with a summary of the findings and a self-reflection on the strengths and limitations of the design and method.

[1]Quotes from the doctors are used to illustrate themes. Quotes that correspond to a consultation used in Chapter 5, the patient's name is included after the quote. This is to assist the reader in following the thread between the stages of data collection for that consultant/patient pairing.

The concept of Ideas, Concerns and Expectations was adapted for this stage of the study and used specifically as an organising framework or framing device with which to 'categorise' initial comments made by the consultants (Table 15). This was done by analytically using the following guidelines:

❖ **Ideas** - comments and assumptions perceived to be about their communication generally, and influences on it.

❖ **Concerns** - comments and assumptions perceived to be expressions of potential concern regarding their interaction with a patient.

❖ **Expectations** - more specific comments and assumptions regarding their communication with *this* patient in the subsequent consultation.

---

[1] The conventional use of three dots notation i.e. **...** is used to indicate where speech has been intentionally omitted.

Anticipated Communication		
Ideas	Concerns	Expectations
Influence of the referrer or the referral information	How the patient may present	Of themselves and their communication with *this* patient about to be seen
A patient or generalised comments on '*that type*' of patient.	Difficult areas of communication	Of this patient and their communication
How they 'usually' communicate with their patients	How the consultation may go	How they intend to communicate
Influences including personal and cultural issues		What they will or won't communicate
(Medical management)		How the consultation will go

TABLE 15: CATAGORISATION OF COMMENTS USING ICE

Within this heuristic framework of Ideas, Concerns and Expectations the following elements were constructed (Table 16):

The construction of the referral
Including the referrer and the format and content of the referral information
The construction of a patient
The doctor's subjective mental image of the patient's physical appearance, personality or psychological state as well as their social standing. This construction was shaped by their perceptions about *this* patient but also more general comments about '*that type*' of patient
The self-construction of the doctor
The doctor's subjective perceptions about their existing or 'usual 'communication as well as influences on their communication which included personal, social and cultural issues that make them who they are (*habitus* of the doctor).
The construction of the consultation
The doctor's perception of being patient centred and how they would communicate with *this* patient. The concept of recognition emerged around this time in the analysis.

TABLE 16: EMERGING THEMES

It is acknowledged that issues identified by the consultants would not be the only influences on the consultation and communication with the patient. As in any communication situation, there were inevitably multiple influences on consultant and patient e.g. subjective, objective, demographic, institutional

and environmental. It is not within the remit of this study to identify all these specific factors. This study is designed to focus on the influence of assumptions expressed by the doctors.

The next section explores themes created from the comments interpreted as representing the consultants' *Ideas*.

Ideas

The construction of the referral

The term 'referral information' is used in this study as a generic term to cover a range of information available to the consultant. This includes the format of the referral, referrer, information describing the circumstances prompting the referral, patient's condition, tests, investigations and results and more personal information about the patient.

However, the following sections exemplify that it was not the written information alone that seemed to be significant.

Format of the referral

There were many potential referrers and the type of referral varied from a comprehensive outline of the patient and their current problem to tick box information with minimal or no additional background information. Before reading the referral, comments were made regarding its format, particularly of the computerised referrals. As illustrated by the following quotes the majority of consultants did not like these, due to their standardised format and the potential to provide information they considered unnecessary, or to hide information regarded as important:

> **Dr Allen:** '*... even before you see what's written on the form you think 'Oh God, it's one of those forms' ... we've gone from holistic care to tick box medicine, which has got to be disastrous.* (George Adams Pt.2)

> **Dr Clarke:** '*There's so much stuff to wade through - do I really need to know if a patient had an abortion thirty years ago?*'

> **Dr Kings:** '*Right here we go, it's a typical GP referral letter of several pages all stapled together and burying vital information among sheaves of paper*'.

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Two consultants, one of which is quoted below, liked this computerised type of referral which gave them more insight into the patient's general lifestyle and past:

> **Dr Workman:** *'This is a good referral, it's well laid out … clear … it's not everybody's cup of tea but I really like these computerised past history' … I think you can read a lot into them, like tea leaves'.*

From these comments it appeared that even before the information was read, the format of the referral influenced the consultant's thoughts regarding the 'value' of the referral. In keeping with the literature, it seemed that even with a lot of information, not all of it was accessible or complete. The consultants' 'starting point' regarding communication with the patient was, in some respects, dictated by their perception of, and response to, the way the information was provided.

The referrer

Not only was the *format* of the referral potentially significant but for some, the referrer also provided 'clues' in addition to the patient's health. Of the eight consultants, five spontaneously mentioned the referrer in all referrals, one had to be prompted for the second referral and one had to be prompted for the first referral. They were all asked what thoughts they had about the referrer. Dr Shaw was of the opinion that medical information from the GP most influenced his communication, but also commented:

> **Dr Shaw:** *'… my personal view has been that it doesn't really matter … I rarely see who has written. In fact I had to check the name when you asked me the question'.* (Appendix Q Jane Sanders Pt.1)

For three referral letters, Dr Shaw needed to be prompted regarding the referrer. Although his perception was he paid little attention to it, and it did not matter, once he did take note of it this did not seem to be the case. Making an assumption about the referrer's gender, he also expressed an opinion about the credibility of the referrer from the layout of the referral:

> **Dr Shaw:** *'… I've never met the guy - I assume it's a guy from the way the letter is written, but it's a well thought out letter,*

he's done the relevant groundwork … it suggests a good quality GP'.

The view the referrer was not necessarily significant was shared by others:

> **Dr Mason:** *'I don't suppose I've really picked up that one particular person is any better than the other. I don't to be honest read who the GP is in much detail'.*

> **Dr Allen:** *'I might have read it, but I did not really take it in'.*

In subsequent referrals, on initial reading of the information, all consultants (excluding Dr Shaw) made spontaneous comments about, or reference to, the referrer. Some were complimentary:

> **Dr Allen:** '*… are quite good … But they're not hugely ignorant. They're unlikely to be making a referral that's completely unnecessary'.* (George Adams Pt.2)

> **Dr Schofield***: 'I've not really had any problems with consultations from him; it's a good referral letter'.*

It would appear that, based on their previous experience with the referrer, the information provided for this referral was considered to be reliable and accurate. The referrer was also significant simply because they made the referral. In this next quote, Dr Padan is perceived to make an assumption about the validity of the referral, and ergo the state of the patient's health, based on her assumption that the surgery would not spend money on referrals unless they had to:

> **Dr Padan:** *'The surgery must be concerned about him because this is a very penny-pinching surgery. The patients have to earn their referrals … they really make their patients earn things'.* (John Williams Pt.3)

Dr Workman also appeared to establish an opinion about the validity and reliability of the referral information because the referrer was a single-handed GP, who, because of his style of referring, was not to be trusted:

> **Dr Workman***: '… another sort of short, unsatisfactory letter from a single handed GP, … you can often extract no useful information at all and you're in this situation that maybe the patient's problems are really trivial and don't merit a hospital assessment, or it may be that actually they are very serious … I feel you can't trust the referring GP to make that triage'.*

What appeared to be happening was that the consultant would either read who the referrer was, and then place a judgement on what they were about to read:

> **Dr Workman:** *'So this looks a challenge and it's from an extremely good GP who's great and I've never had duff referrals from him … it's not going to be something obvious* (Jack Ellis Pt.2)

> **Dr Clarke:** *'… what it would influence is that most of the patients I get referred from this particular doctor don't have anything wrong with them … so I get a feeling that she over-refers'.*

or they became aware of the referrer after reading the information and made a judgement on what they had read. The following quotes indicate that who the referrer was, also appeared to influence the consultant's assumptions regarding how the patient may have been communicated with, and what explanations they may have already had:

> **Dr Padan:** *'… she talks things through well with the patients so I know that she's already covered quite a lot of the ground that I need to cover, which is helpful'.*

> **Dr Mason:** *'… I guess what it's potentially telling me is that simple explanations and tests were not enough or that she's not happy, the relationship between the two of them has been poor and he can't provide her with the reassurance or … you're kind of reading between the lines … looks like he's not got very far here and he's trying to bail out of it in some ways'.* (Barbara Clarke Pt.2)

> **Dr Workman:** *'That's a pretty decent referral, it doesn't make any sort of stupid assumptions, so that's good because it means I am not going to have a patient who is expecting me to cure their leg pain'.*

> **Dr Kings:** *'… the individual is pretty good at their job, I think, but it's still very much a surgical approach, so if there's nothing to chop out or it doesn't come within the routine remit of surgical, accepted surgical problems, then basically they just want shut of them'.* (Appendix R Aden Winterton Pt.1)

As the above examples have illustrated, assumptions were made specifically related to the referrer e.g. what information a referrer would have discussed with the patient, on the basis of the referrer alone and were interpreted as having the potential to influence subsequent communication.

The referral

The significance of medical information was a common theme and one consultant seemed genuinely perplexed that anything other than that would be of any significance or influence:

> **Dr Shaw:** *'The only thing that influences me is the (medical) information – what the GP says - that's all there is to talk about – what else would influence me?'* (Appendix Q Jane Sanders Pt.1)

The inference being the medical focus of the referral was all that required consideration. One consultant considered the medical information but in the context of communication rather than medical management:

> **Dr Kings:** *'You're steeling yourself for the interview; if you anticipate it will be difficult - what can I say to keep them happy?'*

For seven consultants, referral information was not necessarily truth or fact, but merely a resource to compliment the patient's story, whilst the eighth anticipated the patient would just be reinforcing what the referrer wrote:

> **Dr Shaw:** *… the history is fairly good, I mean … the letter's a fairly good quality … in the sense it's telling most of the things I want to know. All I would be doing is corroborating what the GP has written.* (Appendix Q Jane Sanders Pt.1)

As expected, their initial comments illustrated the pattern recognition process. Consultants quickly reached a clinical decision regarding a provisional diagnosis or management plan. However, they also commented on the quality of the referral information and whether they could accept it as the 'truth' about the patient. If the referral came from a 'good' referrer, they were more likely to accept the information provided as representative of the patient's situation. However, for several consultants the information was inadequate and did not provide a clear picture of the patient's situation:

> **Dr Kings:** *'I'm also thinking the letter's pretty standard crap because it doesn't give you any of the information, enough of the information that you need. I mean, there are so many unanswered questions … I would not send a letter like that'.* (Appendix R Aden Winterton Pt.1)

Dr Allen: '... *the GP says she doesn't drink but, you know, one has always got to take that with a slight pinch of salt ... and evaluate for yourself whether that's really true'.*

Dr Mason: '*It's ... pejorative in some ways isn't it, the repeated use of the word 'multiple' suggests the GP thinks it's too many, she's got too many problems, treated with too many tablets ... it doesn't say, 'She's a woman who's really unwell for other reasons' ...'* (Mary Brewer Pt.3)

Dr Workman: '*... if I see an unsatisfactory letter ... my reaction is irritation and that switches me into kind of looking for clues ... maybe take more notice of the patient's name and where they're from ... try and read between the lines ... if the referral doesn't irritate me, if it's a decent referral, I don't question it so much. I'm quite happy to take this information at face value and see the patient'.*

Consultants gained additional information about the possible health of the patient based on their opinion of the referrer:

Dr Schofield: '*... the things written in letters give you a hint the doctor may think there's something else going on ... in the patient's sort of psyche ...'*

Dr Padan: '*Let's say they've followed all the guidance, they can't sort it out. It's an appropriate referral'.* (John Williams Pt.3)

Dr Mason: '*You know, he's very good, he'd normally sort it out, he hasn't, so he either can't or won't or the patient won't let him or...'* (Barbara Clarke Pt.2)

As a result of the referral information, all consultants were able to anticipate medical management, as well as how and what they would communicate with the patient:

Dr Padan: ... *it says that she lives alone and that will be relevant to how we break the news, how we arrange the tests.* (Pt.2)

Dr Mason: ... *but you know, it's been a really helpful heads up from him that she's worried about cancer because if she doesn't raise it herself, we can raise it.* (Barbara Clarke Pt.2)

Clearly, investigation results were factual, but other information regarding the patient was often considered of no significance, as summed up in the following comment:

> **Dr Mason:** '… *the referral is just a kind of ticket in the door. You have a look at it, but then you make your own assessment'.*

The construction of '*a*' patient

This section looks at how various elements were used by consultants to construct a 'patient profile'. Again, comments were not necessarily about the specific patient but more generally about 'patients' emotional state; address or location; health beliefs; education or existing knowledge; ethnicity or cultural issues and age and gender.

The consultants were divided regarding the personal information. Four consultants said they did not notice it, as medical information was all they needed at this stage - they would take notice of the patient's details just before seeing them. Six noted all details, i.e. not just the medical, but also information about the patient – including their emotional state, stating they were crucial to their understanding and expectation of the patient and in anticipating how the consultation would go:

> **Dr Padan:** *'Oh yes, I'm hugely influenced by the information about the patient.'*

One consultant felt it wasn't just the referral information itself but the immediate moments once the patient was in the room that set the tone for the consultation:

> **Dr Clarke:** *'The acute time when you meet the patient and start to make decisions about them – this is a crucial time and impacts on the entire consultation.'*

This last statement was echoed by another consultant:

> **Dr Kings:** '… *but you know there's nothing like them coming in the room and talking for two sentences. How they walk, speak, look, dress, what they say is much more telling I think'.*

These statements were not expanded upon but the inference taken from them is that when observing the way the patient walks, looks and dresses, as well as listening to the way the patient speaks, the consultant is placing meaning on these observations based not only on previous knowledge or experience regarding the medical situation, but also on potential stereotypes and assumptions.

The significance of the patient's name

Initially, not all consultants noted the patient's name. Four of them stated it was something they made particular note of resulting in them creating further expectations or ideas about the patient. Sometimes the name could have medical significance, for example, if Asian and the patient had particular abnormal blood results, then additional health problems were considered very likely. Dr Padan described how, if the name was recognised as representative of a particular group in society, she was 'biased' towards expecting the patient to have psychological issues:

> **Dr Padan:** '… *because quite often it's acceptable in their culture to come with physical complaints when actually it's just they're tired and they want a bit of attention from their family …*'

Some names were associated with professional status or would give a 'clue' to the age of the patient, profession or perceived social position:

> **Dr Workman:** '*If I read the patient is in her thirties and called Tracey, I know exactly what's coming in*'.

Some names were considered typical to the local area; some recognized as a Caucasian name, from which the doctor made the assumption the patient was Caucasian and would speak English as their first language.

The term of address

When teaching consultation communication skills to medical students, emphasis is placed on the importance of ensuring the patient is referred to as they wish e.g. formally as in Mr, Mrs or informally by their first name or a preferred other name. All the consultants preferred to address their patients formally. Three expressed the opinion this would be the case whatever the age of the patient, others felt they were likely to adapt to a young patient:

> **Jill Dales (interviewer):** *How would you normally address your patients?*
>
> **Dr Kings:** *Surname.*
>
> **Jill Dales:** *So it would be Mr So-and-so.*
>
> **Dr Kings:** *Yes.*
>
> **Jill Dales:** *Do you always use that?*

> **Dr Kings:** *99% of the time unless I've known someone for a long, long, long, long time or unless they're 17 or 16, in which case being called Mr Somebody would be quite alien to them, I think.* (Appendix R Aden Winterton Pt.1)

How to address the patient seemed to be irrespective of patient preference - although one did admit thinking about giving the patient choice but usually forgetting to do so:

> **Dr Allen:** *'I might just say ... 'do you like to be called Bill?' ... checking the way people like to be addressed is important ... I definitely don't do it as much as I should'*. (George Adams Pt.2)

The reason seemed to be the consultant's preference to 'set the tone' of the consultation as they had clear ideas about how they wished to be addressed by the patient. This will be covered in more detail in '*Concerns*':110.

The significance of the patient's age

All consultants acknowledged the age of patients was potentially significant from a medical perspective:

> **Dr Allen:** *From the kind of medico, etiological point of view, it's a difficult dynamic because cancer's commoner the older you get, exponentially so. So, you know, cancer's much more likely in an 87-year-old even than in a 67-year-old.* (George Adams Pt.2)

> **Dr Workman:** *If you added 10 years onto his age, I'd be much more inclined to think this was serious. Then if you took 10 years off, I'd be more strongly convinced it wasn't.* (Jack Ellis Pt.2)

However, apart from the *medical* significance of the patient's age, the consultants had varying opinions on whether they adapted their communication on the basis of age. Dr Mason initially felt it probably did not make a difference:

> **Dr Mason:** *'... I don't think it would make any difference really. I would not make a conscious effort to dumb things down or be more paternalistic ... I really kind of try to make my decision on communication based on their opening statements'*. (Barbara Clarke Pt.2)

but then when discussing another referral went on to say:

> **Dr Mason:** *'... I'm kind of wondering whether ... you have to slightly alter your language, behave a little bit more formally*

to older people. Something to do with what they expect from their doctor. I mean … with not being allowed to wear ties, that doesn't sit right with me with older people. I think they don't, anecdotally, like that, they have a certain expectation of you as a consultant. I don't know, it's never something I've really consciously kind of thought about, I have to be honest. I don't know if I change what I do, I probably do. But I don't know that as a matter of fact.

For a few, age was felt not to be an influencing factor:

Dr Allen: *'No, I think it's much more related to their educational achievement. You know, level achieved, rather than their age … I think that (the elderly) are so individual, just as young patients are individual. So it's very, very variable'.* (George Adams Pt.2)

But there were far more comments that seemed to support age *did* have some influence on how patients were regarded. The following comments focus on communication with elderly patients. The first illustrates how the consultant regards elderly patients as more receptive and prepared for open dialogue, even if this included bad or difficult news:

Dr Padan: *'80 years olds are often more honest and they've already come to the terms with the fact that life is finite and therefore I find it easier to use phrases like "you understand these symptoms could mean something more serious" and then quite often that will make them ask "do you mean cancer?" and I say "yes, among other things", so that we pull it out in the open much, much quicker with an 81 year old'.*

This next comment seems to contradict one aspect but also in some ways parallels the above regarding serious or sensitive subjects. It also appears to agree with the idea the elderly have accepted the outcome of their situation may not be a good one:

Dr Schofield: *'… patients of that age (80s) generally are unkeen to have investigations. They often are quite pragmatic about what the likely outcome is going to be. They're also of an age where they don't really want to know anything to do about cancer… they'd rather put their head in the sand …'* (Michael Rivers Pt. 4)

Although the consultants' opinions about how elderly patients' attitudes and behaviour differed, what they did agree was their own communication *was* adapted to accommodate talking to an older person:

> **Dr Schofield:** '… *with somebody who is 82, you're probably going to have to take the consultation fairly slowly and be quite precise in your questioning to get the answers that you want. Elderly patients have more of tendency to ramble on and tell you what they want to tell you, rather than what you want to know so I may have to be a little bit more closed with my questioning style …* '(Michael Rivers Pt. 4)
>
> **Dr Padan:** *They tend to play fewer games so I'm a bit more relaxed about the 81 year olds from …'*

Age wasn't just significant with elderly patients. Several comments were also made about younger patients and their attitudes:

> **Dr Padan:** *'There is a group at 36 that believe they can still drink nine pints every night … party hard and then wonder why they have a problem …'* (John Williams Pt.3)
>
> **Dr Clarke:** '… *frankly these days you might expect less of an 18-year-old than you do of a 60-year-old … general knowledge and stuff for some sections of the younger community … it might be very poor … '*

Once again, alongside their general view of younger people, the consultants felt they made adjustments to their communication to accommodate different fears or expectations:

> **Dr Mason:** *'Younger people often worry inappropriately because of stuff they've read on the internet. So I think sometimes there's a lot about disabusing younger people of things …'*
>
> **Dr Padan:** *'They're usually very much more frightened than the older people – because they often have family at home, dependents, in employment and therefore if I rattle their cage they're worried enough without me adding extra to that and therefore I tend to sort of say things like "I'm doing tests because although it could be gallstones there might be something else there," and I'll just leave it at that and often they do not take it any further at all'.*

So, although initially it was felt by some that age did not make any difference, with further discussion it seemed the opposite was true; there were more comments about 'age' than any other aspect of the patient's details. It appears that 'age' had significant meaning for the consultant regarding the patients' attitudes, education, understanding and ability to engage in dialogue about serious, potentially life threatening information. The general feeling seemed to

be that older patients were more ready to accept this type of information, but the *delivery* of the information needed to be adapted for patients from either end of the age spectrum. The theme 'age' is also covered in the section on the consultants 'Expectations' regarding their communication.

The patient's knowledge, intelligence and education

Comments were made about patient's knowledge or educational level and what this meant regarding their ability to understand. The point at which the doctor made a judgement depended on the information received. For some, the educational level was judged once the patient was present; for others, the judgement was made before seeing them, based on several factors, including where they lived, their occupation and age – the latter, with regard to the elderly, being considered by Dr Padan in the following comment:

> **Dr Padan:** *I think ... mainly they are well educated, they're the survivors.*

By contrast, three consultants considered that elderly patients in general had undergone little, if any, formal education beyond early teens - so it was more important to ascertain *how* the patient communicated and *what* they already knew and then communicate as judged appropriate:

> **Dr Allen:** ' *... so you don't go then so much off their formal education but more about how they speak or what they seem to know. So I quite often check what people know'. ... I mean people who've got higher level education are probably going to understand things more on a numerical or statistical basis ... so saying there's a 5% chance it's cancer, or there's a one in a thousand risk of complications for this test, for people who haven't got a good standard of education, one in a thousand ... the difference between that and one in a million is probably very meaningless'.* (George Adams Pt.2)

Another consideration was the doctor's belief how certain patients i.e. older or with a low educational level, perceived their own contribution to the doctor-patient relationship. Dr Allen felt that if the patient was perceived to have a low educational level, they were also perceived as probably being brought up in a very paternalistic environment. He anticipated that many from this social group might have worked within a factory or similar setting, where they were the *'bottom of the rung'* (Dr Allen). His perception was that a patient

perceived as coming from a factory or rural employment may not expect their own opinion to be sought, the doctor taking the lead.

Knowing or perceiving the occupation of the patient to be a professional one, or one that indicated they had a higher educational level (irrespective of age) was also an influencing factor for the majority of the consultants:

> **Dr Kings***: Yeah, that's more relevant than the age.*
>
> **Jill Dales (interviewer)***: Okay, right, so how will that affect things do you think?*
>
> **Dr Kings***: Well, occupation and ... would more affect the language and familiarity that you talk with, so if someone is unlikely to know very much at all about the human body, human biology, then you have to use more basic language and be more explicit. If someone's, you know ... often reps are graduates, biology graduates for example, so if they've got a higher understanding then you can ... they'd want to be ... have things explained to them in slightly more sophisticated terms and you could use different sorts of language.* (Appendix R Aden Winterton Pt.1)

One expressed that with the more professional patient, their expectation would be different:

> **Dr Mason***: it'd be more of a sort of dialogue rather than an old-fashioned or traditional 'patient talks' 'doctor speaks' kind of thing.* (Barbara Clarke Pt.2)

A comparison was made with private medicine, where, it was assumed the patients have a higher level of education, occupation or profession and the doctor-patient relationship would be more equal and less hierarchical. (The doctors discussing this did not perform private practice themselves).

The significance of the patient's address

All referrals included patient's address, but this was not always noted. For four consultants, the address had little significance as they were not familiar with the location:

> **Dr Kings:** *'I don't think about that when they're coming in because the most ... well a lot of people ... we just see ordinary Geordie people here, so I don't often think about that.*

Those that did know the area were more likely to take note of the address and often had an opinion about patients from particular communities:

> **Dr Padan:** *I do note it sometimes because the patients from the West come with genuine symptoms and they're much easier to deal with. Patients from (name of town removed) come with a lot of extra baggage because they're often the worried well, not always, they are sometimes unrealistic in their expectations of what is possible … and they sometimes play more games in clinic and they drop names as to who they know and "this specialist and that specialist" rather than just letting you get on with the work.*

The address also provided the potential to assume what the patient's occupation may be – even if this wasn't written in the actual referral information:

> **Dr Padan:** *'He comes from … so it's a mix between working class and middle class; he probably works in the town'.* (John Williams Pt.3)
>
> **Dr Allen***: '… his address sounds quite posh. Could be, retired middle classes … I would expect a different level of education with someone from … than from …'* (George Adams Pt.2)
>
> **Dr Clarke:** *I expect she's going to be, so I'm going to be seeing a white middle-aged woman. I don't know what her job is in the local prison so I'm not sure about what class, she's probably not the prison governor …*
>
> **Jill Dales** (interviewer)**:** *What made you say that?*
>
> **Dr Clarke:** *Because I'm making assumptions about people who live in (name of town removed).*

The location of the patient might give the consultant ideas about social class, educational level and potential occupation but also about a patient's possible health, health beliefs, and ability, or not, to deal with ill-health. This consultant appeared to be validating the patient's illness just because of where they lived, a local town:

> **Dr Shaw***: '… they come from a sturdier breed I think. They are more stoical … if they complain there's usually something wrong. … people are usually fairly robust and healthy … good and clean lifestyles in general …'* (Appendix Q Jane Sanders Pt.1)

Significance also attached to rural or suburban addresses. The impact of being ill for somebody living a rural life was felt to be more disruptive and the doctor seemed to consider the implications more in these patients when preparing a treatment plan:

> **Dr Workman:** '… *for this sort of address … as a farmer, that would maybe slot me into a load of different prejudices really … some of these people having really very high threshold for seeking help and often present quite late … having to consider issues of their ability to work, has been the kind of primary thing and … bringing people into hospital or giving them treatments that incapacitate them in agricultural work … is a big issue … so there are connotations with a rural address'* (Jack Ellis Pt.2)

Does the patient's gender make a difference?

Opinions were mixed about whether the patient's gender made any difference to the consultant and if so, how. There is a significant literature indicating that men and woman respond differently to being ill and are likely to seek help or advice at different stages of their illness (Green and Pope, 1999; Courtney, 2000a; Courtney, 2000b; Addis and Mahalik, 2003; Bertakis, 2009). In this study gender in relation to where they lived was also potentially influential:

> **Dr Schofield:** *'Obviously, you can't generalise until you see the patient but … looking at the letter of an 87 year old man from … being somebody who's more likely than not very masculine, that kind of man from a working class mining background, you have to be tough and you have to not show any weakness, will influence me …'* (Michael Rivers Pt. 4)

Many of the comments reinforced the stereotypical gender differences about help-seeking behaviour. The general feeling was that men usually wait longer before seeking help. The following quote is representative of six of the consultants who commented that the combination of gender and age also made a difference:

> **Dr Padan:** *'a 36 year old male is unlikely to bother their General Practitioner unless they are being significantly troubled by their symptoms'* (John Williams Pt.3)

The inference being that such a patient was likely to put up with symptoms for longer, potentially have more complex symptoms, be more anxious and require more reassurance.

Not only were men considered to seek help later than women, but also likely to find it more difficult to talk about their illness when seeing the doctor:

> **Dr Mason:** *'So sometimes it's easier to talk to women because they'll just tell you'. (Barbara Clarke Pt.2)*

All the doctors indicated that seeing a patient of the opposite sex wasn't something they really considered an issue. However, one male consultant felt the combination of age and gender had potential implications. He assumed that a younger female patient would probably be expecting to see a male doctor and therefore willing to discuss their symptoms as well as undergo a physical examination by him:

> **Dr Mason:** *'I have to acknowledge the way they've been bought up, I think you know, in the sort of thirty-eight year olds I would naively imagine would have no problems about being examined by a young male doctor…'* (Mary Brewer Pt.3)

Although older female patients were felt to also have an expectation of seeing a male doctor, the same consultant was conscious that for some this may still be a difficult and intrusive situation particularly if a physical examination was required:

> **Dr Mason:** *… often we assume we can just put them through whatever we want because they're old and their dignity must have gone … my belief is its more traumatic for old people to be examined intimately because if this woman is unmarried, she may have never been seen naked by anybody since she was a child and if I start doing a rectal exam on her that may be very, very traumatic for her. So I think, you know, I would try and …treat her more in the way that things were done where younger people treated older people with more respect and … that she may be discussing things with us that she finds embarrassing or intimate …* (Mary Brewer Pt.3)

Summary of this section

The consultants' comments provided in this section are perceived to illustrate the existence of *a priori* assumptions about referrals, the consultant's consultation style and experiences, as well as issues relating to patients. As summed up in the following comment, it would appear that they not only occur when initially seeing the new patient, but may also be triggered during the process of reading the referral information, prior to the patient being seen:

> **Dr Workman:** *I keep an open mind ... I think you can go down a list of a clinic and look at the names and look at the age and the sex ... I do like to play this game actually, guessing what I think they are all going to have from the name and the sex and their age ... something about being that age and being called that name, I think it does kind of fit well ...*

Concerns

Introduction

The doctors expressed few concerns. None doubted their clinical judgement and all felt confident in dealing with patients' problems from a clinical perspective. Some referrals made them feel more apprehensive, particularly if they felt the patient could be confrontational because of being unhappy with treatment received so far; having to wait for an appointment; problems with communication between primary and secondary care. However, the central theme for any misgivings or cause of tension was themselves.

The self-construction of the doctor

The doctors had clear ideas about how they wished to interact with patients, or how they believed they *did* interact with them, but also, in order to feel comfortable in the relationship, how they wished the patient to interact with them.

Six consultants identified subjective influences i.e. their gender or age; their feelings on the day. The following is an example of what was said:

> **Dr Allen:** *'I think the biggest influences are my own emotions - for example, being irritated by the GP (referrer) or being concerned about the patient'*

Providing an equitable and fair delivery of care

For some, the notion of being fair and giving all patients the same opportunities was important. One consultant described feeling uncomfortable when dealing with female patients from one particular cultural group, anticipating they would have significant psychological issues. Her perception was they manifested their distress or need for attention in physical symptoms:

> **Dr Padan:** *'They're expected to fetch and carry. The only way to get a bit of attention and rest is if they have symptoms'*

Although stating that she liked the patients themselves, Dr Padan did not like *'the baggage that comes with them'* and felt manipulated by the male relatives who telephone insisting their relative is fast-tracked:

> **Dr Padan:** *'I feel uncomfortable about the community pressure and just wish they'd be honest about it. It's a big game and it is designed that they get preferential treatment and I don't like that'.*

The pressure from the expectations of patients from certain areas was something that Dr Padan expressed quite a strong view about:

> **Dr Padan:** *'The ones from (name of town removed) I'm slightly more tense about because they often come from a higher educated background and they try to run rings round you sometimes, and that always takes much, much longer ... they have high expectations of what the NHS will offer and they can sometimes expect to be treated as a private patient just because they live in an important place and that I don't like.*

Dr Padan also voiced her experience of working as a young female doctor in what was then a 'macho' dominated environment and specialty. Young patients, but females in particular, were often treated patronisingly by male and 'macho' female consultants who had the attitude that such a '*young thing*' would not be capable of taking responsibility for their own health decisions and therefore did not need information or explanations. In her opinion, such attitudes were indefensible led to some patients being '*badly scarred'*. It was very important to Dr Padan that she set a standard by which all young patients could expect to feel listened to and valued.

Her own age and gender was also an influencing factor for Dr Clarke. She described having to 'brace' herself for the look of surprise from some patients, particularly older male patients, when they realised that she was in fact the consultant:

> **Dr Clarke:** *... he might see me as some young whipper-snapper female ... who's not very experienced. We'll see ... I'll try and generate some gravitas from somewhere* (David Price Pt.3)

Dr Mason, another younger consultant, was also conscious of his age and gender and how personal experiences and beliefs influenced his communication and interactions with the patients.

One referral quoted the patient's description of her pain as 'like labour'. Dr Mason expressed his concern that the consultation would be confrontational because of his scepticism about the patient's description of the intensity of her pain:

> **Dr Mason:** ... *makes me worry about people. I don't know why ... because pain can never be ten out of ten, it seems to me ... that would be like being thrown into a fire or something ... having seen my wife in labour I don't think you could function if you have pain as bad as being in labour...* (Barbara Clarke Pt.2)

Although Dr Mason seems to be making a general comment about 'people', he was specifically focused on this particular patient – who he was concerned may sense his own views and consequently feel disbelieved – hence the potential for the consultation to be confrontational. However, although he felt the description hard to accept, he regarded it as an indication of the patient's level of distress and would not challenge it.

Dr Mason described when he was likely to modify his communication. As he does not moderate his language when talking to his mother, he would not 'upscale or downscale' anything if the patient was his mother's age. He felt his communication with elderly patients in particular was significantly influenced by his own background. His elderly grandmothers hated what they perceived as inappropriate informality of health professionals encountered. He felt strongly that elderly patients should be treated with appropriate respect and unless they specifically asked otherwise, should always be referred to by their title:

> **Dr Mason:** ... *you know that to me is how you should speak to old people, but that's my upbringing more than anything else.* (Mary Brewer Pt.3)

The significance of personal inter-family influences or experiences was also referred to by Dr Padan:

> **Dr Padan:** *I really like everything to be fair for individuals ... that's why I think my guard is always a little bit raised about people who seem a bit like my mother ...*

The consultant's own discomfort

The consultants worked in a specialty where the emotional distress and stress of the patient was often fundamental to the symptoms presented. For Dr Kings, this presented more of a practical issue:

> **Dr Kings:** *It just adds to perhaps the likelihood that it's a functional disorder and therefore perhaps difficult to treat and in terms of managing expectations or concerns*

All but one consultant commented on their need to establish the psychosocial issues or mental ill health of a patient, but Dr Workman appeared to be the most comfortable with this:

> **Dr Workman:** ... *he hasn't explored her psychological health and so I'm left feeling that I'm going to have to do that in clinic and start from scratch ... so I'd want to know about triggers, how long it's been going on and if appropriate, explore the kind of psychological perspective.*

However, probing further or dealing with the psychological distress of patients was an area that seemed to create discomfort for most of the others who, despite their experience and expertise, assumed they did not have the skills or that it was outside their role:

> **Dr Allen:** ... *where you're providing some kind of psychological support for them it's probably not appropriate 'cos, you know, that's not my job as a gastroenterologist to provide long term psychological support for people.*

> **Dr Clarke:** *I don't have the skills to help them stop drinking ... the counselling skills and the psychological support has to be gained elsewhere...*

Dr Mason felt he did not have the skills to deal with psychological issues and used the following comment on a referrer to sum his own ability up:

> **Dr Mason:** *He's even more not psychological than I am.* (Barbara Clarke Pt.2)

Dr Allen assumed that some patients regard hospital doctors as only providing a high knowledge base and level of expertise i.e. '*technical stuff*', whilst regarding General Practitioners as patient advocates who care and listen. Most important to him was that patients felt listened to which he and some of his colleagues, felt was a significant part of their role:

> **Dr Allen:** *I think that we can do that a lot … you sit down, you listen to the patient and nothing else needs doing … and you think 'Why did not someone sit down and just listen to that patient?'*

However, dealing with emotions such as irritation, frustration or anger were still identified as areas most likely to cause concern for all but one consultant - particularly if they perceived the consultation was likely to be more confrontational as a result.

The consultant's preference for keeping a distance

Keeping some formality to or control of the consultation seemed important to many consultants and was exemplified in comments regarding how they wished to be addressed. This was stated as a general preference and specific to the study consultation. Six of them stating they 'always' introduced themselves by their title 'Dr':

> **Dr Schofield:** *… but I think, you know, first of all, the patient has to ask you … and give you permission to use their first name, in my opinion and actually, if someone wants to call me by my first name then I'd rather they ask me for permission to do that as well, actually cause … that's how I like to be addressed … rather than being addressed as a first name term …*

One may argue that they perceived this as being their general consulting style, and therefore assumed they would continue this style with *every* patient - including those in this study. It was also felt to illustrate another assumption that a professional doctor-patient relationship should be maintained on a formal level in order to maintain clearly defined roles.

> **Dr Allen:** *I don't want to be on first name exchanges with my patients particularly. I mean there's a lot of patients that I have seen for say... ten or 12 years, and one or two of them call me (by my first name) and it makes me uneasy. It makes me feel they are...you know, they're stepping over a boundary. They're normally patients who are a bit dependent, who, you know, haven't actually got that much wrong but every time you discharge them they get back into your clinic again.*

All the consultants gave the impression that they felt that if a patient called them by their first name, they were being over-familiar or dependent. This is despite the use of first names having increased in many social contexts, such as

the media, politics, business and retail. Because of this, it may be that for some patients, the use of first names is regarded as a contemporary style of address, not necessarily an indication they know the other person well, or are being too familiar.

Dr Mason couldn't quite decide whether he minded or not:

> **Dr Mason:** *I always say 'Tom Mason' and I don't know whether that's the right thing to do because I've never, ever referred to myself as 'Dr' Mason because it just seems unbearably pompous to me … I mean doctors do it to each other on the phone. And yet sometimes when patients say 'oh, hi Tom', I'm like what, hang on a second, I'm the doctor. So I kind of set myself up a bit to fail there I think. But I always introduce myself by my first name 'Tom' Mason. And then I think they can choose what to call me. And I don't really mind what they call me, to be honest.*

Summary of this section

The aim of this section was to convey the consultants' comments, which were interpreted as assumptions. The quotes given are aim to give a flavour of the concerns the doctors had regarding aspects of their practice. Very few comments were made that could be interpreted as concerns regarding their clinical judgements and management of the patients' physical symptoms. The majority of the consultants did express views, interpreted as assumptions, regarding aspects of their consultation style based on their professional boundaries and personal experiences.

Expectations

It is no surprise that expectations play a critical role, in view of the strong impact expectancies exert on social perception and human communication (Rosenthal, 2002). Ditto and Hilton (1990:98) declared, "It is hard to imagine a health care interaction devoid of expectations".

The referral information triggered comments which were interpreted as 'Ideas' about '*a patient*' or '*these patients*' rather than '*this patient*'. In this section, their comments are interpreted as specific expectations regarding the patient about whom the referral was made; the consultation; themselves and their own communication.

The construction of the consultation

What, when and how to communicate

When reading the referral it was apparent the consultants were already preparing and constructing their communication with the patient:

> **Dr Mason:** *Well I think this is going to be really getting onto our ideas concerns and expectations of the patient, you know. I think this is going to be a real one for a nice kind of neutral opening, letting her do her talking … really just saying hi, how are you?* (Barbara Clarke Pt.2)

Having noted the referrer, and the way the referral was written, one consultant expressed a clear expectation based on an assumption of what the patient may already know – although this was not explicit in the referral information – and how the consultation may be influenced:

> **Dr Shaw:** *I would expect her to sort of be aware that a (named investigation) may land up being offered her. So it might make it a bit easier because of that.*

All consultants expressed an expectation about how they intended the consultation to go from a clinical perspective, e.g. what further medical information to obtain, either through further investigations and tests or information from the patient. All had expectations about questions they would ask, ensuring they had the necessary information to establish a diagnosis and management plan. They also anticipated the medical explanations they would need to give to ensure the patient had clear understanding.

The consultants often had specific 'favourite' phrases regarding how they open a consultation, or encourage the patient to tell their story:

> **Dr Allen:** *'Can I just ask your understanding of why you're here today?'*

Some also had a tentative plan of the communication process from the beginning of the consultation to the end:

> **Dr Mason:** *… the first thing I would plan to do would be to review the investigations that she's had and try and get a little assessment of what her understanding is about, why she's here, what she and her GP have discussed … and say 'okay, now we'll move on to address your symptoms and when they started', and*

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then I'd probably try and take her through to how she is now …
do the normal past medical history and whatever and
examination.

Not only were they preparing their verbal communication, but as the following example shows, one of the consultants also assumed how they would put information across non-verbally:

Dr Padan: *… I'll draw her diagrams.*

The following section explores the views expressed by the doctors on what they would not say.

What the doctors won't/don't say

Timing issues and how the clinic was progressing were considered to be influential in the doctors being selective with what got discussed within the consultation:

Dr Allen: *I mean to tell you the truth, this is the kind of consultation that you could fix in 20 seconds if you wanted to … I'm definitely not going to do that but, you know, I do make short cuts sometimes, … if I'm really behind.*

If they were not sure the patient knew why they had had investigations three doctors felt it inappropriate to raise or make reference to some results. This was particularly the case for blood tests for more socially 'sensitive' health issues, such as Hepatitis B and C, which was the case for one of the study referrals. The doctor commented he would avoid making it obvious the tests had been done:

Dr Allen: *'I mean probably I'll gloss over it as well, you know, and it will just, you know, won't…nothing will happen'.*

He drew on prior assumptions that a patient would *not* know unless the referrer stated otherwise, and so would accommodate his communication accordingly for all similar situations.

Dr Padan also commented that she would modify her communication regarding a negative scan result, as the patient hadn't been told why the scan was done (it was investigating the possibility of pancreatic cancer):

> **Dr Padan:** '... *if I know that actually the pancreas is completely normal then I'll probably not even mention that pancreas problems can cause that. We'll talk about gall bladders and we'll talk about stones stuck and we'll talk about liver inflammation and so on, so I won't even touch that territory ...*'

These examples illustrate the additional thoughts doctors had when processing the referral letter and how they drew on *a priori* assumptions about what information may be problematic to *a* patient and ergo to the patient about to be seen. This seemed to be based on an assumption about information that was *not* included in the referral information – but it was through the process of assimilating and contextualising the referral information that this comment was made, and the decision made regarding what *not* to say to the patient.

Another area that some would avoid was challenging the patient's health belief. An example of this was an elderly patient of Dr Mason who believed one of her health problems, a hoarse voice, was due to paracetamol. As the belief was regarded by the consultant as 'benign' i.e. unlikely to cause any harm, and (because the patient was elderly) quite fixed:

> **Dr Mason:** *'there's no mileage in challenging them'* (Mary Brewer Pt.3)

With one referral, the consultant stated he was sure the patient would be expecting a particular investigation, even though the referrer gave no indication that this was the case:

> **Dr Shaw:** *'I will not purposely raise the issue, but if she expects ... thinks she needs one, at the end when I ask any questions and stuff and she says 'what about an endoscopy?' then I would tell her I don't think she needs one'.* (Appendix Q Jane Sanders Pt.1)

The construction of 'the' patient (about to be seen)

It was apparent from comments that although yet to be seen, the patient would have an influence on the construction of the doctor's communication.

Social status and ethnicity

If information such as the patient's weight was provided, consultants had an expectation of the patient's general appearance. However, even when not

provided, they still constructed a mental image, based on their own assumptions. Sometimes they placed the patient in a social level based on where the patient lived:

> **Dr Padan:** *'I think she's going to look like my mother … I think she'll be intelligent, well-spoken … and will come dressed well to the consultation because she wants to make a good impression … that's because of where she lives'*

> **Dr Clarke:** … *he could be anything coming from (there) … apart from he's probably not going to be super, duper posh.* (David Price Pt.3)

Not only was their social status anticipated, but unless information was given to the contrary, the consultants made an assumption as to the ethnicity of the patient; whether or not English was their first language and their colour:

> **Dr Clarke:** *'I expect … I'm going to be seeing a white middle-aged woman. I don't know what her job is in the local prison so I'm not sure about what class; she's probably not the prison governor …*

> **Jill Dales (interviewer):** *'What made you say that?*

> **Dr Clarke:** *'… because I'm making assumptions about people who live (there)'*

Patient's profession

Dr Workman gave the most expressive and reflective reaction to the profession of a patient. His occupation was given as 'actor' and this set off a stream of thoughts and expectations. Firstly, he had a very definite mental image of what the patient would be like physically as well as emotionally:

> **Dr Workman:** *'… if you ask me to sort of picture him, I think he might be slightly eccentric, but I would not make any more assumptions than that. … it conjures up pictures of somebody who is artistic but vulnerable … having great strengths in some aspects of their life but … the sort of flawed artistic temperament. … I guess it's likely to be somebody who is quite in tune with their feelings … but these sort of skills that make a good actor, would perhaps make you vulnerable to psychosomatic type illness'* (Jack Ellis Pt.2)

Dr Workman also laughingly commented that he anticipated the patient *'strutting in … chest puffed forward'*. He admitted to reading a lot into the fact the patient was an actor, and had quite a strong idea of what that meant

to him regarding the patient's general demeanour, intellect and style of communication. He described the patient as being a *'demanding consumer'* somebody who would have his own views and who would want a *'participative consultation'*. He admitted to liking that type of patient. He also assumed the patient would not be *'financially straightened'* because, although actors can be out of work, the area in which he lived was *'pretty well heeled'*. It was unusual to have an actor for a patient and Dr Workman was looking forward to meeting him.

Being Patient Centred

Thus far, various *Expectations* expressed by the consultants have been explored but the most frequently occurring theme was their perception of being inclusive of the patient during the consultation. They would ask the patient's view; opinion and interpretation of events leading up to their appointment; listen to their story as well as discussing treatment and management options.

Although the phrase 'patient-centred' was not used, it was apparent this was what they meant –they would be inclusive of the patient and would build the consultation around the patient. Because of their attendance on communication skills workshops and the discussions that took place prior to the research taking place, I was aware that some consultants were not only familiar with the Calgary Cambridge framework (Kurtz and Silverman, 1996; Silverman *et al.*, 2008) but used it to underpin their own communication and consultation style. All expressed the intention to focus on exploring the patient's perspective and needs and there were several examples of how the consultant proposed to do this:

> **Dr Padan:** *'I'll also offer to speak to anyone that she wants me to speak to'.*

> **Dr Clarke:** *'I'm going to check out his perspective, check out what his GP has told him, check out what he already knows … find out what his concerns and ideas are around his symptoms'.*

Some were also anticipating handing a degree of control and decision-making to the patient:

> **Dr Padan:** *'I don't want to force her into things that she is not happy about … I will be careful to check her consent and her*

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understanding for each stage of the process and if she chooses not to opt for investigation that's actually up to her … I won't judge her or be cross with her or frustrated with her. That's her choice'

As identified by Mead and Bower (2000), acknowledging the person as an individual is fundamental to being patient-centred, but some consultants felt that to treat one person differently from another had negative connotations i.e. being selective or judgemental. There was clearly a tension between treating patients as an individual and being seen to treat everybody the same:

> **Dr Mason:** '*… and I would not consciously try and use different language or more or less of it if I thought someone was social class one or five … '* (Barbara Clarke Pt.2)

> **Dr Shaw:** ' *… only in respect to age would be what sort of diseases I would be thinking about … but with regard to the question of how I would approach them … doesn't make any difference to me'.* (Appendix Q Jane Sanders Pt.1)

However, they also expressed the opposite view:

> **Dr Kings:** '*… there's nothing like them coming in the room and talking for two sentences … you know, on an individual basis … you watch them and you listen to how they speak, their mannerisms and their non-verbals and you make judgments as you go along'.* (Appendix R Aden Winterton Pt.1)

This comment suggests Dr Kings tries not to stereotype or assume anything about the patient, before seeing them. However, if his judgements are based on how the patient speaks or behaves, then it would be reasonable to assume that he is drawing on some existing understanding or knowledge in order to make sense of what is being observed. One could argue that this process in itself is stereotyping. The following comment indicated the consultant's expectation was to accommodate her communication accordingly whilst addressing the patient's agenda:

> **Dr Clarke:** '*… I'm going to have to be a very kind of calming … as empathic as I can, listen to her and try and … give her an opportunity to talk about stuff that's maybe going on for her and … I'm not going to need to do anything apart from listen, examine her, I'll obviously examine her because that's what she's expecting'.*

Knowledge of the management options are not usually within the remit of the patient and so it is inevitable that for part of the consultation, the doctor's biomedical model would take priority and the doctor would take the lead. However, it seemed the consultants had quite fixed ideas about other aspects of the consultation for which they would take the lead and follow their own agenda, irrespective of the patient's:

> **Dr Mason:** *'My style is too information heavy … I give too many ifs and buts and we might do this and then we might do that … especially in older people, who are more used to being told more a paternalistic model of medicine … I don't mean it in a kind of patronising way but I might try and judge how much I should guide somebody'.*

> **Dr Clarke:** *'I think what I have to do is make very clear to him that I don't have the skills to help them stop drinking … the counselling skills and the psychological support has to be gained elsewhere …'*

One consultant expressed very clearly that, when faced with the prospect of discussing personal information, or undertaking an intimate examination, the gender and age of a female patient was significant to him. Another colleague considered it irrelevant:

> **Dr Shaw:** *'… I'm not more reticent about talking about women's bowel habits with them because they're women - I've done it 5000 times, you know'.*

What these contradictory statements raised was not whether the consultant *intended* to include the patient, but whether they actually would and if so, what their motives for doing so were. Patient-centeredness is generally accepted as involving the patient because their contribution is valued and valuable, and because the consultant wants to gain insight into their experience, as well as include them in the treatment plans. But in some instances, it appeared the patient's contribution was a means to an end for the consultant. That is, asking the patient's version of events served to corroborate the referrer's version, rather than to check the referrer's version was a good representation of the patient's actual experience:

> **Dr Shaw:** *'… if the history is the same as the GP has said then I probably won't take it much further than that … the history is fairly good … the letter's a fairly good quality … it's telling*

most of the things I want to know. All I would be doing is corroborating what the GP has written'. (Appendix Q Jane Sanders Pt.1)

One consultant also assumed that if a patient was accompanied - they would be happy for their companion to hear whatever was said to the consultant by the patient and vice versa:

Dr Allen: *'I would just assume that if they've brought somebody into the room they don't have anything to hide from them ... if someone comes with someone they've brought them there ... because they want them to hear'.* (George Adams Pt.2)

This was said in the context of the patient being responsive to questions, not in telling their 'story', so the consultant was assuming he could ask about anything, even if the patient was accompanied. This is an interesting view, because clearly, before the appointment the patient would not know everything they may be asked to disclose. Not answering a question could also result in ambiguity or inappropriate assumptions by the consultant and or the companion, so there was the potential of placing the patient in a difficult situation.

Summary of this section

This section has shown that although first impressions and assumptions regarding the patient take place as the patient enters the room, consultants also spoke of how they may begin to construct the consultation and their communication *before* seeing the patient. Depending on what they read in the referral information, they began to plan what they would (or intended to) say, how they would say it and also what they would not say during the consultation.

Chapter summary

Although there is a body of literature describing the issues referral processes, this predominantly explores the clinical efficacy of the content (Dupont, 2002) or format (Patel *et al.*, 2011). This chapter illustrates that when assimilating referral information and engaging in the task of thinking-aloud, a tendency to stereotype and resort to certain kinds of assumption both general about 'patients' and specific to the new patient, were commonplace, indeed perhaps, almost unavoidable. How the referral was written and by whom influenced its

perceived value in reflecting the patient's current physical and emotional health; what the patient had been told and the patient's relationship with the referrer, often their GP. As a consequence, assumptions were made regarding what the consultant could expect and what focus their communication with the new patient would take.

With regards to themselves, the consultants identified aspects of their consultation style, such as the degree of formality they considered appropriate, based on their professional boundaries and personal experiences. They each perceived themselves to be patient-centred both retrospectively and envisaging future consultations. Although all consultants were confident in their clinical expertise and knowledge, a common assumption about themselves as individuals was that they lacked the skills required to address underlying psychosocial issues affecting their patients.

The limitations to the think-aloud process are addressed in Chapter 7. But when people say in an interview they will or will not do something, they make an assumption that a direct link exists between their intentions and actual behaviour. However, 'the relationship between beliefs, opinions, knowledge and actual behaviour is not a straightforward one. What people say in an interview is not the whole picture' (Gillham, 2000:94). At this stage it was the *expression* of assumptions that was most significant. The characteristics of participants and their ability to apply skills of verbalising to thinking aloud have been raised by other authors (Fonteyn *et al.*, 1993). I note here that one participant in this study appeared to find this more difficult than others.

My positionality is covered in Chapter 3 but specific to this chapter, I have reflected on what influence my questions may have had on the doctor's comments and observations. The main influence identified was whether this process actually made the consultant think more, or pay more attention to detail than they would do normally. One consultant thought this was the case; a couple felt this was likely. But they also all stated that the thoughts were theirs, they hadn't been 'put there'

.Chapter 5. Communication during the consultation

Introduction

This chapter presents a series of case-studies from Stage 2 'Actual communication' (Table 17) with examples of the dialogue and the analytical process and with particular focus on communication relevant to comments and assumptions made in the cognitive interview.

Actual communication
When, what & how communication took place.
Identifying links between Anticipated communication and Actual Communication

TABLE 17: AIMS OF STAGE 2

The 'why?' of the communication is explored in Chapter 6 which describes consultants' reflections on their communication.

The interactions were, by their very nature, personal and at times emotional and difficult. Whilst using them for purposes of generalisation and abstract theorising, in order to allow the reader get a sense of the different emotional contexts in which the consultations took place, the chapter retains a significant amount of data from selected consultations. However, there are sections where the interaction is represented descriptively, as it is not possible to include all dialogue.

In total, 26 consultations with eight consultants were observed. Although analysis of all consultations took place, pragmatically it was not possible to represent each one in detail. All consultants were asked their opinion of how they felt the consultation had gone. The following represents an example response:

> **Dr Clarke**: *'That was one of the worst interactions I've had in a long time. That was a shocker*. (David Price Pt.3)

In the following comment, Dr Allen felt the consultation had gone well. His comment appeared to be reinforcing his assumption that he always listens to the patient. Why this is significant will be explored in Chapter 6.

Dr Allen: *I thought it was very interesting ... I'd anticipated the problem wasn't going to be diarrhoea and she said a very, very, very kind of key thing ... which you know, if you listen to the patient, you know, really told you ... that it was not diarrhoea and she said she told the GP that it wasn't diarrhoea.* (George Adams Pt.2)

Therefore, seven consultations from six consultants have been selected. It is important to stress they are representative of the consultations as a whole. In order to focus on an appropriate number for inclusion; the following selection criteria were used (Table 18) whilst two consultations from two consultants are Appendices Q & R.

Consultation selection criteria
The doctors felt it went exactly as they had anticipated
There was a distinct contradiction between the expected and what happened
The interactions were particularly striking or memorable to the doctor and/or to me. This could include the above criteria but also if anything happened or was said which made the consultation stand out

TABLE 18 : CONSULTATION SELECTION CRITERIA

In the introduction to each consultation, a précis of the linked cognitive interview is given. Numbers given as a suffix to the patients names e.g. (Patient 3) indicate the order in which they were seen by the consultant.

To avoid repetition, if relevant quotes have previously been used, the reader is guided to the appropriate place in Chapter 4.

Dr Padan

Dr Padan was one of the senior consultants. During the previous interview she reflected on factors that influence her communication. She stated she was '*hugely influenced*' by the information provided and also gave a lot of thought to the situations and difficulties in which many patients find themselves. It was important to her that relationships with her patients was built on mutual respect and understanding

John Williams (Patient 3)

Introduction

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This consultation was chosen because what Dr Padan anticipated was quite different to the actual consultation. Before seeing this man in his thirties, Dr Padan made several assumptions about the patient. Firstly, when asked if his age made any difference, Dr Padan indicated it did and commented on what would be a significant focus during the consultation:

Dr Padan: *There is a group at 36 that have... believe*

they can still drink nine pints every night, party hard and then wonder why they have a problem … so there may be, I'll ask him very carefully about his lifestyle ... and focus quite hard on that, (as a 36 year old) he'll be a bit more honest about his alcohol.

Of her own communication, Dr Padan had expressed her intention to allow the patient to tell his 'story' and emphasised he would be in control of what tests, investigations etc. were carried out. She also felt the consultation may be *'a challenge'* as the patient had had very unpleasant experiences during previous investigations. She anticipated he would be very anxious and reluctant to undergo further tests.

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TABLE 19: CONSULTATION PRÉCIS_DR PADAN/JOHN WILLIAMS PT.3

The consultation

Dr Padan called the patient into the room by his first and surname and made a light-hearted comment drawing attention to my presence before introducing herself as 'Dr Padan':

> **Dr Padan:** *Will you come in? Now you know we're being spied on today?*

Dr Padan's opening question did not seem to be as open as anticipated, asking him to add detail to what the referrer had written rather than hearing the patient's version:

> **Dr Padan:** *Dr Smith has written to me saying that you're getting quite a lot of problems … with your gullet. When did you first start to have problems?*

As the following illustrates, the style of questioning became focused on his physical symptoms, which Dr Padan had anticipated she *would not* do:

> **Dr Padan:** *… any trouble swallowing?*
>
> **John Williams:** *… at the minute I am. I'm starting to find it really hard to swallow bread*
>
> **Dr Padan:** *Right, so lumpy things again. Okay. What about hot liquids?*
>
> **John Williams:** *… hot chocolates not too bad.*

Dr Padan: *you can manage it? … It doesn't hurt on the way down?*

John Williams: *No*

Dr Padan: *Okay, do you get any bad pains in the chest?*

John Williams: *Yeah,*

Dr Padan: *Do you get fingers that change colour in the cold?*

John Williams: *Yeah,*

Dr Padan: *What colour do they go?*

John Williams: *They go blotchy.*

Dr Padan: *Do they? Do you ever notice them go white?*

John Williams: *Well, yeah they're sort of like white and red*

Dr Padan: *They go … and really painful…*

John Williams: *Yeah, yeah, yeah,*

Dr Padan: *Any family members have that happen to them?*

John Williams: *Not that I know of*

Dr Padan: *Okay. Any problems with constipation?*

John Williams: *… occasionally (laughs)*

The patient had previously lost weight which had helped with his symptoms, but was unable to maintain this. Dr Padan gave very positive encouragement to him, but he did not seem able to currently tackle the problem because of his time-consuming profession:

Dr Padan: *Really? … that's quite an achievement!*

John Williams: *... when I was down to 11 stone it was kept totally in control but since I've come back home it's crept back up again*

Dr Padan: *How did you lose it before?*

John Williams: *Just really watched what I ate*

Dr Padan: *Just… willpower*

John Williams: *Yeah - just pure willpower, went to the gym, but in my new job I haven't got time to go to the gym or anything now*

Dr Padan: *What's your job?*

John Williams: *I'm a chef*

Dr Padan appeared to make further assumptions based on a stereotype of a chef regarding eating habits – but this was affirmed by the patient:

> **Dr Padan:** *Right. Yeah, that will make it difficult, won't it because it's erratic eating patterns and everything*
>
> **John Williams:** *Yeah, yeah exactly*

Dr Padan did pick up a cue the patient was unhappy in his job, and asked about an alternative, before returning to more medical questions about his smoking habits and his medication. There were no more questions about his lifestyle.

Although Dr Padan anticipated the opposite, the patient was quite willing to undergo further investigations. This may in part be because of the way she broached the subject, which was quite apologetic:

> **Dr Padan**: *I'm afraid it … it would be really helpful for me to do an endoscopy*
>
> **John Williams**: *Yeah*

and with emphasis on the patient's agreement being '*really helpful*' to her, but also because his symptoms were impacting significantly on his physical and emotional well-being, which Dr Padan had anticipated may be the case:

> **John Williams:** *I just want it sorted out as soon as possible because I've just had enough of it*
>
> **Dr Padan:** *You're sick and fed up with it…*

The dialogue then focused around the investigations to be carried out, for which a date was set.

Summary of this consultation

- ❖ The opening question was more focused than Dr Padan had indicated.

- ❖ It was not as challenging – the patient was not anxious and was willing to undertake further investigations.

- ❖ A different style of communication than assumed by Dr Padan took place.

- ❖ Before the consultation, an assumption was expressed that exploration of the patient's lifestyle, particularly his alcohol intake, would take place. However, *his alcohol intake was not explored.*

Dr Mason

Dr Mason was a younger consultant and, as quotes in the previous and following chapters illustrate, demonstrated a more nuanced and reflective process about his consultation style and communication. His self-perception of his skills seemed to be quite critical. He felt that dealing with the patients' emotional or psychological distress was beyond his capabilities and described the referrer of the next patient as being '*even more not psychological than I am'*.

He anticipated being very patient focused, preferring an informal approach to his patients and these two examples illustrate very different consultations, but have in common the patients' obvious appreciation of how they had been dealt with.

Barbara Clarke (Patient 2)

Introduction

This consultation was one which caused Dr Mason some concern. Firstly, he was very sceptical at the patient's description of her pain. But also, because he was aware the patient had seen several doctors, including Accident & Emergency, because of her symptoms, he assumed she may be critical of the health service. Because of this he felt quite apprehensive:

Dr Mason: *... slightly nervous about this one. I don't know why, just feel it's going to be a bit more confrontational than the last one ...*

He considered the referrer a specialist in this type of pain, and was unsure why they were unable to help the patient and what the reason was behind the referral. He wondered whether the patient and referrer had had a problem with each other. Dr Mason also commented that although he felt her description of pain was unrealistic he would not judge or challenge the patient but would see what she had to say.

TABLE 20: CONSULTATION PRÉCIS_DR MASON/BARBARA CLARKE PT 2

The consultation

He introduced himself by his first and surname as anticipated and invited the patient to tell her story:

> **Dr Mason:** *Would you like to tell me what's been happening?*

It was evident from her description that she had been seen by several doctors including a specialist who apparently said there was nothing he could do for her:

Barbara Clarke: *I took ill on the 8th December with this pain, and I went to the doctors on the Monday and she thought it was appendicitis so she sent us down to casualty which I was there for seven hours and the Doctor said he thought it was just my osteoporosis. And I said no.*

Dr Mason: *Okay.*

Barbara Clarke: *So I phoned the hospital and told them the doctor who I was under and they said 'Go back and tell them he doesn't know what he's talking about'.*

Dr Mason: *Okay.*

Barbara Clarke: *So, I went to casualty three times and they did not help us. And so I went back to the doctors and I told them I wanted something done, and I kept telling 'em 'it's me bowel', well that's how it feels.*

Dr Mason: *Uhmm.*

Barbara Clarke: *And, they sent us to see Mr Grey, I requested to see Mr Flynn …*

Dr Mason: *Uhmm.*

Barbara Clarke: *Because I've been under him before, and then he said after three month that really he doesn't … couldn't deal with me problem.*

Dr Mason: *Uhmm.*

Barbara Clarke: *And he referred us to you.*

Dr Mason stayed with what was clearly the main issue for the patient, her pain:

Dr Mason: *Uhmm. And how's it doing at the moment, the pain?*

There were many pauses as she described her situation and during this time Dr Mason was mostly silent, with the occasional prompt *'ok'* or a clarification question *'in what way?'*. The atmosphere in the consultation quickly became intensely focused on Barbara Clarke and what she was saying. She sounded quite flat and had an air of resignation or weariness as she described how she *'hadn't had a life'* for several months due to her pain, and in response to a query about her ideas of a cause or a trigger, was unable to identify anything. She used the description that her pain was like labour and Dr Mason encouraged her to give more information:

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Barbara Clarke: *The only way I can describe the pain is being in labour.*

Dr Mason: *Okay.*

Barbara Clarke: *It's the worst pain.*

Dr Mason: *Okay. And how long does it last for when you have an attack?*

Barbara Clarke: *Sometimes it all depends; I just stay there until it goes away.*

Dr Mason: *So roughly how long, like a few minutes or half an hour?*

Dr Mason: *Oh no, about, let's see, ten to twenty minutes.*

Dr Mason asked more specific questions about other symptoms or general health problems. The patient disclosed that she had been badly burned as a child. She also described a strong family history of bowel cancer – including a cousin who had extensive disease:

Barbara Clarke: *… and me cousin, everything, all sorts of cancer…*

Dr Mason: *Everything? Oh dear, really? Again, on Dad's side of the family?*

Having clarified what he understood by what the patient had told him, Dr Mason asked if her family history was a concern for her:

Dr Mason: *Okay. So your father had bowel cancer at fifty-three and yours father's sister had bowel cancer and, so will it be your father's sister's kids …*

Barbara Clarke: *Yes*

Dr Mason: *… who are your cousins?*

Barbara Clarke: *Yes*

Dr Mason: *One has breast cancer and another has …*

Barbara Clarke: *All over in fact*

Dr Mason: *… lots of cancer? Okay so on your Dad's side quite a strong history there of cancer. Is that something that's on your mind as well?*

This clearly was a significant concern for the patient, but she was unable to talk to her GP about her fears due to getting too upset. Her GP had told her to try and not think about it, which she had tried to do, until a recent article in a local paper had raised her concerns again. Dr Mason appeared to be very aware of the patient's mood, which came across as part frustration, but also part despair. He used collaborative language whilst acknowledging her worry about her situation:

> **Dr Mason:** *Well, we'll kind of talk about what we're gonna do to try and figure all of this out and obviously the tests we do, you know so far there's been nothing that's been worrying.*
>
> **Barbara Clarke**: *I know that's what I can't understand.*
>
> **Dr Mason:** *Yeah, okay. But I guess there's maybe some more tests we're gonna need to do to try and figure this out.*

Before examining the patient, Dr Mason was still maintaining total focus on the patient and was inclusive of the patient in the way that he spoke.

> **Dr Mason:** *Okay, well I want to have a little feel of your tummy and you can show me where the pain is and then we'll have a think about what kind of tests we need to do to figure it out, and while we're waiting for those tests we'll have a think about whether there's some different kind of tablets we can give you which might start to help things, so we'll kind of do all those things today.*

It is obviously difficult to re-create in writing an atmosphere, but Dr Mason wasn't just talking about medical management. His tone and manner came across as somebody who was genuinely 'seeing' the person in front of him, genuinely understanding her distress and caring for and about her and wanting to provide her with some form of respite from it.

On examination, the patient was precise about the site of her pain. Afterwards, Dr Mason explained in detail the investigation he wanted to carry out, acknowledging she had had an unpleasant experience previously when having a similar investigation:

> **Dr Mason:** *I think it was painful for you, yeah.*

but reassured her that steps would be taken to make it less painful this time whilst acknowledging it was unlikely to be pain free:

> **Dr Mason:** *This time you would get an injection of a strong painkiller as well to try and make it more comfortable for you … but hopefully with the injections on board, the injections of painkiller and sedative you'll find it a lot easier. That being said it can still be a bit crampy and uncomfortable so you need to be prepared that sometimes it's a bit sore when we're doing it. There's no real way of avoiding that to be honest, but we'll give you as much painkiller as we possibly can.*

The patient appeared to be listening very attentively and indicated that she understood and also agreed to go through with the investigation again. Dr Mason explained the investigation would look for cancer, amongst other things but also stressed that whatever the test showed, he and the patient would deal with it together:

> **Dr Mason:** *… obviously it'll look for cancers of the bowel … it'll look for absolutely everything there … if its normal …. I can reassure you that you haven't got any of those things and if we find something then … we'll have to deal with it as we find it.*

This raised a further concern for the patient:

> **Barbara Clarke:** *And what if you don't find anything?*

The following dialogue was a very significant part of the consultation, not only because Dr Mason acknowledged this can be difficult for patients to deal with, but also because he stressed the importance of recognising the degree of pain some patients experience – and that some may feel they are either not believed, or there is nothing that can be done to help them. He reassured the patient this would not be the case for her:

> **Dr Mason:** *Well that's a possibility and you know, if we don't find anything then it will obviously be very good …*
>
> **Barbara Clarke**: *Oh God, ay*
>
> **Dr Mason:** *… we would be able to tell you that you did not have bowel cancer …*
>
> **Barbara Clarke**: *Aha*
>
> **Dr Mason:** *… So there would be some good part of it but we do see a lot of people in this clinic who have really severe … crippling bowel pain …*

> **Barbara Clarke**: *Uhmm*
>
> **Dr Mason:** *… that our tests can't identify the problem … although we can't give you anything that'll specifically get rid of it there are lots of specific pain killers that could help, so even if the tests are normal there are still, we've still got things up our sleeve that we can try to help you.*
>
> **Barbara Clarke**: *Alright*
>
> **Dr Mason:** *Okay? So even if the tests are normal it's not, you know, it's not the end … it's not bad news. Sometimes people are really upset when we find a normal bowel, 'cause they think 'Oh God, well what do I do now?' but there are still things we can try to help you with this bad pain.*

Phrases like 'severe…crippling bowel pain' although used as a general reference to 'people' seen in the clinic, came across as an acknowledgement, an acceptance, that that was what she was experiencing. Following this, Dr Mason and the patient discussed other concerns she had and focussed on finalising the arrangements for the investigation. Dr Mason negotiated with the patient not only the date for the appointment but also the preferred hospital. As had been the case throughout the consultation, Dr Mason again checked whether the patient had any further concerns:

> **Dr Mason:** *Is there anything else that we haven't covered that you wanted to cover today or any other sort of concerns that you have that we haven't talked about?*

To which the patient responded quite emotionally:

> **Barbara Clarke**: *Ah no … this is the best time I've been able to talk - anybody's took notice of us*

The consultation ended by Dr Mason taking her to have a blood test done; assuring her he would then bring her all the relevant paperwork she would need for her current prescription and planned investigations.

Throughout this consultation, Dr Mason used collaborative language, making reference to what 'we' can do to help the situation. The following notes from my diary describe a quite intense atmosphere:

> **Jill Dales (transcription memo): …** *atmosphere intense - felt like I was holding my breath! (the patient) volunteered a lot of information - clearly felt able to do so - felt safe? … able to*

talk about her concerns – Dr M gave every indication to the patient that he was really listening to her- came across as extremely calm, considerate, caring … the patient felt she had been listened to? paid attention to? … mutual trust and understanding …

Summary of this consultation

Dr Mason appeared to make several pre-consultation assumptions:

❖ **About the referral** - the referrer may have wanted to 'bail out' because of being unable to help the patient or their relationship had broken down. This would appear to be accurate, as the patient had been told by him that he couldn't help her.

❖ Dr Mason did not mention what the referrer had written but was focused on the patient telling her own story.

❖ **The patient** - that she may be defensive and angry about 'the system'; that her description of her pain was unrealistic or even impossible and may create a confrontational atmosphere. This consultation did not seem confrontational although the patient did appear to be frustrated with her experiences.

❖ **Of himself** – that he was unable or unskilled at dealing with the patient's psychosocial needs; he would find the consultation more difficult because of this.

❖ This consultation stood out because of the atmosphere created and the complete focus the patient and Dr Mason had on each other and what each other were saying.

❖ When considering this consultation, the concepts of recognition and presence immediately came to mind (and *vice versa*) particularly because of the patient's comment ' … *anybody's took notice of us'*. This was interpreted as the patient not just being listened to but feeling actually 'seen'.

❖ No other consultation created the same type of atmosphere.

Mary Brewer (Patient 3)

Introduction

> This consultation is included because the focus was different from others observed. When reading the referral, Dr Mason's initial comment was about needing to be careful how he addressed this patient:
>
> **Dr Mason:** *So I have to be careful not to call her Mrs, 'cause that upsets people if they're not.*
>
> He expressed the view that elderly prefer to be called Mr, Mrs or Miss – as such, he would never refer to them by their first name unless they specifically asked to be. This referral came from the patient's usual GP, from which Dr Mason assumed she would know the patient very well, so was puzzled at the use of the honorific 'Ms'.
>
> **Dr Mason:** … well, I don't know how to interpret the Ms bit, no interpretation needed really, that… it probably means she's unmarried at her age … *so either she's widowed or was, you know, unmarried.*
>
> Dr Mason also assumed that elderly patients expected a degree of formality, or a more hierarchical structure:
>
> **Dr Mason:** *Older people might expect to turn up, describe their symptoms, be given a diagnosis and be told what to do about it. And you may have to kind of not do that because that's not what we should be doing, but you may have to sort of use that framework …*
>
> He also commented on the GP's use of the word 'multiple' to describe the patient's problems and treatments, feeling the referrer's tone was somewhat dismissive which would seem to be reinforced by his assumption the GP may be fed up with this patient for repeatedly complaining about problems with swallowing.
>
> The patient's age was very significant to Dr Mason, who had views on how an elderly person should be addressed and spoken to. He felt that because of her age, she was likely to be a 'worried well' who had a health belief about swallowing tablets. He assumed that as people got older, they become more fixed in their ways, so if the belief was benign, as with this patient, he would not challenge it. Unlike one of his colleagues who felt the patient's gender was not a consideration, Dr Mason felt that both her gender and age had to be considered when examining the patient. Thus far, the comments and assumptions made were either general about the elderly, or specific in anticipation of seeing the patient about her swallowing difficulties.

TABLE 21: CONSULTATION PRÉCIS_DR MASON/MARY BREWER PT 3

The consultation

At the beginning of the consultation, Dr Mason introduced himself by his first and last name, as he said he would. The patient's name wasn't actually used. The patient immediately identified her problems as being the number of painkillers she was taking and the ongoing problem of pain:

> **Mary Brewer:** *I have a real problem …*
>
> **Dr Mason:** *Okay … tell me*
>
> **Mary Brewer:** *… I'll tell you what I've come for … I'm desperate for some pain relief*

The patient then described her painful knees and how little relief she had gained from a combination of ten painkillers. In fact, she had taken the decision to cut down on most of them as she felt they were negatively affecting her general health. This was picked up immediately by Dr Mason:

> **Dr Mason:** ... *it sounds in some ways like there's two different kinds of messages, what we're picking up from your GP is that your GP has asked us to consider why you struggle to swallow tablets. But what I'm hearing from you obviously is that, you know, we've gotta sort these knees out*
>
> **Mary Brewer:** *Yes ... well in priority*
>
> **Dr Mason:** *In priority ...*

Once this had been established, the patient then (apologetically) mentioned her concerns about her voice which had been investigated before, with no abnormalities found. This had been mentioned in the referral letter, and Dr Mason was aware she had quite a fixed idea how the problem came about, but he gave no indication of this, nor did he challenge her, as he had anticipated as she described how she believed the problem came about:

> **Mary Brewer:** *I think there's something, this occurred when I had a breast cancer, and I was taking tablets. And one of the tablets stuck in the back of my throat, from early evening until the next morning and I felt it burned and ever since then I have a sore spot there, and there is something there. But I saw a doctor...*
>
> **Dr Mason:** *Uhmm ... tell me when that was*
>
> **Mary Brewer:** *Perhaps one year, two years ago and I sore the, the speech therapists...*
>
> **Dr Mason:** *Okay, okay*
>
> **Mary Brewer:** *And this is going to be very rambling, I'm sorry*
>
> **Dr Mason:** *No no, carry on...*
>
> **Mary Brewer:** *It left me, it has...*
>
> **Dr Mason:** *...because we want to...*
>
> **Mary Brewer:** *...it has left me with a growing worse cough...*
>
> **Dr Mason:** *Okay*

Mary Brewer: *…just in my throat*

Dr Mason: *Okay, okay*

Although she was keen to have repeat investigations, Dr Mason explained this was unnecessary as it was unlikely to see anything new. This was accepted by the patient, Dr Mason made adjustments to her medication which he felt might help.

Dr Mason returned to the topic of her painful knees:

> **Dr Mason:** *… just thinking in kind of priority order for yourself, let's think about the knees first.*
>
> **Mary Brewer:** *Yes.*

The next bit of dialogue was influential in establishing the atmosphere of the consultation. It also seemed to reinforce Dr Mason's attitude of respect towards the elderly and the influence his own elderly relatives had had on him.

> **Dr Mason:** *Would you think that seeing them again with regard to your knees would be useful, to see what else they could do?*
>
> **Mary Brewer:** *I will go anywhere, see anybody because the amount of pain I'm having, if I walk or do anything very much today…*
>
> **Dr Mason:** *Okay*
>
> **Mary Brewer:** *… tomorrow I'm finished*
>
> **Dr Mason:** *You'll pay for it. … why don't I refer you back to Doctor Street, the rheumatologist, today and ask him to see you in the clinic*
>
> **Mary Brewer:** *He couldn't see me today could he?*
>
> **Dr Mason:** *I could ask him*
>
> **Mary Brewer:** *Would you?*
>
> **Dr Mason:** *Probably not I would guess 'cause his clinics usually run about three hours over…*
>
> **Mary Brewer:** *Right*
>
> **Dr Mason:** *But I can ask him. Okay, well that's problem number one and what about me trying you on some cream to rub on your knees. Have you tried those?*
>
> **Mary Brewer:** *Well I've tried various creams and so on; it's beyond that cause now I have a skin… I feel most embarrassed; I have skin sensitivity in my knee as well*

Dr Mason: *… Have you ever been on a cream made out of chilli peppers, they call it Capsaicin?*

Mary Brewer: *No*

Dr Mason: *Well that's quite a good one for pain of arthritis of the knees*

Mary Brewer: *Uhmm*

Dr Mason: *What would you think to trying that if we can't get you seen by Doctor Street today?*

Mary Brewer: *Yes I'll happily try anything*

Dr Mason: *Okay. Okay*

Mary Brewer: *And pain doesn't improve your temper I don't think*

Dr Mason: *No well for sure. Okay so with regard to your knees then, we'll get you started on something new as a sort of painkilling cream that is often effective*

Mary Brewer: *Uhmm*

Dr Mason: *… and we'll ask Doctor Street - and I can bomb round there now…*

Mary Brewer: *Would you?*

Dr Mason: *… and see …*

Mary Brewer: *I'd be very grateful*

Dr Mason: *Well that's no problem at all*

Mary Brewer: *Uhmm*

Dr Mason: *I'll bomb round there now and see if he's got a slot*

With that, he went off to the rheumatology clinic and returned to say the consultant wasn't able to see her, but if she was prepared to have a cup of tea and wait, another doctor would see her at the end of their clinic. Dr Mason then went to find the patient's son to advise him of the situation, and walked with them to the other clinic's waiting area.

The patient was very appreciative of his help:

Mary Brewer: *Well I'm just saying that I've had more conversation with you than with any of the myriad of doctors – all very helpful and so on – but thank you for your…*

Dr Mason: *Yeah, yeah you're welcome*

Mary Brewer: *… for your patience*

Dr Mason returned to his own clinic. This level of attention to a problem that was not his specialty, the personal intervention and arrangement on behalf of the patient is, in my experience, quite unusual.

Summary of this consultation

- ❖ Dr Mason had assumed that referral information (from the patient's GP) would be reliable and accurate. This did not appear to be the case.

- ❖ Dr Mason's communication was quickly adapted to deal with the patient's concerns on the day. He came across as being totally focused on the patient's agenda and this was reflected in the atmosphere created in the clinic.

- ❖ Dr Mason had also assumed that he would behave more formally with his elderly patients as he also assumed that this was an expectation on their part. The consultation did not feel or appear to be formal.

- ❖ The concept of recognition was again very relevant to this consultation.

Both patients commented that, from all the doctors they had seen, Dr Mason had been the one who listened to them, had helped them and from an interpretation of what they said, and the atmosphere created, had genuinely recognised them and their situation.

Dr Allen

Dr Allen clearly reflected on his own communication and what influenced it. Before seeing this patient, he stressed how important listening to the patient's version of events was - *'I always try and find out the patient's perspective'*. This statement was interpreted as an expectation by Dr Allen that this *was* how he conducted his consultations and also of the assumption that ergo, he would use the same consulting style with the patient to be seen.

George Adams (Patient 2)

Introduction

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This consultation was chosen as it illustrates that Dr Allen communicated with the patient very differently than anticipated i.e. finding out the patient's perspective and listening to *the patient's* version of their situation.

George Adams was an elderly man, described in the referral letter as having dementia and recently, changed bowel habits:

Dr Allen: *Well, the guy's got dementia. I hope he comes with somebody who knows what he's talking about, or she's talking about.*

Before seeing the patient Dr Allen expressed his view that depending on the general health of the patient, he may have to discuss the possibility of bowel cancer with the patient and further, invasive investigations.

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TABLE 22: CONSULTATION PRÉCIS_DR ALLEN/GEORGE ADAMS PT 2

The consultation

The format of the referral was a medical history pro-forma print-out, something that Dr Allen particularly disliked. The patient was accompanied by his wife who seemed quite stoical, was articulate and well organised. The consultation started as anticipated, the consultant introducing himself as 'Dr Allen'. Despite his pre-consultation comment i.e. asking the patient how he preferred to be addressed, he called him Mr Adams and acknowledged the patient's wife. At this point the patient deferred to his wife:

> **Mr Adams:** *She answers all my questions.*
>
> **Dr Allen:** *Good, okay.*
>
> **Mr Adams:** *She knows all the answers.*

Dr Allen then, as he anticipated he would, asked the patient what had been happening:

> **Dr Allen:** *So I've just got a little bit of information from your doctor, here … but it's always nice to hear from the patient what the problem is. So tell me what's been happening and we'll see how we can help you, shall we?*

Again the patient deferred to his wife:

> **Mr Adams:** *Well, ask the patient's wife …*

The patient's wife laughed, saying he had a memory problem. The referral focused on altered bowel habits but it became apparent the real problem was faecal incontinence. Mrs Adams had a diary of events, and spoke uninterrupted describing events in graphic detail.

Dr Allen commented the problem was '*obviously distressing*'. Having clarified details of the problem with the patient's wife, Dr Allen then spoke to Mr Allen:

> **Dr Allen:** *So what...what's your normal bowel habit, Mr Adams?*
>
> **Mr Adams:** *Well, I go...I hope to go once...once a day.*
>
> **Mrs Adams:** *But he hasn't been for two days since the last little episode*

From that point, a significant part of the dialogue took place between Dr Allen and the patient's wife. On the occasion Dr Allen did address a question to Mr Adams, his wife provided the answer. This seemed to be influential in setting the pattern of the patient being referred to in the third person by consultant and Mrs Adams. However, the patient interjected with several relevant comments.

Dr Allen explained that he had anticipated the problem would be incontinence rather than diarrhoea, mainly because of the patient's dementia and age:

> **Dr Allen:** *Unfortunately, the problem is that Anno Domini is marching on*
>
> **Mr Adams:** *I'm 86.*
>
> **Mrs Adams:** *87 in two weeks' time*

The patient's wife indicated that their GP had suggested her husband may have to have further investigations:

Mrs Adams: *A colon...colonoscomy....colonoscopy, yes, colonoscopy*

Dr Allen: *Well just reading the letter I was thinking I hope we don't have to do a colonoscopy because colonoscopy is not a straightforward test. In fact it's a very difficult test …*

Mr Adams: *You shove something up your bottom or ...*

Dr Allen: *You do, yes …*

As the consultation progressed, Mrs Adams explained the importance of getting away for a break, and her husband could go to a respite care home, which prompted the following comment:

Mr Adams: *Broad Oak House, wonderful place, lovely.*

When explaining that her husband's poor mobility made it difficult for him to get to the toilet easily, Mr Adam's commented:

Mr Adams: *I used to do a lot of walking. I broke my leg twice.*

It was apparent he had had various short term health problems, such as chest infections. When making the following comment, it would seem Dr Allen assumed the patient would have been advised of his diagnosis before attending the memory clinic. Whether that was the case or not, George's response indicated it was, for him, new and worrying information:

Dr Allen: *Well, I guess what happens with...when you've got a long term illness like dementia, another illness comes along and you go down a bit but you never go straight back up to where you were. And that's the pattern. That's very typical. But it can take six weeks, three months to kind of, you know, get back on the slope to the maximum …*

Mr Adams: *I've got dementia?* (concerned voice)

Dr Allen: *That's what they tell me, yes.*

Mrs Adams: *Yes, yes, yes. You go to the memory clinic, George*

Mr Adams: *Dementia's just to do with memory, is it?*

Dr Allen: *Sorry?*

Mr Adams: *Dementia's just to do with memory, isn't it?*

Dr Allen: *It is, yeah.*

> **Mrs Adams:** *Yes, yes. Oh no he can sit and listen to a political broadcast and give a sensible answer or thoughts on it. It's...it's all the memory.*
>
> **Mr Adams:** *short-term memory*

There were other interjections by the patient that were completely relevant to the discussion between his wife and the doctor. This indicated he not only understood, but was keeping up with the dialogue - but questions and explanations by Dr Allen were addressed to his wife.

Mr Adams was also not asked about his feelings or concerns, even though Dr Allen anticipated he would get the patient's perspective. Dr Allen clearly appreciated the difficulty of the situation, but empathic statements were directed at the patient's *wife* as she described the care her husband required and the impact it was having on her:

> **Dr Allen:** *'It's obviously a distressing problem …'*
>
> *'Right, I appreciate it's difficult …'*
>
> *'Yeah, I know … I appreciate that fully …'*

Further discussion took place between consultant and patient's wife about medication and the appropriateness of submitting the patient to invasive investigations and the decision was made to 'leave well alone'.

Throughout, Dr Allen's manner towards the patient was courteous and gentle and he demonstrated concern for the wife, but when making his closing comments, the patient's presence did not appear to be taken into consideration:

> **Dr Allen:** *And it's obviously going to impact quite heavily on, you know, your ability to care for him at home long term, you know, if this becomes...*
>
> **Mrs Adams:** *well I realise that …*
>
> **Dr Allen:** *… a daily problem or something*

Despite the empathic statements, there seemed to be lack of recognition of the depth of Mrs Adams' distress:

> **Mrs Adams:** *Let's just say I sort of feel very easily moved to tears now and I'm not the tearful type. But I could just sit and weep at the minute.*

To which the response was a non sequitur:

> **Dr Allen:** *There you go then. That's two things for you. One is your prescription. Unfortunately the pharmacy will be closed for now; you'll have to come back another day.*

As this clearly indicated the end of the consultation, both patient and wife expressed their thanks to the consultant who at that point received a text message on his mobile phone:

> **Dr Allen:** *That's my wife telling me it's my son's birthday. I'd better go home.*

Summary of this consultation

Dr Allen made several assumptions before this consultation. With regard to the referrer, he felt it was a good practice, and therefore assumed the referral would be appropriate. However, the information was not accurate, requiring a completely different focus for questions and explanations. He also expressed the view that he did not check often enough how the patient wished to be addressed, anticipating asking the patient if he preferred being called by his first name. This was not done. The patient's educational level was considered by Dr Allen to be more of an influencing factor on his communication than their age. Having assumed the patient lived in a 'posh' area, it may also be the case that Dr Allen assumed the educational level of the patient and his wife – hence the references to Shakespeare, and the use of Latin. Dr Allen also assumed that patients regard hospital doctors as more 'technical' and GPs more caring. He had stated how important it is to be perceived as somebody who was friendly; showed understanding towards the patient and the experiences they were going through. Most important to him was that patients felt listened to and he, like some of his colleagues, felt that a significant part of their role was just to listen to the patient. Dr Allen's own perspective of his communication is that he is patient centred and inclusive. However, the patient was given very little opportunity to contribute to the discussions and when he did, neither Dr Allen nor Mrs Adams seemed to encourage it. For most of the consultation Mr Adams was referred to in the third person.

This was so contradictory to his own anticipations and assumptions of his practice. The next chapter describes Dr Allen's reflections on this consultation and his explanation why his own assumptions regarding his anticipated communication were not acted upon in practice.

Dr Workman

Dr Workman's clinic was at a small peripheral 'cottage hospital' and the atmosphere was very different to that of the city hospitals. The waiting area was small and comfortable. Dr Workman appeared to enjoy interactions with his colleagues and patients.

Before the consultation, Dr Workman commented he has a couple of opening questions which he likes to use. Most frequently he starts by asking the patient if they know why they are there but another question he likes to use when '*feeling mellow*' is '*tell me how I can help you today*'. According to Dr Workman, when '*things go wrong*' in a consultation it's because he uses the wrong opening question.

Jack Ellis – (Patient 2)

Introduction

This case has been chosen because the referral created quite a response from Dr Workman, primarily because of the patient's occupation as an actor. Significant for Dr Mason was the referrer was somebody he knew well and regarded highly (Chapter 4:124) so assumed that because his colleague had been unable to relieve the patient's situation, he would find the consultation challenging. He light-heartedly described quite vividly how he anticipated the patient to look, what his general demeanour might be and also his psychological make-up. He also had quite clear expectations of how the patient may influence the consultation:

Dr Workman: *he's an actor so I think he's probably going to be an articulate … I would think you know empowered consumer … I'm anticipating him being somebody who's got his own views on it and you know who will want to have quite a sort of participative type consultation.*

Dr Workman also made a link, which he admitted was tenuous, between the patient's skin condition, HIV and his profession as an actor and therefore made a further assumption regarding communication:

Dr Workman: *… this is kind of flicker of a possibility, but he is an actor and he has seborrheic dermatitis and … there is a link with HIV … there is obviously a kind of big spectrum of GI disease in HIV. I think there is normal bloods and the fact he's generally well and doesn't have any diarrhoea, I think that makes it pretty unlikely, but I would anticipate that when I come to see him, I will ask some kind of gently probing questions about his sexuality I think.*

The significance of the patient's occupation was mentioned again when Dr Workman commented on what significant information was missing from the referral:

Dr Workman: *so what's missing from this letter is a couple of things, he's a moderate smoker, there is no reference to alcohol and I'm kind of thinking well he's an actor so you know potentially a lot of occupational exposure to booze, and the other thing that is missing is there is no real reference to his personal life or his psychological health*

Dr Mason was confident patient's problems would be stress related, and because of this, had clear ideas about his anticipated communication and assumed he would be able to follow his usual process of exploring the patient's concerns, asking him to identify a time-scale associated with the onset of their problems in relation to personal stress or trauma, including bereavement, relationship or work problems.

He also felt the patient would be '*pretty well heeled*' because of where he lived and he looked forward to meeting him.

TABLE 23: CONSULTATION PRÉCIS_DR WORKMAN/JACK ELLIS PT 2

The consultation

Dr Workman introduced himself by his title and first and surname but referred to the patient as Mr Ellis. As anticipated, he asked the patient if he understood why his doctor had made the referral and then encouraged him to describe his problems. The consultant and patient were of similar ages and the patient came across as being quite comfortable talking to Dr Workman. He spoke quietly, but was articulate and confident not only in himself but also in the use of medical terms, having qualified as a nurse several years before becoming an actor:

> **Jack Ellis:** *I had a scan which showed that my liver function came back fine, there was no sign of infection in the blood either and the results of the scan were immediate, nothing wrong with my liver, apparently nothing wrong with my kidneys, spleen, suspected gall bladder, nothing wrong with the gall bladder, no gall stones in evidence so that was all good news cause you know, that's vital organs all functioning nicely.*

He took control of the focus of the dialogue several times, at one point questioning why he needed to disclose personal information:

> **Dr Workman:** *… and would you say that has been … you've been more down this year than last?*
>
> **Jack Ellis:** *It's been a very stressful year yes*
>
> **Dr Workman:** *Has it? In what way?*
>
> **Jack Ellis:** *Oooh [laughs] that's quite personal*
>
> **Dr Workman:** *Is it, okay, okay*
>
> **Jack Ellis:** *Unless that's necessary to share with you now*

Although he acknowledged Dr Workman's explanation that he was asking the question in order to establish a trigger to the onset of his symptoms, he chose not to disclose more information, stating there was no connection between life events and his physical symptoms. Although Dr Workman had anticipated asking for more personal information concerning the patient's sexuality, this was not done.

Following the initial questions about his health Dr Workman checked with the patient that he was ok about being examined. Unusually, as the patient was male, he also arranged for the nurse to be present:

> **Dr Workman:** *I need to examine you, can I...and err, if I can get you to slip down to your under things, will that be alright? Next door and I'll get nurse to give me a hand.*

 After the physical examination (for which Dr Workman apologised), the patient shut the door of the examination room as he re-entered the consulting room and then prompted the consultant, *'so?'* to talk through his thoughts about what investigations would be appropriate and also what his initial potential diagnosis was. Dr Workman admitted he wasn't sure:

Dr Workman: *it's not clear immediately what the cause of your symptoms is … you can get a little tear in the...basically the sort of six pack muscle, the rectus abdominus …*

… But there's a condition called Crohn's Disease, have you heard of that?

Jack Ellis: *My father has it.*

Dr Workman: *Your father has it? Right, I should have asked you about that shouldn't I [laughs].*

Further direction came from the patient when he asked for more information:

Jack Ellis: *could you tell me a little bit more, I mean I should really know because my poor old dad's had it for quite some time but err, you know, I've only sort of erm...and quite acutely really erm, very bad phases. I mean he's okay, sort of watches his diet and things, I don't know, that might be for other reasons but I don't really know what Crohn's Disease is, what causes it, what's going on with it.*

Dr Workman: *Yeah, I mean I'm happy to do that although, I don't wanna kind of overload you with information that might not be relevant if you don't have Crohn's.*

Jack Ellis: *no, I realise it's not the diagnosis yet*

The patient also asked about other options if the initial diagnosis was disproved, asking directly if his symptoms would be considered '*psychosomatic*'. This resulted in a discussion about the potential for there still being a physical cause for his symptoms. Having made arrangements for an investigative procedure, (Dr Workman apologised several times for not being able to provide a specific time) instead of asking the patient if he understood what he had explained, he asked if the patient agreed with it:

Dr Workman: *Is that alright?*

Jack Ellis: *Yeah, that makes perfect sense.*

Dr Workman: *Okay, so I'll see you on the 20th.*

Jack Ellis: *Okay, thank you very much*

Dr Workman: *Take care.*

Jack Ellis: *Not at all, good luck with everything.*

It was unusual to hear a patient wish the consultant good luck before leaving. Throughout the consultation, both the patient and the consultant used humour, laughed and appeared comfortable with each other.

Summary of this consultation

- ❖ Whether the patient met Dr Workman's assumptions about an 'actor' was not clear but several assumptions Dr Workman had made about the patient appeared to be fairly accurate.

- ❖ He was articulate and took a pro-active role in the consultation, as Dr Workman anticipated.

- ❖ Dr Workman had said he was looking forward to meeting the patient, and it appeared that he did enjoy doing so, as the interaction was relaxed and friendly.

- ❖ The actor-lifestyle assumptions Dr Workman made i.e. alcohol intake being relatively high, were also affirmed. The stressors in the patient's life were not explored – possibly because the patient declined to discuss what he described as a '*stressful year*' but also because he did not accept that stress had anything to do with his symptoms.

- ❖ Dr Workman had also assumed that he would also ask gently probing questions about the patient's sexuality, but he did not do so.

Dr Schofield

Dr Schofield was one of the younger consultants. He had clear ideas about how he would greet any patient, irrespective of age. He was apprehensive about potentially stereotyping patients, but was sure he adapts his communication depending on the social class of the patient. However found it difficult to describe what the influence is. He felt that a lot of communication is based on habit, and once adults learn a certain thing or way or practicing, it's very difficult to change.

This consultation has been chosen because although there were similarities with the consultation of Dr Allen, the patient had dementia, but there were significant differences. Dr Schofield reflections on the consultation were also very interesting.

Michael Rivers (Patient 4)

Introduction

This was an elderly gentleman referred with unexplained anaemia needing investigation before undergoing a second knee operation. He was described as suffering from mild dementia. Dr Schofield expressed several expectations regarding influences on his communication. Firstly, that an elderly person was likely to be more respectful towards him, but would also prefer the more traditional 'paternalistic' doctor-patient relationship:

Dr Schofield: *the older patients tend to be more of that generation where they want you to tell them what's wrong with them and tell them what you're going to do about it and are less likely to take ownership of their illness*

Although he was certain he would discuss investigation options and the potential of cancer being the cause of his symptoms, Dr Schofield also felt that the patient would be unlikely to want to know very much:

Dr Schofield: *I'm going to have to be quite sensitive about that and consider what the patient's likely to think*

The age of the patient would also reflect on Dr Schofield's history-taking and how he obtains information.

Secondly, the fact the patient was described as having dementia was also anticipated as being a significant influence. Dr Schofield assumed he would probably have to get the majority of the information from the daughter (who accompanied her father to the GP appointment):

Dr Schofield: *So I would expect that it might not be straight forward in terms of getting the information from the patient and that I may expect to spend some of this interview or significant amount of the interview actually getting the information from the daughter … I would hope that this patient would come with the daughter to give me that information*

At the same time, he felt it was very important the patient understood the implications of any tests or investigations required.

Dr Schofield: I want to make sure they understand *what the implications are of having an investigation or not having an investigation enable the patient and/or sort of the family around the patient to make an informed decision about whether they would want me to do that investigation in the light of what I've mentioned so far*

Finally, the gender of the patient and the area in which he lived was also perceived by Dr Schofield as influential because of the way the patient may potentially regard illness and seeking medical help.

TABLE 24: CONSULTATION PRÉCIS_DR SCHOFIELD/MICHAEL RIVERS PT 4

The consultation

Although Dr Schofield had previously said he always calls patients Mr/Mrs irrespective of their age, he greeted the patient as 'Sir' but introduced himself as 'Dr Schofield' as anticipated. The patient was accompanied by his daughter. Dr Schofield set quite a business-like but friendly atmosphere, describing what the referrer had written and why he had been referred. He acknowledged the problem the patient was having with his knees and asked how things were.

> **Dr Schofield:** *Okay, how's that going?*

Michael Rivers: *It's err…*

Dr Schofield: *…working okay is it?*

Michael Rivers: *It's fine…*

Dr Schofield: *…not so bad. Are you getting much pain in this knee?*

Michael Rivers: *This one, I get quite a soreness …*

Dr Schofield: *… quite a soreness, yeah. You take tablets for that don't you, for the pain. Do you know what they're called, the tablets that you take for your knee?*

Michael Rivers: *No, I have a handful…*

Dr Schofield clarified with the daughter what medication her father was taking, but addressed his question about any side-effects to the patient:

Dr Schofield: *Okay. Do you get any discomfort in your stomach when you take those at all?*

Michael Rivers: *Do I get any comfort?*

Dr Schofield: *Any indigestion at all?*

Michael Rivers: *No.*

Dr Schofield: *Not really, okay.*

Despite the patient appearing unable to provide very much information, Dr Schofield continued to address every question to him, including whether he understood what it meant to be iron deficient – to which the patient replied '*not really*'. The daughter explained that it had been explained to her father but as far as he was concerned, it was just something that was stopping him from having his knees operated on. His painful knee was his main concern and a couple of times pulled his trouser leg up to uncover his knee. His daughter returned the clothing to its appropriate place.

Dr Schofield continued to address the patient as he explained what iron deficiency meant and the implications of having investigations:

> *'The iron deficiency is … a lack of iron and there's really only two ways that you can become short on iron, one is that you're not absorbing it properly and the other is that you're losing iron and the way you lose iron is by bleeding, and that bleeding*

can be from your stomach or from your bowel … the tablets that you're taking often can cause this type of bleeding but there are other things as well that can cause this type of anaemia such as ulcers in the stomach, lumps and polyps in the bowel, cancers in the bowel … and the reason why we've got you up today is to see whether you would be happy for us to go ahead and do an investigation to check that out for you'.

Dr Schofield continued with an explanation of the investigations:

Dr Schofield: *The investigation would involve putting a camera down into your stomach and then a camera around your bowel and that would give us a very good idea as to whether there's anything significant causing the trouble and I think once we've sorted that out, then the Doctors would be happy enough to go on and do your knee operation. How do you feel about that?*

Michael Rivers: *Alright.*

Dr Schofield assumed he would send information about the arrangements for the patient's future hospital appointment to his daughter, but the daughter corrected him, saying all correspondence could go to her father's home as, although he lived on his own, she would see it.

Dr Schofield advised the patient he would need to come in to hospital a day before his investigation, and then described in detail how it would be carried out, from the administration of the sedative to the actual insertion of the 'tubes' and also explained the risks:

Dr Schofield: *The procedures are safe, but there are risks involved with what we do. The risks … are small, but we would quote a rate of a serious complication occurring in about 1 in every 1000 patients and the most serious risk is us making a hole in the bowel as we do the test and that can need an operation to sort out, so you need to be aware of that and if that changes your decision then we need to know that, but I consider it to be a very safe procedure and I think to get on and have your knee operation, they'll want us to have had done this for you … So I'll be in touch, we'll organise that for you and it'll likely be obviously in the New Year now but it shouldn't be more than a few weeks before we can get it done for you, and then your Doctor can get you back in touch with the Orthopaedic doctors to sort out your knee operation.*

Michael Rivers: *Oh, thank you…*

Dr Schofield: *…okay, any questions at all?*

Michael Rivers: *No, I'd just like to get it done…*

Throughout all of these explanations, neither the patient nor his daughter interjected. At no point during the consultation did Dr Schofield address a question to the patient's daughter or refer to her father in the third person. Every question was directed at the patient and the consultant's manner remained gentle throughout.

At the end, Dr Schofield wished the patient well – referring to him as 'Sir'. This was reciprocated by the patient.

Summary of this consultation:

❖ Dr Schofield had assumed he would address his patient as Mr, as that is his normal practice, but instead he referred to him as 'sir'.

❖ Despite Dr Schofield's intention to deal with the subject of cancer sensitively, it appeared to be raised quite suddenly. There was no check with the patient or the daughter if they had considered it, or were concerned about it, before it was mentioned. However, there was no apparent reaction by patient or carer of any surprise or distress.

❖ He had anticipated providing a clear explanation of the cause of the problem and the potential investigations, which he did.

❖ It came across as a functional consultation. It served the purpose for which it was intended.

❖ Although appearing mutually respectful there appeared to be no sense of engagement other than 'the patient' providing the problem and 'the doctor' providing the answer.

Dr Clarke

Dr Clarke was also a young consultant, which seemed to be significant for her in her interactions, particularly with male patients. She stated she would use different language for patients at the extreme end of ages i.e. young and an older person. She believed her communication would not be influenced by the social class of a patient, as most patients, unless in a profession related to human anatomy or health, have the same level of understanding. She also felt that any psychological support needed to come from someone other than herself (Chapter 4:145).

David Price (Patient 3)

Introduction

When reading the referral about this 62 year old man, with difficulty in swallowing and vomiting, it was apparent that previous investigations for his physical symptoms had not shown any obvious cause. This provoked a groan from Dr Clarke who had the task of having to explain that although he has pain, there was nothing found to cause it and no specific treatment either:

Dr Clarke: *'Oh no....how am I going to tell....'*

The patient also had an extensive history of mental ill-health spanning over many years. Dr Clark admitted this would be quite an influence:

Dr Clarke: *I think it's important not to pre-judge with these people actually because sometimes these people are very sensitive to that, they kind of think you know, 'I've got a depressive illness and so everyone puts all my symptoms down to that but I know there is something wrong ... you've got to be able to avoid that really, cause otherwise, you've lost them right at the beginning of the consultation.*

The phrase '*these people*' was used twice in the context of describing patients with mental health problems.

He also had a history of being referred for Pain Management of many different physical pains which indicated to her that he may be manifesting his emotional distress in physical pain.

When commenting on where the patient lived, she expressed the assumption that he would not be '*super posh*' (Chapter 4:151)

Her own age was significant, in that male patients of a similar age were sometimes less respectful of her position and she may need to create some 'gravitas'.

TABLE 25: CONSULTATION PRÉCIS_DR CLARKE/DAVID PRICE PT 3

The consultation

The patient walked into the consulting room using a stick. He looked very apprehensive and subdued. He was physically shaking and throughout the consultation appeared unable to make eye contact with Dr Clarke. Initially, she asked very specific questions about his physical symptoms, and made notes as

he spoke. As he described the impact his symptoms were having on his life his voice was a very flat mono-tone.

There were long periods of silence when he seemed to struggle to articulate his thoughts and to answer questions about his physical symptoms:

> **Dr Clarke:** *Is it coming from your stomach or is it coming from your chest? Are you coughing it or are you retching it up?*
>
> **David Price:** *Er retching, it's…it's not coming from my chest I don't think. I mean [sighs] I don't know, I'll be quite honest, I don't know.*

He was visibly shaking and frequently sighed heavily. Dr Clarke stopped writing and appeared to give him her undivided attention. The tone of her voice lowered and she appeared genuinely concerned for him. The atmosphere in the room became very still.

Dr Clarke raised the issue of his depression and asked the patient how long it had been going on for and if he saw a specialist, which he confirmed he did. She also asked how felt now:

> **Dr Clarke:** *Is your depression bad at the moment?*
>
> **David Price:** *[sighs] it's not good.*
>
> **Dr Clarke:** *No.*

She seemed unsure how much his mental state was influencing his physical symptoms:

> **Dr Clarke:** *This is a difficult one because what you're unsure about and I'm also unsure about is how much your symptoms are making your depression worse or how much your depression is making these symptoms worse*

asking his permission to contact his psychiatrist – to which he agreed.

Following this, Dr Clarke explained possible management options, tests and investigations. At times her voice rose to her usual level, her delivery more 'business-like' but the patient remained very flat – frequently sighing. Dr Clarke was clearly trying to make sense of his description of his symptoms and his general demeanour:

> **Dr Clarke:** *Your symptoms seem a little bit out of keeping with your depression. It seems to be making you much more distressed and causing more symptoms for you than I would expect it to*

The patient had previously expressed his anxiety at being at the out-patient clinic of this large hospital and the investigations proposed by Dr Clarke would require the patient being quite a bit longer. Throughout her discussions, Dr Clarke was clearly aware of his anxiety and frequently checked with him if it was ok. At the end of the consultation, Dr Clarke again expressed her concern about his mental health, but the patient seemed to disagree this was a key issue:

> **Dr Clarke:** *Ok. I think, my impression from seeing you today is that your depression is a real problem for you at the moment.*
>
> **David Price:** *[long pause] ...it's.. [sighs]... it's this what's causing my depression at the minute.*
>
> **Dr Clarke:** *Ok. Well, we're trying to sort this out for you ... we'll write to you with the results of everything when they're available, ok?*

This was clearly a difficult consultation with a very distressed individual.

Summary of this consultation

- ❖ It appeared that this consultation had not progressed as anticipated. Although able to take enough medical information to formulate a potential diagnosis, the main focus was the patient's mental health, which from the referral information, was not what Dr Clarke had assumed it would be.

- ❖ Her communication was clearly influenced by the patient's emotional state, and there were times when, far from creating some 'gravitas' to emphasise her 'authority', Dr Clarke seemed to be at a loss what to say.

- ❖ Her manner throughout appeared to be of concern, for his state but also whether he would actually be able to undergo the investigations suggested.

Chapter Summary

This chapter seeks to do three things. Firstly, it presents a series of case studies from the consultations which followed pre-consultation interviews. Second, in doing so, it presents the second stage of the study in context, highlighting the observations made. Thirdly, it shows the method and design of the study in action.

Some, but not all, stereotypes and/or assumptions expressed in the cognitive interviews appeared to influence the communication. The style of opening of the consultation and use of specific phrases to start the consultation were not always as anticipated. The envisaged focus of some consultation was very different to the actual focus and there were also occasions when consultants discussed investigations they had anticipated they would not.

With regard to the referral, those who assumed the information to be accurate and reliable found in the majority that this was not the case. Assumptions regarding the patient seemed to be acted on, specifically with elderly patients, who appeared to be asked more focused and closed questions.

The consultants had also expressed several assumptions regarding their consultation style, that they would be patient-centred; always listen to the patient's story. This did not appear to be the case in all situations, and the patients were sometimes interrupted, asked more closed and focused questions or in the case of one patient, not included in the majority of the dialogue, which took place between the doctor and the patient's wife. This changed the assumed style of consultation quite significantly.

The consultants' assumption that they were not *able* to deal with the psychological needs of the patient was for the most part difficult to ascertain; they were always acknowledged, but usually not explored. This was not the case with one consultant, who appeared to meet these needs.

Finally, although consultants assumed they did not stereotype or make assumptions, many of these were respectively, expressed and made.

It is acknowledged that, if being observed modified the 'norm' of the consultation, even if unknowingly, then the credibility and trustworthiness of the information could potentially be reduced. However, because the consultants frequently had observers in their clinics, the consultants themselves were in little doubt that the consultations observed were in most respects 'typical' examples of their consultation style.

In the next chapter, the consultants reflect on their communication and express thoughts on why they said what they said, or why they did not say something.

Some of the reflections are about the illustrated consultations but there are also examples of reflection on other consultations, as appropriate, in order to contextualise their comments.

Chapter 6. Post-consultation reflections

Introduction

The aim of this chapter is to represent Stage 3 of the study (Table 26) i.e. the consultants reflect on their anticipated and actual communication with a new patient. It explores the doctor's perceptions on what influenced their interaction with the patient and also reflects on the consultant's perception of their consulting style. Interpretation of their consulting style then leads to consideration of questions about recognition, misrecognition and presence. The chapter concludes with an exploration of the findings and strengths and limitations of this final stage of the study.

Reflection on Communication
To explore the link between anticipated communication and the actual communication
To explore the influence of previously identified **and/or** newly identified prior assumptions on the communication. Specifically in relation to:
How the consultation went : how & why
Why did they say what they said?
Why did not they say what they did not say?

TABLE 26: AIMS OF STAGE 3

In Chapter 5, observations of the consultations identified that some of the *a priori* assumptions identified in Chapter 4 were influential on the communication, either by being acted upon, or not. In all observed consultations, there were other aspects of the consultants' communication that appeared to be significant, but apparently unrelated, to previously expressed assumptions. The previous chapter identified *why* these communication events happened. This chapter explores whether there was a rationale or judgement associated with what the doctors said or did not say. This was achieved by the doctor's giving their opinion of the consultation; their explanations as to what may have contributed to how it went and influences on what was said or what was omitted. Much of what was said was spontaneous, with the doctor following their own threads of reflection. However, they also provided comments in response to questions aimed at clarifying a point or specifically asking why they had said something, or why they hadn't said something they anticipated they would. It needs to be stressed these questions were not based on any

interpretation by me i.e. assuming something was said or not said for a particular reason, but merely for clarification purposes. Inevitably, in some consultations, the anticipated consultation was different from the actual consultation, but all the consultants were able to marry the actual communications with preceding assumptions and subsequent perceptions. All were able to offer a judgement on how they felt the consultation went, with only three comments from two consultants feeling it had gone as expected.

Another aim for this stage of the study was to establish how readily the doctors adapted their communication, depending on the accuracy (or not) of their *a priori* assumptions or when other assumptions arose during the consultation.

Influences on the communication

There were many influences on the communication. However, there were also comments which the doctors contextualised by using a general reflection, for example, about their general preference not to explore a patient's psychosocial issue. However, it was possible to identify similar broad categories as identified in Chapter 4 (Table 27).

The influence of assumptions regarding the following:
The consultation
How it went; being patient centred
The referral
Including the referrer and content of the referral information e.g.: referrer's perspective on the necessity/reason for the referral; reliability and accuracy;
The patient
Their immediate influence: their demographic age; their gender; their appearance; their emotional state. During the consultation.
The doctors themselves
Dealing with the psychosocial needs of the patient; own age/background; feelings towards the patient; self-imposed boundaries

TABLE 27: INFLUENCES ON COMMUNICATION

Some influences were directly associated with *a priori* assumptions about the referral or individual patients i.e. the way they presented or spoke. There were also other influences related to how the consultants had assumed the consultation would go and their own style of consultation and communication.

The consultation

By way of introduction to asking them to reflect on why their communication went as it did, the doctors were asked how they felt the consultation had gone. What they said, as exemplified by the following quote, was often an indication of their *a priori* assumptions as to what they anticipated:

> **Dr Padan:** *I thought that went very well. I thought that he would be a lot more apprehensive (and angry) … he wasn't at all, he was just very accepting. (John Williams Pt.3)*

It seemed that it was the potential for confrontation during the consultation that caused most concern; patients being demanding or having unrealistic expectations of what could be done to help them; being less willing to accept explanations or management suggestions. The consultants knew that in some situations, they would have to be more challenging or assertive, stressing the limitations of their interventions, and reinforcing the responsibility of the patient to improve their situation. This did not sit well with their desire to have

a constructive and collaborative interaction with the patient. They were confident about their medical or technical knowledge but not about dealing with emotions, theirs as well as the patients – this had already been identified as more difficult for some. They were therefore pleasantly surprised when anticipated difficulties did not arise and the consultation went well:

> **Dr Clarke:** *Well, maybe better than expected … because he's not complaining of any symptoms.* (Pt.4)

> **Dr Workman:** *… much more straightforward than anticipated … he did not need that much reassurance. I was expecting him to be curious … but he said 'I don't want to know' and that was helpful really because I did not have to waste time on that.* (Pt.1)

There were of course consultations that did not go as well as expected:

> **Dr Workman:** *That was hard - she was … a little bit held back, a little bit defensive from the word go.* (Pt.3)

Dr Clarke described one consultation as follows:

> **Dr Clarke:** *one of the worst interactions I've had in a long time. That was a shocker. My god, he's so depressed.* (David Price Pt.3)

This was not what she had anticipated and therefore her communication with the patient was completely different than she assumed it would be. Dr Shaw did what he said he would not do i.e. raise with the patient the option of a particular investigation. As the consultation went in a direction the consultant said he would actively avoid, Dr Shaw was asked how he felt it had gone:

> **Dr Shaw:** *I don't think it went very well to be honest. Because at the end of it I got a feeling she still did not believe what I told her.* (Appendix Q Jane Sanders Pt.1)

Communication in any situation is influenced by those present, but in my experience as a teacher of communication skills, when asked, the majority of health professionals attribute real or potential communication difficulties to the 'other person' (i.e. the patient, carer, colleague) and this was also the case in my study. It was relatively rare for the consultant to reflect on or recognise *their* contribution to the outcome. Unusually, the following comments indicate the consultant's awareness of their own part in how the consultation went:

> **Dr Clarke**: *I thought that went quite well actually. I was a little bit anxious at first because I, she seemed a bit cross, a bit irritated that no one had come to any kind of answer and nobody had sorted her out … but actually I think I managed to win her round, … it turned into quite a nice interaction.* (Pt.1)

> **Dr Allen:** *We got there, I think … she wasn't as angry as I thought but she had issues … and the delays … she wanted to be able to say how much this was affecting her. I was probably a bit buried in the notes at the start … then perhaps towards the end bit … maybe it got a little bit more conversational …* (Pt.3)

In these consultations, the consulting style came across as collaborative and adaptive to the emotional state of the patient. This seemed to be particularly apparent when the consultant felt the patient was unhappy about previous care or perceived that the patient had not previously been given an opportunity to tell their story.

The consultants all had opinions about how the consultation went – particularly related to inter-personal communication. Sometimes it was apparent they were basing their thoughts on preconceived ideas generated before seeing the patient, but also, were basing them on impressions and opinions established from the time the patient entered the room. However, all of them described how they felt the consultation went in comparative terms i.e. 'it did not go as expected'; 'it went better than I thought it would'. This indicated they had preconceived ideas about how the consultation would go, how the patient may present, how they anticipated the communication would go and how that compared with the actual communication. It was clear that before seeing the new patient the consultants had started to develop an idea or expectation of their communication and had even begun to structure its content.

Having explored how they felt it went, the consultants were then asked to reflect on why and how it went the way it did. The following sections look at the many influences identified.

Being patient centred

The terms 'agenda' and 'agenda setting' are frequently used in medicine. Unlike a meeting, which is usually formulated before the meeting, the agenda within a consultation is often explored as the 'meeting' commences and

proceeds. The purpose is to provide an overt structure to the consultation, taking into account the needs of both the doctor and the patient. The implication being that some or all of these needs will be the focus of the consultation. Before the consultations, the consultants expressed they would be patient-centred, focusing on the patient's needs and agenda.

Some patients were willing to follow the lead and focus set by the consultant, describing their situation by responding to questions. Others, although they did respond to questioning, were more proactive in bringing the focus back to a particular aspect of their situation and continued to describe this or seek answers. When this happened, consultants were observed to 'go with it' and stay focused on the patient's agenda:

> **Dr Mason:** ... *trying to signpost it all before she came in did not work because she wasn't at all bothered about the diagnosis really ... she was very focussed on her symptoms ... so the whole kind of trying to roadmap what we were going to do went out the window straight away.* (Pt.1)

In another consultation, Dr Mason had assumed the patient would be more confrontational but instead she was very focused – returning to her pain description – and the dialogue was led by her:

> **Dr Mason:** ... *she felt like an actor or actress who was trying to help somebody get to the diagnosis by continually dragging them back into the thing that's at the top of their script ... I just think she really wanted to impress on us how bad they were and they needed to be sorted out ... to have moved her off that, she would have been unhappy.* (Barbara Clarke Pt.2)

The following example indicates one consultant's realisation that he missed the patient's main concern:

> **Dr Workman:** *She doesn't feel that I've grasped what is the really big problem for her ... and actually I don't think I did ... right at the end she said 'you know it's the pain', and became quite tearful ... I'd been concentrating on ... the cramps but it's actually the kind of chronic pain issues that maybe are most immediate for her.* (Pt.3)

Being patient centred is more complex than simply asking patients to tell their story but even doing that did not necessarily mean the patient's agenda was given priority. There seemed to be different motives for asking the question

'tell me': to make medical sense of the patient's situation; to confirm or refute the doctor's assessment and anticipated potential diagnosis; to gain insight into the patient's lived experience. Most of the consultants were able to combine these but there was evidence that sometimes, for pragmatic reasons, the default position was to focus on the anticipated diagnosis and limit the additional information from the patient:

> **Dr Mason:** *… I probably come pretty quickly to a conclusion about what I thought was going on … and I wasn't really looking for alternatives, I was really looking for things that would knock me off that diagnosis … knock me away from that.* (Pt.1)

> **Dr Schofield:** *… I chose in this situation to keep it medical … I took as much information as I needed to make a medical diagnosis and be happy with that diagnosis …* (Pt.3)

> **Dr Kings:** *I had enough information as soon as he said the bit about getting so much better on a gluten free diet, it was … for me the whole thing was over and I carried on to dot the I's and cross the t's really just to make sure there wasn't a one in a thousand chance of discovering anything else.* (Appendix R Aden Winterton Pt.1)

This style of consultation was observed several times during which the patient was still 'telling their story' when apparently guided into another direction by the consultant.

Dr Workman had been looking forward to his consultation with Jack Ellis (Pt.2) and as anticipated, liked him. However, he was observed to interrupt him several times:

> **Dr Workman:** *… he required a bit of interrupting … I did not want to block his flow because I felt there might be more to come out … but to stop my brain thinking I really wanted to stop him and just kind of get a hand on what sort of pain this was … I need(ed) a bit more detail …* (Jack Ellis Pt.2)

On some occasions the doctor was reluctant to follow the patient or rather felt the focus for the patient needed to be challenged and the consultation brought 'back on track' i.e. to the doctor's agenda. An example of this was when the patient was talking in detail not only about presenting symptoms but also other health symptoms and concerns:

> **Dr Workman:** … *it's almost not helpful for me to listen and then say 'actually I'm not qualified to tell you, I'm just being nosey and listening to your symptoms' … but I wasn't doing an unnecessary piece of examination in order to shut him up. I was just focussing on what I needed to do … If I was dealing with unexplained symptoms in my domain and I was casting a wider net then I would be interested in pursuing those kind of threads … but here I'm absolutely not going to pursue that thread because it was, you know, this is a different sort of consultation.* (Pt.1)

> **Dr Clarke:** *She was someone who talks a lot …. and repeated her symptoms a lot. … sometimes it's like pulling teeth trying to get information from patients but there was no lack of information from her. I had to kind of steer her … that interaction needed a fair bit of control once she'd had her sort of her say.* (Pt.3)

During the consultation between Dr Shaw and Jane Sanders (Appendix Q), it was very apparent the doctor and the patient were following different agendas. The patient seemed most concerned to understand the cause for her symptoms. This initially seemed an agenda shared by the consultant but as the patient appeared to have difficulty making sense of the explanation given, it was apparent that the consultant's manner and tone changed. He was asked why he felt this had happened:

> **Dr Shaw:** *When I realised that she wasn't going to believe in what I was saying, I felt there might be an agenda, there usually is. And the fact that she did not believe this explanation meant there was some other agenda. And some stage I must have felt (the investigation) was the agenda. So once we agreed on it I thought 'well, let's get it done.'* (Appendix Q Jane Sanders Pt.1)

Dr Shaw had actually mentioned the investigation *before* giving any detailed explanation about her symptoms. Also, the patient did not suggest or request having the investigation and seemed quite prepared *not* to have it if it was felt unnecessary. On raising this with Dr Shaw, he was clear the investigation was arranged because the patient wanted it:

> **Dr Shaw***: And I think she got (the investigation) she was after because I think she was worried she might have cancer. Even though she probably knows she doesn't have cancer. But she just wants to make sure there's nothing we are missing. So she's, I think the agenda was getting (the investigation) done,*

so to that end she succeeded and the consultation was fruitful.
(Appendix Q Jane Sanders – Pt.1)

This assumption that the investigation was what the patient wanted was developed before the patient was actually seen and Dr Shaw maintained this view despite indications from the patient that this wasn't actually the case. He gave the following comment by way of explanation:

> **Dr Shaw:** *I was quite sure I wasn't going to offer her (the procedure) (laughs). Maybe it was my way of a closure?*
> (Appendix Q Jane Sanders Pt.1)

Of course, following their own agenda was not necessarily an indication the doctor was not focusing on the patient. In one consultation, the patient was much more unwell than the referral information implied:

> **Dr Clarke:** *I was expecting to see someone with … not very much wrong with them really. She looks quite ill.* (Pt.2)

The focus and prime concern of the doctor was to arrange urgent admission of the patient to hospital, despite the fact the patient did not want to go.

Being patient centred and time limitations

Several consultants made a conscious decision either not to ask something, or to steer the patient away from a topic or issue. As has been identified earlier, this was often because of the consultant's reluctance to focus on the psychosocial issues, but the issue of 'time' was also a significant influencing factor, about which all eight consultants commented when reflecting on fourteen consultations. Of those, in twelve consultations, time was referred to as a pressure or a constraint:

> **Dr Schofield:** … *clinic's running behind - I needed to switch gear and I just decided to just quickly check out what his agenda was. You do have time constraints … I've got 20 minutes to see the patient, examine them, make a diagnosis and write my notes.* (Pt.3)
>
> **Dr Workman:** *I left that consultation thinking it was harder than I thought and there was more there than I thought. … if the patient's agenda is very much about their physical symptoms … you can't drive a completely different agenda in the 20 minute consultation and expect a happy outcome … So I think what I aimed for was a kind of low risk non-invasive,*

physical approach, to allow some of the ideas to filter in … and then see where that leads into. (Pt.3)

As a result, the patient was interrupted more often, as explained in the following quote:

> **Dr Shaw:** *I probably needed more information out of the limited time for consultation, so that might be why I was interrupting. It was pointless her rummaging through her bag looking for those (list of medication), I already knew what she was on … That's why the consultation went (well) … I'd got what I wanted out of that.* (Violet Stokes Pt.2)

Guiding the patient away from what they were talking about, or not picking up on cues or issues, was also identified as a conscious tactic by the consultants when they felt the information being provided was not required by them in order to support their diagnosis or management plan:

> **Dr Kings:** *His story was very, very clear, he sounded like he could have talked a bit more than he did and I deliberately cut him short slightly one of two times because I've got to see other patients and I had enough information as soon as he really said the bit about getting so much better on a gluten free diet … for me the whole thing was over, and I carried on to dot the I's and cross the t's just to sort of make sure there wasn't a one in a thousand chance of discovering anything else.* (Appendix R Aden Winterton Pt.1)

> **Dr Allen:** *… you know, maybe time, not that that's an excuse, but maybe time was ticking on rather kind of late on a Friday afternoon by that stage and so probably … you know, if it had been at the beginning of the afternoon I might have done it slightly differently I suppose ...* (George Adams Pt.2)

> **Dr Padan:** *I think part of it was that I knew that we were running a little late and therefore I was going to be more efficient.* (John Williams Pt.3)

However, two of the consultants, reflecting on two consultations, felt that giving the patient more time actually saved time in the long run:

> **Dr Mason:** *I thought it was good. I mean … what was nice was that it was obvious there was only going to be a small investment of time needed and it would speed us up. If I'd interrupted her continually, thinking that she was rambling, we would have ended up taking twice as long to get a happy outcome. But I think just letting her say her bit was useful because I think we got … through it quite quickly. And that*

was because she had a clear agenda and a clear history, so I thought that was fine. (Pt.1)

Having explored the consultant's views on how the consultation went, the following section explores whether their assumptions about the referrer or the referral influenced their communication.

The referral

As identified in Chapter 4, the referral information, format of the referral or referrer generated many comments. After the consultations, five of the consultants commented on the referral with regard to seven of the consultations. The main comments reflected the literature in Chapter 2 regarding inaccuracy of the referral information. However, Dr Mason's assumption that one referral was because the GP was not sure what to do seemed to be the case. The focus of another referral (that he assumed would be accurate) was completely different from that identified by the patient and consequently, the dialogue between him and the patient was very different from what he assumed it would be:

> **Dr Mason:** *Well her agenda was completely different from the GPs wasn't it? … (Mary Brewer Pt.3)*
>
> **Jill Dales:** *… does that happen often that somebody is seeing you as a GI specialist and you end up trying to sort out their knees?*
>
> **Dr Mason:** *No, not that often but … the GPs letter hasn't really helped with what their agenda is and you do have to kind of maybe try and explore that quite early - what they actually want you to do for them and … sometimes you have to be explicit and say … 'What were you and your GP hoping we would achieve, what you were hoping, do you know why you're here?', sometimes they don't know why they've come.*

Another comment indicated that although the referrer wasn't clear on what the actual problem was, the information provided in the referral was clear and the consultation went much as was anticipated:

> **Dr Workman:** *So … this was a much more straightforward consultation … really what's going on here is the GP's not sure, so refers the patient on so what I'm doing is reassuring the GP as much as I'm reassuring him. He did not need that much reassurance. (Pt.1)*

In the following consultations, the consultant described how the referral was significant in directly influencing the way the consultation progressed and the communication between them and the patient. The first one indicates how the consultant was unable to pursue what he anticipated being a significant part of the dialogue with the patient, due to the omission of test results:

> **Dr Schofield:** *Unfortunately, the GP hasn't given me them and they're not on the computer, so I couldn't really comment too much about that and I did not therefore go into too much detail about the possibility of this being a potential malignancy… (Pt.2)*

Once again, the lack of information was key to the consultant having to change her anticipated communication:

> **Dr Clarke:** *Well it's interesting that I said to him 'have you got any other health problems?' and he wasn't going to volunteer depression … and so I introduced it by saying well you're on these antidepressants … and he's actually seeing a specialist. I mean he's actually seeing a psychiatrist. So he wasn't going to volunteer that. It wasn't in the referral letter either that he's seeing a psychiatrist.* (David Price Pt.3)

Once knowing the patient had a long-standing history of mental ill health and that it continued to be a problem, Dr Clarke did not want to give the impression that she blamed all his problems on his depression. She anticipated keeping questions about his mental health minimal. Instead, it was probably the main focus of the dialogue.

In this next example, the consultant had made an assumption that certain discussions would have taken place between the patient and the GP, although there was nothing in the referral information to substantiate this. This led him to use the word 'tumour' without first checking whether it was something mentioned before or that the patient or his wife had been worried about:

> **Dr Allen:** *I...I probably mentioned it because … the GP would have put it in their minds … or at least in her mind … so I thought I'd better make sure that she knows that I'm thinking that it's not likely to be ...* (George Adams Pt.2)

The patient did not pick up on the word, and his wife seemed aware that this was not likely, but the consultant did comment that he would not usually have

used the word without checking. He felt that he may have done it because of the patient's dementia, and assumption he would not have taken it 'on board'.

The patient

Regarding the influence of the patient, the eight consultants made over fifty comments collectively, covering all consultations. This section explores what the consultant was responding to – what was significant regarding the patient and how and why that influenced the consultation process. Sometimes it was due to the consultant's feelings towards, or opinion of, the patient. Alternatively, the patient said something or behaved in a certain way to which the consultant responded. In other situations, the consultant was assuming or perceiving things about the patient that were less obvious but still influential.

First impressions

Several of the consultants had an expectation of forming an opinion or impression about the patient as soon as the patient entered the consultation room. This first quote indicates how the patient's appearance was not as the doctor assumed it would be, and how this set the focus of the communication:

> **Dr Kings:** *I was immediately struck by how thin and gaunt he looked compared with what I imagined he might be. You normally expect someone to be perhaps a little bit chubby or normal body habitus, but he was definitely...he looked like he'd been losing weight.*
>
> **Jill Dales:** *and did that...*
>
> **Dr Kings:** *Yes, it does influence you, doesn't it?*
>
> **Jill Dales:** *Can you describe how?*
>
> **Dr Kings:** *It just makes you think of pathology rather than a functional disorder.* (Appendix R Aden Winterton Pt.1)

Altogether, five consultants describing nine consultations, indicated that by looking at the patient they categorized the person into one or several social groups e.g. social class, age etc. This in turn resulted in an assumption about their educational/knowledge level and also influenced how they were likely to be communicated with:

> **Dr Schofield:** *When she came in she seemed to be a well-educated quite formal lady …and that's how I wanted to approach her – possibly a little anxious and you know I could feel it was not going to be lots of chit chat and being jolly what have you I was going to be a quite formal…*
>
> *I took an opinion at that stage that she was going to understand a bit more technical jargon than other people … I do tend to use language that I think is appropriate to the person … I mean she was obviously somebody who was going to be able; she did not look particularly frail, she looked (like) somebody who would be able to give me a reasonable history …* (Pt.1)

The next section will explore the reflections of the doctors on how they perceived *they* influenced the communication with the patient.

The doctors themselves

Not only did the consultants make comments about the patients' influence, but all of them also identified aspects about themselves that appeared to be influential. These comments, of which there were nearly seventy covering all consultations, were interpreted to be broadly about the following: their professional experience; how they imposed a restriction on the areas they (preferably) would or would not cover or go into i.e. self-imposed boundaries; their own agendas and their confidence with certain issues. The following example was interpreted as indicating a lack of confidence in one consultant:

> **Dr Mason:** *I worried I was being slightly condescending at the start with my kind of 'Uhmm, uhmm'… I'm always worried that looks disinterested, like you're on the phone sort of going 'Yeah, uhmm, yeah'. So … I was slightly nervous about appearing uncaring and disinterested, but I thought that went quite well actually, I thought that could have ended up in a… I don't think she was really spoiling for a fight actually.* (Barbara Clarke Pt.2)

whilst this second one was perceived as the doctor following his own agenda by using medical jargon:

> **Jill Dales (Interviewer):** *… you used the terms 'metabolic disorder' and 'vascular disease' … I'm assuming that you assumed they were terms she would possibly understand?*
>
> **Dr Allen:** *I don't think metabolic syndrome is a great term to use, you know. No, and vascular is a little bit technical as well.*

> *I'm probably using them subconsciously without being aware. I mean I try not to use too much jargon.* (Pt.1)

The previous comment also seemed to indicate the doctor was not as patient centred as he assumed he would be. Alongside the other consultants he had expressed they would use language appropriate for the patient, which he felt this probably was not. This following example of the use of quite medical terms:

> **Dr Schofield:** ... *it's likely that this has been caused by what we call primary hyper-parathyroidism due to ... what we call an adenoma which is just a benign overgrowth of one of the glands in the neck which produce hormones which control your calcium levels. Now in terms of how that relates to other symptoms; high calcium levels can result in kidney stones...*
>
> *P1: ...yes...*

was explained by the consultant as being a result of assumptions he made about *what* the patient may previously been told - in addition to another assumption about *how* she may have been told:

> **Dr Schofield:** ... *the use of that term is that she will have been told that diagnosis I'm assuming what she's already been told and if she'd said 'what the hell's that..' you know I would have explained it to her but you know ... I assumed she had been seen – she had been given this long word diagnosis and I'm assuming that that's been discussed with her ... um ...* (Pt 1)

In this explanation, the consultant was apparently making an assumption about the patient's ability to interrupt him to ask for an explanation, and that she would have the opportunity to do so. The consultant actually talked for several minutes, raising several differential diagnosis: stomach ulcers; gallstones and acid reflux. He also raised the potential of removal of the gall bladder, quoting a 20% rate of the procedure not being effective in symptom management and the significance of the size of the gallstone. There did not appear to be an appropriate opportunity for the patient to interrupt and there was also a lot of additional information being provided.

Dr Shaw's patients were of similar ages and had similar physical circumstances and symptoms. However, his approach to them was very different. He was very business-like towards one but much softer in his approach towards. By way of explanation he commented:

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> **Dr Shaw:** *I don't think I did (warm to her) … I wasn't upset by her … no - probably did not bond with her.* (Appendix Q Jane Sanders Pt.1)

> **Dr Shaw:** *Right. I don't know why I did it* (placed his hand on her arm) *… maybe I did bond with her because I liked her … she was a cute little lady.*

The decision regarding *how* and *what* to communicate was sometimes taken quite early in some consultations:

> **Dr Workman:** *… I guess I formed a decision early on that this is a guy who was going to understand what I was saying and I found myself using a bit of jargon but instantly checking the response and he did not screw up his face or look perplexed, … this wasn't a guy who was asking for lots of explanation of his symptoms, so I guess I did not need to take so much care over that bit.* (Pt.4)

During the following consultation, Dr Kings quickly adapted his style of language to accommodate his inaccurate *a priori* assumption about the patient's knowledge:

> **Dr Kings:** *… and just by his language, he seemed to be of a certain level of intelligence and understanding, so that helped base the discussion, but he also said that he hadn't been a rep for a long time … and he hadn't really done very much biology, so I think I just kept it to a reasonably, easily understandable level and when I started talking about things that perhaps were slightly too basic for him, he was quickly nodding so I moved on and changed the tone of the discussion.* (Appendix R Aden Winterton Pt.1)

Also influential in several consultations was the demeanour of the patient. This was particularly apparent in the two patients seeing Dr Shaw:

> **Dr Shaw:** *Must be body language of some sort or the other. Has to be. The first lady was very erect, sat back, and … come to think of it … distancing herself almost … almost a barrier, already, when we started. This other old lady was kind of comfortably sitting …* (Appendix Q Jane Sanders Pt.1 & Violet Stokes Pt.3)

Dr Shaw had previously been quite certain the only thing that would influence his communication was the information in the referral letter.

With this following patient, the referral provided very little information about the patient. However, Dr Workman felt he had a good idea what was wrong

with her, but also what her expectations would be – that she would not want investigations but more symptom management. This assumption seemed to be held up when he saw the patient:

> **Dr Workman:** *… she was … a little bit held back, a little bit defensive from the word go and I thought … I think she was quite a bright woman actually and was open and you know chatty and she could smile and laugh appropriately, so she … wasn't kind of… barn door depressive, you know? But I think it was clear to me that we were going to have a very physically orientated consultation and it was going to be difficult to really get to the bottom of the problem.* (Pt.3)

Some consultants clearly had a very positive response to certain patients; particularly those who the consultants felt were taking a more pro-active role in coping with their illness.

> **Dr Workman:** *… as predicated I liked him, he was … a bright bloke and … a kind of empowered consumer of health care without getting my heckles up, … he asked some good questions and I think got what he needed out of the consultation which was … respect I suppose. (Jack Ellis Pt.2)*

The stoical 'tryer' is well recognised as being regarded as a positive attribute in a patient and in one case, the consultant's positive feelings were reflected in the general discussions and interaction that took place during the consultation:

> **Dr Mason:** *I kind of sort of warmed to her as things went along really, she seemed … quite sensible and she's obviously tried to work through it, and you know she hasn't just … adopted the sick role, perhaps as much as some … (Barbara Clarke Pt.2)*

In other situations, how the consultant felt was influenced not only by the manner or demeanour of the patient, particularly if the patient was generally well, but also when the consultant felt confident the consultation had a positive outcome – that there had been no conflict or explanations the patient may have found difficult to accept:

> **Dr Clarke:** *Maybe I just felt comfortable with him, I don't know. I mean I do try and have a laugh with patients; it's easier with some than with others. … maybe the whole thing just felt more relaxed because I thought this is going to be pretty straightforward, and it's going to be lots of kind of*

reassurance and ... that I, you know, I was being seen as just someone safe ... (Pt.4)

There were clearly other situations where the consultant had less positive feelings towards the patient. Again, this was influenced by how engaging the patient was perceived to be or whether the consultant felt they had achieved what they wanted for the patient.

Self-imposed, perceived or actual boundaries

It was apparent that the physical state of the patient, or the symptoms described, changed the focus of the dialogue. However, the consultant's assumptions (age-related in the following example), were not only given as reasons for things being said but also for some things *not* being said. Dr Padan had intended to speak to a patient about his lifestyle, particularly his alcohol intake, which she felt was an important issue on which to focus. However, this was not broached:

> **Dr Padan:** *I started to ask about lifestyle when I asked about the chef business ... we hadn't covered alcohol. Chefs don't get a chance to drink 'cos they're working every night. So in a way that was me assuming that he would not get a chance to drink ... that probably was an oversight, I should have asked about that ... especially with the car crash.* (John Williams Pt.3)

Psychosocial issues

Salinskey and Sackin (2000) explored defences used by General Practitioners to protect themselves from engaging emotionally with the patient. They found that emotional withdrawal can happen at 'lightening speed before the doctor realises what is happening' (Preface p.x). The need for these defences is described as partly to protect the doctor from becoming '*overwhelmed by the pain and anguish of those seeking help*' without which they would be unable to function professionally. (Salinsky and Sackin, 2000:25). From experience working in palliative care, it was essential to be able to protect one self and certainly, dealing with overt distress could be very draining. However, in this study, it seemed that a judgement was often made regarding potential issues, and whether the doctor would/could deal with them *before* they were disclosed. Once disclosed, there was then the potential to avoid or ignore them.

Of the eight consultants, five of them specifically mentioned the psychosocial issues of patients. Sometimes it was to comment they actively chose not to pursue them because it was not the focus or direction they wanted the consultation to take, but primarily it was because it was not something they felt comfortable dealing with:

> **Dr Schofield:** *I accept my limitations in terms of what sort of psychological counselling I can give, I can give very little really you know, I'm not trained, I'm not experienced in doing that … but recognised that she needs to have that process with somebody. … you know, heading in that direction is something I'm uncomfortable with, I guess probably time is an issue, but probably personally as well, I sometimes find it more difficult to go down that road and I guess I elected to steer a little bit away from her having the opportunity to you know, pour things out and maybe I should have done, I don't know really … but I chose not to… Some colleagues do spend much more time talking through exactly what patients' stresses are but … I don't know maybe I'm…I don't…I try and avoid that, I don't know.* (Pt.3)

Dr Allen, as illustrated in the previous chapter, engaged predominantly with the patient's wife, and made several empathic comments which were interpreted as him acknowledging the distressing *situation* she was in, caring for her husband. It would be fair to assume that he was also, by default, recognizing that it was a difficult and distressing situation for the patient, but this was never overtly expressed. The following comment explains why this was:

> **Dr Allen:** *In a sense, she was the patient. The clinical problem had been her going to the GP to say 'I'm having a problem with, George' (or whatever his name is) … 'he's messing the bed at night'. So in a sense it was her needs that we were dealing with here. We were not dealing with his needs. Now I agree with you that he may have found it distressing and we should have focused on that a bit and asked him about that … seen what emotional effect it had got on him … But I actually think she is the patient, in a sense.* (George Adams Pt.2)

However, he did not acknowledge her comments about feeling overwhelmed, and when asked why this might have been, gave the following explanation:

> **Dr Allen:** *I think the reason I did not say anything is I just wasn't prioritising her emotional … needs. She seemed to have that all reasonably, packaged up and I did not feel I needed to or it was my place to … I'm just being a bit practical and thinking well, if we can help you sort that problem out then it won't be*

overwhelming and actually if you're overwhelmed, it's not my responsibility. You know, I'm just here to help you with this one problem … (George Adams Pt.2)

In another consultation, a patient mentioned one of her children was unwell. Initially not picked up by the doctor, he later specifically asked about their ages. When asked why, he wasn't really sure, but felt it was possibly just by way of having some 'chat' whilst waiting for the nurse - it wasn't because he wanted to explore any 'issues' the patient may have had:

> **Dr Mason:** *I don't really try and delve into these things. And there's two reasons … I don't really feel that I can help people with it, I don't want them to unburden a huge psychological element to me, but I'm happy to listen. The other thing is I don't think that I can help, you know, I don't want to know. It takes too much time. This sounds horrible doesn't it? but also if they suddenly start saying 'oh god, nobody's ever asked me about this before and yes, my kids are beating me up' I'm just like, 'oh Christ, I can't help you'. You know, this is something that I really would rely on the GP to have explored - and that's perhaps naïve. I don't do the whole kind of 'oh, are you under a lot of stress thing very well?' I don't find that I'm that sincere of doing, I'm nervous about doing it. Partly, because I'm not wanting to delve into it. Because I'm not very good at dealing with psychological kind of things.* (Pt.1)

This was an interesting comment, as Dr Mason seemed to have a natural ability to ask questions that gave the patient the opportunity to express her concerns or worries. The assumption by the consultant that he does not have the skills, and therefore avoids the psychological needs of the patient, did not appear to be the reality.

The next section explores the concepts of Recognition and Presence within the context of the observed consultations and the consultants expressed expectations they would be patient-focused or centred in their approach.

Recognition

Before seeing the patients, all the consultants had expectations of themselves being patient centred or focused, giving priority to the patient's agenda. Through observations, and reflections and comments of the doctors, this was not always the case. However, the subtle changes in the focus of the dialogue, or the intentional disregarding of some information did not appear to

(necessarily) result in an unsatisfactory consultation for the patient. Using the concepts of *recognition* and *presence* a different interpretation of the doctor-patient relationship was gained.

Mutual recognition and presence

Only one consultant, over two consultations, was considered to achieve mutual recognition. As previously noted Dr Mason, in particular, was self-deprecating and seemed reluctant to consider himself able to deal with the patients psychological and/or emotional needs. Although the other consultants were perceived as having a pleasant manner, friendly and empathic - the difference in the atmosphere created by him was palpable. In the consultation between him and Mary Brewer he recognised not only her mixture of emotions but, taking into account the time constraints of the clinics, focused on what were clearly her main concerns, despite them having nothing to do with his area of medicine.

> **Dr Mason:** *She was obviously quite frustrated and a bit angry and she was happy to talk about her swallowing problems and her voice, obviously it's a bother to her if she's been a professional voice type of person. I suspect she's saying 'Why are we bothering with this, you know, my life is ruined by my knees'. Her agenda was very clearly to sort these knees out, and this swallowing thing, well it bothered her but it looked like her quality of life was being ruined by her knees.* (Mary Brewer – Patient 3)

Dr Mason not only focused on the patients concerns about her knees but also went round to another clinic to arrange for her to be seen by colleague. When asked about this he replied this wasn't unusual for him:

> **Dr Mason:** *Oh I do that quite a lot … I think it's just human courtesy, it's what I would want a doctor to do for my mother or my wife or, you know. It's no effort … and she's got an appointment, you know, how little effort was that?* (Mary Brewer – Patient 3)

With another patient, before the consultation he expressed feeling nervous the consultation was going to be confrontational:

> **Dr Mason:** *I worried when she first came in that she was just gonna launch into a big anti-NHS thing, and I've got this real thing about people having a go at the NHS…it's one of my few touch paper things, I get very angry with people who criticise the NHS so I was a bit kind of thinking, 'Oh God, here we go,*

I'm gonna have to sit through another diatribe against the NHS'
(Barbara Clarke Pt. 2)

Dr Mason did not find this consultation particularly easy and appeared to have his own medical agenda of establishing medical facts and arranging medical tests and investigations. Despite this and his initial apprehensions about the patient, he admitted to '*warming to her*' and caring for and about her:

> **Dr Mason:** *... you suddenly find that you're confronted with someone who's working, who's gone through maybe a bit of a hard life, who's contended with a lot and who seems to be genuinely suffering and wants to go on holiday and is trying to maintain a positive outlook ... I felt more kind of sorry ... I was keen that we got her sorted out ... just trying to make her realise that we acknowledge what she's going through ... we know that you're suffering, and that you're really working hard ... to cope with it ... So something about validating what she's going through, I think. I don't know ... I feel that's an important thing that we don't do enough.* (Barbara Clarke Pt. 2)

One might argue the tone of the consultation was set more by how he *felt* about the patient (i.e. based on sympathy), but his engagement with the patient was more than giving empathic responses. His comment was interpreted as exemplifying his ability to 'see' the patient, beyond her presenting symptoms. The words, tone and general atmosphere appeared to have made an impact on the patient too, who sounded quite emotional at the end of the consultation:

> **Barbara Clarke:** *This is the best time I've been able to talk; anybody's took notice of us.* (Dr Mason Pt.2)

When the patient made this comment, Dr Mason looked quite uncomfortable and later, when I drew his attention to it, he was again quite self-deprecating:

> **Dr Mason:** *Which is kind of sad for her really isn't it, if it's me that, you know, cause I'm not particularly, you know I'm not a kind of counsellor I think.* (Barbara Clarke Pt. 2)

But he also admitted to making a particular effort to make the patients feel listened to:

> **Dr Mason:** *I was very struck by what you read sometimes about the amount of time that doctors interrupt patients and I really have tried in the last year or two to not do it, to really let them talk at the start.* (Barbara Clarke Pt. 2)

His relationship with both patients, whose consultations are included in Chapter 5, was perceived to be one of recognition. This was regarded as being fundamental to the tone of the consultations and also the communication, establishing what was perceived as *presence*. Dr Mason admitted being aware of changing how he spoke and what he said because of wanting the patient to feel he was really identifying with her present and past health problems and their impact and sharing her desire to reduce her distress.

Misrecognition

There were two consultations that were interpreted as being examples of *misrecognition*. The first, Dr Allen: George Adams Pt.3 because the patient ceased to be the patient in the eyes of the consultant. Again, this consultant had what was perceived to be a gentle and kind attitude. However, his dialogue was predominantly with the patient's wife, who he described as 'the patient' in his explanation why this happened. If that was the case, it perhaps begs the question 'who or what was George Adams in this interaction?'

The second consultation was Dr Shaw: Jane Sanders Pt.1 because the doctor-patient relationship was based on the assumptions of the consultant, and not on the patient's own need. The consultant did not see *her*. He saw his perception of her and her ideas, concerns and expectations.

In both of these consultations, the consultant was observed to 'close it down' although the patient and/or carer appeared not to be ready for this.

Reciprocal recognition

For the remainder of the consultations, the relationship was perceived as reciprocal recognition in that it was what was required to participate in the consultation process, but went no further. As illustrated, several comments had been made that once the consultant's had enough information to confirm their preliminary diagnosis, additional information provided by the patient was not required. Cues regarding the patient's emotional state were sometimes not picked up on, or not explored. Consultations were intentionally medically focused rather than encompassing broader issues. For the patient's part, some preferred to maintain this medical focus, either declining to explore more psychosocial issues, or denying their existence.

The consultants in this category were not perceived to be uncaring or lacking in interest in the patient but as being more 'functional'; more 'business-like'. They identified a job to do, and focused on doing it.

Researcher presence

It would be remiss to ignore the potential influence of researcher presence. Three of the consultants were known through my role of Communication Skills Lead and they appeared anxious about the 'quality' of communication being observed. Others not met did not have the same concern. However, because they knew their communication was the focus, each consultant was reminded they were not being judged. They were all asked specifically if they felt my presence had influenced them and if so, how. The following represent very similar comments from all of the consultants:

> **Dr Kings:** *Possibly a tiny bit but not a lot. I would honestly say if you stuck the nurses who are normally in here and asked them whether that was different, I don't think it would have been very different.*
>
> **Dr Schofield:** *I was pretty able to ignore you being there – don't think you changed it very much.*
>
> **Dr Allen:** *… it made me kind of make sure I was on my best behaviour [laughs]. Using my consultation skills as well as possible. But I don't think I changed that much.*

It was apparent from the comments made the consultants often had observers in clinics e.g. medical students, junior doctors, nurses, and other professionals allied to medicine, such as pharmacists - so although all initially conscious of my presence, they quickly forgot and became focused on the consultation in hand.

It was also my perception the patients who gave consent to have their consultations observed were not uncomfortable with my presence, and appeared to be able to talk freely. This may be partly due to the fact they are aware of consultants having other people in the clinic and perceived it as a normal process.

Chapter Summary

This chapter identified the consultants' perceptions regarding influences on their communication – their explanations as to '*why*' rather than '*what*' was said. At the very early stages of discussion with the consultants about the study, they made it very clear that their time commitment had to be kept as small as possible. It was therefore not possible or appropriate to ask them to listen to the recordings of their cognitive interviews and observed consultations before undertaking this reflective stage. It may be considered that this is a limitation of this part of the design, and the doctors should have listened to the data and explored what they thought was happening in the consultation and how it matched their assumptions. However, judging what data may have been missed because of this situation can at best be speculative. The strength of this part of the design was that the focus of the initial discussion was established by the doctors. They were asked to reflect on their Cognitive Interview and to re-visit what they had said regarding their anticipated communication with the patient. They were then asked how they felt the consultation had gone and to reflect on why the consultation had gone as it had, with particular focus on communication. The material chosen for discussion in these reflective interviews could have been researcher-biased, but to prevent this, the consultants were asked to reflect and explore why things were said and why some things were not said. They also reflected on how they adapted their communication, when this adaptation occurred and what influenced this happening. As the transcripts from Stages 1 and 2 were not available to inform the discussion, my own field notes and jottings were used, when appropriate, to provide descriptive information to support discussion on general and specific elements of the communication.

It may also be recognised that not all retrospective interview studies use the original recordings and there are other examples of the use of 'relevant parts' of consultation transcripts being recounted in order to assist reflection (Burkitt Wright *et al.*, 2004).

The potential for any loss of additional data was also minimised because the majority of the consultants (6 out of 8) carried out all three stages of the data collection on the same day, and had good recall of each stage and what they

had said. Of the other consultants, one carried out the reflective interview two days and one three days after the consultation.

It was clear that not only had assumptions in their first interview been influential, but also assumptions made *during* the consultation. The issue of time in consultations has been the focus of research for several years (Morrell *et al.*, 1986; Jenkins *et al.*, 2002; Ogden *et al.*, 2004) as has patient centeredness or patient focused care (Marvel *et al.*, 1999; Levinson *et al.*, 2000; Rogers and Todd, 2000; Campion *et al.*, 2002). The consultants in this study also felt it to be key to their consultation style. However, at times, they made a conscious decision to move the dialogue away from the patient's agenda or not pick up on patients' cues. One reason given was time limitations but another was the consultant had the information wanted and further information was considered irrelevant or not necessary. These practical reasons appear to be contradictory to their aim of patient-centeredness, and their consultation style appeared more goal driven (Veldhuizen, 2011). This style is considered to be appropriate in some situations, (Bensing *et al.*, 2003; de Haes, 2006) but is not the style that consultants assumed they used.

The negative effect of chronic of chronic inflammatory bowel disorders on an individual's life and on psychological morbidity is well recognised (Graff *et al.*, 2006) and yet, dealing with the patients' psychological needs was something some of the consultants felt ill-equipped to deal with, or actively avoided. One consultant in particular, seemed to find it difficult to accept that he actually *was* dealing with this aspect of the patients care.

Together with their wish to maintain some formality to the consultation, these factors indicated most of the consultants were perceived as not achieving mutual recognition with patients. Two of the consultations, who it was perceived *misrecognised* certain patients, described reasons for their communication which clearly had implications for the patients involved.

This stage of the study enabled the consultants to discuss what they perceived as relevant, which invariably led them to cover general and specific experiences and issues, also identified by Veldhuizen (2011). By doing this, there was the potential to uncover different things with each participant or to uncover new

or unexpected ways of thinking or doing. There were occasions when the participants went off on tangents and made associations between things that were not necessarily relevant to the aims and objectives of the study - and as one may expect, not all influences on, or reasons for, their communication could be explained. This is explored in more detail in Chapter 7.

Chapter 7. Discussion, implications and conclusions

Introduction

This study started from a premise and a question. The premise being that while plentiful attention had been given to the dynamic of the doctor-patient relationship, little had been written about the prior assumptions regarding patients that doctors may bring to their consultations.

It is well recognised that communication in the doctor-patient context has considerable influence on the immediate and long-term emotional and physical well-being of a patient (Stewart, 1995; Stewart, 2003). Increasing our understanding of communication generally, but specifically in the doctor-patient context, is key to developing and improving health care and reducing patient complaints (Parliamentary and Health Service Ombudsman, 2012; Health and Social Care Information Centre, 2013).

Consequently, the exploration of what may influence the communication has been the focus of much research over many years e.g. gender of the patient and/or clinician (Roter *et al.*, 1991; Hall *et al.*, 1994; Hall and Roter, 1998; Elderkin–Thompson and Waitzkin, 1999; Roter and Hall, 2004; Bertakis, 2009) and/or socio-economic status (van Ryn and Burke, 2000; Willems *et al.*, 2005).

Other authors focused on communication adaptations by the doctor in response to the patient's action e.g. the doctor discusses the topic raised when a patient utters concerns about their illness or treatment (Street Jr, 1991; Street Jr, 2001) or asks questions or offers opinions (Greenfield *et al.*, 1985; Street Jr, 1991; Street Jr, 1992; Street Jr and Millay, 2001)

However, the focus of the above studies were to *retrospectively* explore thematic influencing factors on the communication whilst the patient was in the room.

The aim of *this* study was to explore the doctor's *a priori* assumptions starting from first point of contact with patient information – the referral letter - before the patient was even seen, right through to the actual patient consultation.

Next I turn to the question: how might prior assumptions be investigated empirically by a social scientist? Social scientific research is itself commonly premised on what people say and articulate and has a problem with seeking to give due weight to what is not said, or with reading between the lines . Thus the research had to find a way to collect data about those initial moments of information processing, to elicit what was not usually voiced throughout the referral-consultation process. Moreover, it required seeking clinicians to be involved.

One may question whether prior assumptions or stereotypes emerge once the patient enters the room and if they do, whether it matters that doctors bring prior assumptions and/or stereotypes to consultations. This chapter reflects on the challenges associated with exploring the phenomena of *a priori* assumptions, the theoretical implications of the key findings and their implications for medical education. There is also some reflection given to further applications involving other health related contexts and specialties. As this is an evaluative chapter, when considered appropriate, it is written in the first person.

Reflections on studying *a priori* assumptions

According to Epstein et al (2007) there are methodological 'problems' in collecting data from interactions between physicians and actual patients. However, I prefer to view them as 'issues to be dealt with', or 'challenges', rather than problems. When planning this study therefore, there were several areas of challenge – the nature of phenomena to be studied; the design of the study, the practical issues relating to the data collection and the challenges associated with the interpretation and analysis of the data. The following sections will explore these challenges in more detail.

Many challenges arose with regard to the phenomena to be studied – *a priori* assumptions. The nature of the phenomena is in itself challenging as by their very nature, the *a priori* assumptions of others are not easy to access and research. Thus many issues arose for consideration: how to access these assumptions, how to gather data or evidence about such assumptions, which are often implicit, and how to recognise assumptions.

By their very nature, our assumptions are based on meanings that we hold for the world and these meanings are potentially developed and modified depending on whether we take a positivist or interpretive stance. The interpretive stance taken for this study is in itself predicated on an assumption that categories and themes identified are relevant to, and closely mirror, the study participants. This poses problems for studying this issue and means that the researcher depends to a certain extent on a) the participants surfacing and disclosing such assumptions and b) the researchers own ability to undertake a rigorous and systematic analysis of the data which allows un-surfaced assumptions to be identified and well-founded i.e. evidenced by the data.

This is compounded by the propensity of research in the social sciences and in relation to communication, to utilise retrospective interviewing as a method of data collection. Such a method relies on recollection and as with all speech based research relating to behaviour, is based upon the assumption that people are able to articulate why they do things, or what they are thinking.

The challenge then was to find a way to collect data that a) facilitated the participants in verbalising their thoughts when they first saw the referral letters and as near as possible to the point in which they were having those thoughts, b) to collect data regarding their anticipated communication close to the point of them reading the referral information and c) collecting data about the communication that took place, i.e. the actual communication (observed consultations) and their thoughts on how the communication went – again as close to the point of the actual communication as possible. Fundamental to this study was the ability of the consultants to talk their thoughts out loud as they processed the referral information they were reading. The challenge was to allow this process to take place without premature interruption influencing the direction of their comments. For some people, this process of talking out loud as they think, or 'reactivity' (Young, 2005) is quite difficult - particularly if the task was usually done in silence – which was the case for this study. In addition, drawing the participant's attention to the cognitive processes underlying the reading and processing of the referral (which they may have not previously been aware of), could also have affected their ability to do the task. This is literally making an individual 'self-conscious' which as a result could interfere with their

usual behaviour. It also is acknowledged that individuals don't all think at the same speed, and fast thinkers may have found it more difficult to process and then articulate their thoughts.

Doctors may not be communication specialists, with the communication and interactions they have with patients operating on a fine moment-by-moment level. Therefore, in the post-consultation interviews when the consultants were asked to reflect on, explain or rationalise aspects of their communication with the new patient, some were unable to offer an explanation or rationale for some of what was said. This begs the question then as to whether it is possible to always be able to rationalise what is said, particularly if what is said is in the heat of an emotional or difficult situation, and whether retrospective reflection even reflects the situation at the time. It may be that it is reasonable to expect them to be able to explain the more obvious, superficial reasons e.g. formulating a diagnosis and treatment plan, but it may be unreasonable to ask them to explain the subtle nuances to which they may be blind.

Although retrospective reflection has been used in health-related studies for exploring aspects of communication (Bugge *et al.*, 2006; Bugge and Jones, 2007; Lundgren-Laine and Salantera, 2010; Lingemann *et al.*, 2012) one may question whether these nuances and subtleties of expression are 'capturable'? Perhaps the plausibility or feasibility of their explanation may for some individuals reinforce their perception that the explanation does reflect the 'reality'. It could be argued that retrospective reflection and rationalisation after the fact i.e. providing sense to what happened may itself be based on the assumption that this may be the only way of rationalising or explaining something.

It was felt that to facilitate the doctors' explanation of their communication, the communication needed to be put in context. As the reader needs context to understand the significance of what is being written about, or drawn to their attention, the consultants may have found it difficult to reflect on their communication without contextual information. They were encouraged to create their own contextual information by expressing an opinion and reflecting on it and were then often able to pin-point significant aspects of the consultation that influenced their communication e.g. time limitations; their

impressions of the patient, or other issues relating to those identified in Chapter 4.

One may argue that if asked of them, a doctor should be able to give a rationale behind *why* they did or said something, because of the outcome they were hoping to achieve e.g. to focus the patient; clarify information; confirm their provisional diagnosis; reassure; challenge. The participants' were asked to reflect on and explain or rationalise their communication, either specifically with the new patient or with patients generally. On several occasions, when asked why they said what they said or why they did not say what they did not say, the participants' answer was 'I don't know' or 'I'm not really sure'.

There may be several explanations for this. There may have been verbal and non-verbal communication which could not retrospectively be brought to mind. However, the identification of the non-verbal was not as significant as the doctor being able to identify what thoughts, feelings he/she had during the consultation which resulted in *why* they communicated as they did. Doctors are unlikely to speak in non-sequiturs, or just for the sake of it. Their dialogue usually has some purpose, or focus that informs what they do or say. Not being aware of *what* is said, one could argue, is not the same as not being aware *why* something is said.

Another explanation could be because of the familiar process of the consultation carried out in a familiar environment for the doctor. All consultants were very experienced and likely to be making on-the-spot judgements and decisions as a consequence of their 'wisdom of practice' or craft knowledge (Leinhardt, 1990:18) and skill of pattern recognition of symptoms (Skånér *et al.*, 2005:8). This ability to use one's skills without conscious thought is clearly an important attribute of a skilled doctor, but this process is still done with an outcome in mind. It is acknowledged that the doctor's role is multi-faceted and they have many considerations, judgements and decisions to make at any one time, however one may argue therefore that their communication, whilst not possible to completely de-construct, should overall, also have an identifiable purpose or outcome.

The following section explores the challenges and issues associated with designing and carrying out this study

Design and Process

The study design was a coherent, three-stage original design which attempted (as sensitively but also systematically as possible) to elicit some explicit reflection on something that is normally implicit and to address questions which, it is believed, have not previously been addressed so directly.

This study also had the additional complication of the unpredictable, busy day to day clinical situation in which the doctors worked and where patients are involved. This presented several practical, organisational and ethical challenges. The practicalities of meeting up with the consultants was made easier due to prior contact with two of the consultants providing the 'foot in the door' to meet the others. Practical and logistical challenges regarding interviewing across different clinical sites involved significant co-ordination with the individual participants' schedules and the organisation of clinics. As previously identified in chapter 3, the involvement of any patient in a study understandably requires consideration of ethical issues and obtaining approval from the relevant authorities. However further considerations also included study specific judgements regarding what is a reasonable expectation to place on a patient, and ensuring they were not advantaged or disadvantaged by taking part, or preferring not to.

This study was, methodologically, interview and observation based. Although the use of video is recognised as a valuable means of capturing doctor-patient interaction (Heath *et al.*, 2007) it is known that the presence of the camera may have an inhibiting effect on doctor and patient, (Coleman, 2000). Some patients are less likely to give consent for the consultation to be observed if it was to be filmed, or if they intended to talk about mental health issues (Martin and Martin, 1984; Howe, 1997; Coleman, 2000; Heath *et al.*, 2007; Themessl-Huber *et al.*, 2008). Therefore, although the use of video was potentially an option, it was felt it would make the research more complicated, not only ethically but also practically. Consultations did not take place at the same site and some consulting rooms were very small - the setting up of equipment would

therefore have been time consuming, potentially impractical and/or unlikely to be possible.

It may be that other approaches (such as giving the doctors fictitious case studies or using role players as 'patients') and doing the study in a more controlled environment could have offered another more simple way of doing the study. However it was felt that the 'realness' of the cases and the situation was important in order to elicit data which was true to the everyday life of the doctors and reduce the potential for participants to 'act' their part, albeit unconsciously.

Thus the logistics of undertaking the study did to some extent direct what could and could not be done in terms of data collection. However, all possible attempts were made to keep the data collection as close to all communication points as possible in order to maintain the 'reality' of the study and reduce the problems associated with retrospective reconceptualization by the doctors. Because the process of trying to capture a priori assumptions is by its nature difficult, I now consider the issue of inference and its limits.

The limits of inference

According to Paul and Elder (2012:92) 'assumptions and inferences permeate our lives precisely because we cannot act without them. We make judgments, form interpretations, and come to conclusions based on the beliefs we have formed'. And thereby lays the challenge. The limitation of this type of study, i.e. interpretative, is that it is based on individual as well as social beliefs and ergo inferences and assumptions which are two elements associated with the intellectual exercise of reasoning. These are closely interrelated and often confused with each other so it may be appropriate to distinguish between the two when exploring limitations. The definition of inference is 'a guess that you make or an opinion that you form based on the information that you have' (Cambridge Dictionaries Online) 'a step of the mind, an intellectual act by which one concludes that something is true in light of something else being true, or seeming to be true. Inferences can be accurate or inaccurate, logical or illogical, justified or unjustified' (Paul and Elder, 2012:92). An assumption is something we take for granted or pre-suppose, and is often something about

which we have learned and do not question. It can be interpreted as being part of our belief system, through which we believe things to be true, and with them we interpret the world around us. Our beliefs, and therefore our assumptions can also be sound or unsound, logical or illogical, justified or unjustified, depending on the depth of information with which to substantiate them (Paul and Elder, 2012).

This study aims to provide *representations* - through *interpretation*, *description* or *reproduction* (as appropriate), of the comments, behaviours, characteristics and attitudes of the doctors through all three stages of the data collection process. When possible, representation is through reproduction of what was said or observed, but inevitably, sometimes it is through interpretation or description. According to Sperber (1985:16), 'it is dubious that what is achieved through interpretations could be achieved by any other means'. For example, representation of a doctor's demeanour may be through the interpretation or subjective understanding of a characteristic e.g. 'concern'. It may not be explicitly named by the doctor e.g. 'I am concerned'. The doctor may then be described in interpretive terms as 'sounding concerned' or 'having a concerned manner' as this characteristic is commonly perceived the same by those sharing a similar cultural understanding (Sperber, 1985).

As the researcher, my role was to assess the weight of 'data evidence' in order to place an interpretation on it, i.e. on what was said and observed. From that an opinion was formed – based on my own ability to reason - that an assumption had been expressed. My own thought processes were inevitably based on my own inferences and assumptions, which, according to Thomas (2007:132), are 'uneliminable' and are what make the research both 'worthwhile' and 'possible'. Critical thinking, as attempted during the analysis of the data, means that thinking should not just be taken at face value, but explored for its 'clarity, accuracy relevance, depth breadth and logic' (Paul and Elder, 2012:8). All reasoning comes from a standpoint, point of view or frame of reference and it would be intellectual arrogance to assume that alternative meanings or interpretations from the data could not be made by another researcher. However, whilst I can never assume a value-neutral stance, what I have endeavoured to do is to describe, interpret, analyse and understand the

consultants' interpersonal communication with a new patient whilst limiting as much as possible my own prior assumptions, beliefs and values.

Despite this, in the process of interpretation, I have inevitably laid myself open to the charge that I have projected my own inferences onto the data - and while systematic rounds of checking of my own analysis and examining the weight of supporting data, shows the reader that I have an awareness of the problem, I can never finally refute the charge that I might have over-interpreted. However, many anthropological studies are vulnerable in the same way. To minimise the potential for unjustified interpretations, one needs to be as open with the process of thinking as possible, and be as honest to the material as possible, which is what I have endeavoured to be.

The challenges described were dealt with via the methods described in detail in Chapters 3 – 6, but questions will remain: Did the research facilitate the surfacing of the participants' assumptions, either consciously or unconsciously? Were assumptions being made? Were other phenomena such as observation or interpretation by the doctor being interpreted as an assumption by me? Was the analysis rigorous enough? Given the novel nature of the design, which was as close to reality as possible, and the systematic attention to detail in undertaking data collection and analysing the data, it is hoped that the research got as close as possible to the reality of a doctor's communication and identified a priori assumptions.

ICE - Ideas, Concerns and Expectations

In this thesis, the trio of terms making up ICE has been used as an *organising framework* or *heuristic device*. Although the concept of ICE is more commonly recognised as a means for establishing insight into a patient's lived experience (Kurtz and Silverman, 1996; Kurtz *et al.*, 1998; Silverman *et al.*, 1998; Kurtz *et al.*, 2005; Silverman *et al.*, 2008), as a framework focusing on human experience, one can argue it has transferability and can be used to identify unique individual experience in other contexts. Indeed, as explored in Chapter 2, other research has used very similar frameworks across a range of contexts – thus indicating the potential of such a framework as a heuristic device which can assist analysis.

If we can listen to the thoughts, comments and discussions of a doctor as he/she prepares to see a patient, and place the same interpretative categories on what is said, we may be able to gain further insight into the experience of the doctor, in their role as the doctor for that individual (or in fact any health professional interacting in a similar way). If we are able to identify recurring themes of ideas but perhaps specifically concerns, or expectations, it may be possible to make them explicit and offer strategies with which to deal with them. It is human nature to feel apprehensive about situations in which we do not feel confident, so, for example, if a theme is concern about dealing with a patient who it is anticipated will behave in a certain way, then identifying this concern through interpretation of what is said, may enable the individual to be more aware of their feelings and develop ways of dealing with the issues.

A great deal of data is often produced in qualitative studies. It is rich in its description and representation of the world, but can also be unwieldy and difficult to manage. The ICE framework was fundamental in providing a structured approach to, and thematic categorization of, the data. However, it wasn't just the *quantity* of data that this approach provided useful for. At times, the density of data may make it difficult to 'see' what was being said i.e. where the ends of the threads of discourse were. The framework of ICE significantly helped in providing three discrete but interlinked categories in which to place (but not force) the data. It facilitated the first stage of the sorting process by providing a means of paying attention to certain parts or sections of the data instead of keeping it all together. By using ICE, the data was teased apart and further categories or themes identified, but the ideas, concerns and expectations remained separate although part of a whole.

The use of Ideas, Concerns and Expectations as a research tool is not unique, although there was no evidence found to indicate that it had been used to categorise the thoughts and experiences of *doctors* in their consulting role, which may add to the novelty of this study. Using ICE as a heuristic device is not a complex process, but as with adapting or changing the use of any framework or process, there are likely to be limitations. Its use in any context is to categorise either expressed or interpreted aspects of a person's thoughts or feelings regarding an event or situation. This process is based on the

researcher's interpretation and care needs to be taken not to over interpret or 'force' the data to fit the categories (in this case ICE). Anyone using ICE in the future needs to be aware of this potential and maintain a reflexive and a systematic approach in order to limit such 'forcing'.

Theoretical implications and key findings

This analysis was organised around the concept of ICE as a framework through which to examine the place of assumptions in interaction, which is the cornerstone of this thesis. On that foundation, the analysis was then developed using three concepts in particular: stereotype, recognition and presence. In this section I draw together the distinct strands of this conceptual framework with theoretical underpinnings and consider the insights, lessons and implications to emerge from this work.

Theoretical Implications

While the sociological attempt to 'reach' or incorporate the significance of assumptions is, methodologically, far from straightforward, it is also widespread. The very idea of ethnography, for instance, is premised upon the conceptual insufficiency of explicit statements (i.e. based on interview data) as a foundation for the understanding of social life and relationships. Thus, ethnography seeks to reach beyond the explicit, to try – partially and unevenly – to encapsulate the tacit or assumed dimensions of social life – precisely what is taken for granted. Theorists also have sought to frame what is not made readily explicit and Goffman and Bourdieu are two who are widely drawn on by social scientists in this regard.

This thesis has drawn on the concept of stereotyping to define and illuminate some of the processes at work prior to a clinical encounter as the doctor anticipates the session to come. For sociologists it was Goffman who first effectively described in analytical terms the dynamics of self-presentation and inference about the other in his exploration of inter-subjectivity. In two books in particular, 'The Presentation of Self in Everyday Life' (1959) and 'Stigma' (1963b), he highlighted the micro- details of interaction, and the part played by embedded assumptions in these interactions – whether these reflected class,

gender, age, ethnicity, locality, religion or other of the yardsticks of social differentiation.

Subsequently, Bourdieu (1977; 1979) also addressed the part played by assumptions and tacit inferences, most notably through his concept of habitus which is comprised of 'a system of dispositions which generate 'perceptions, appreciations and practices' (Bourdieu, 1990:53). Bourdieu's' purpose was very different to Goffman in that he was seeking a more abstract theoretical means to bridge the so-called structure-agency divide. If social actors are not simply free actors, unconstrained by social forces, nor mere robots determined by these social forces, how can we conceptualise the more nuanced way in which structure influences agency without determining it? Part of his answer was through his concept of 'habitus'. Its relevance for this thesis is that habitus was precisely about the significance of internalised predispositions – assumptions by another name – in shaping our lives. It was though, in effect, habitus that we internalised, quite unconsciously, understandings about class or gender or other forms of social distinction. And it was that last word, distinction that led him to explore the working of habitus in the sphere of taste (Bourdieu, 1984). In an echo of Durkheim's (1897) identification of suicide as an act which seemed utterly individual yet in practice imbued with the forces of society and social structure, Bourdieu showed how taste, so readily assumed to be wholly individual, was in reality saturated with internalised structural values – classed or gendered or generational assumptions (see Moffatt and Higgs (2007) regarding the significance of generational habitus).

In this thesis I have sought to do for the doctors' anticipation of a clinical meeting with a new patient what Bourdieu (1984) did with the notion of 'taste'. That is, to show how their initial depiction of the patient-to-be-met gets coloured (below the level of conscious awareness) by tacit assumptions that owe more to stereotypes than to anything else. Goffman's alertness to the role played by unconscious or semi-conscious stereotyping and Bourdieu's sensitivity to the ways in which society or social forces embed themselves in the ways we are predisposed to act habitually – through habit – are thus lynch-pins of my argument. But the final stages of this account also draws on two further concepts – recognition and presence.

The sociological importance of recognition as a concept – particularly through the many kinds of socio-political action that now gets described as 'the politics of recognition' can be seen as an attempt to disrupt other forms of habitus and inculcate newer forms of habitus. But in the context of my thesis, it is less the political dimension and more the micro-dynamics of intersubjectivity that make the concept of recognition useful. Whilst there is an extensive body of work on the politics of recognition, partly as a response to the surge in identity politics in the second half of the 20th Century, the more relevant approach to recognition for my purpose came from Ricouer (2005), the reason being that he focuses much more on the intersubjective in encounters between the self and others, which is so relevant to my interest in assumptions in one-to-one interaction. Ricouer (2005) describes the concept of *ipseity* (*ipse* or *'self'*) i.e. what a person stands for, their values and their actions, as central to their identity or self-recognition but he also explores our relationships with others, and to what extent our self-recognition and full sense of self, requires (and even depends upon) recognition of and by others. We recognise ourselves because of our recognition of others, where we are placed with those others, and the recognition given to us as ourselves by those others. Closely linked with this concept of recognising and feeling recognised is the concept of ICE (ideas, concerns, expectations). Although the use of ICE is primarily as a framework with which to categorise the subjective experience of another person, its theoretical purpose or aim is to echo the significance of recognising the other in relation to ourselves, and where they are placed in relation to others, whilst maintaining their individuality, with their own role in their society and narrative to reveal. The imperative is for the doctor to recognise the other, not for the other person to recognise the lived experience of the doctor within that context. However, through the process of recognition and ICE, a mutual interaction may be achieved, in the form of Presence. The significance of presence is that it represents the physical, psychosocial and spiritual presence in a relationship that is transforming of the other (Egan, 1975; Egan, 2009). Presence represents the investment, receptiveness and mutual commitment of all parties within an interpersonal interaction. It is inextricably linked to the doctor being non-judgemental, receptive, and having the ability to access personal experience and knowledge in order to form a unique interactive

relationship with the patient. In achieving presence, the doctor drops any preconceptions they may have about the patient, and does not allow the process of intellectualizing to interrupt the emerging experience. The significance of these concepts can be seen in the following section which describes the key findings of this study.

Key findings

This study has illustrated that when assimilating referral information and engaging in the task of thinking-aloud, a tendency to stereotype and resort to certain kinds of assumption, both general about 'patients' and specific to the new patient, were commonplace, indeed perhaps, almost unavoidable. Although some consultants assumed they did not stereotype, this study also identified that *a priori* assumptions occurred *before* and *during* the consultation and continued to be influential even after they appeared to be inaccurate. They not only influenced communication but also the treatment and medical management of the patient. *A priori* assumptions were made regarding what the consultant could expect of the patient, themselves and the consultation to take place and also regarding the focus their communication with the new patient would take. The consultants identified aspects of their consultation style, and each one perceived themselves, both retrospectively and prospectively, to be patient-centred. Despite this, they all also expressed an opinion on their preference for the 'tone' of consultations i.e. the degree of formality they considered appropriate, based on their professional boundaries and personal experiences. Although all consultants were confident in their clinical expertise and knowledge, a common assumption about themselves as individuals was that they lacked the skills required to address underlying psychosocial issues affecting their patients.

Some, but not all, stereotypes and/or assumptions expressed in the cognitive interviews appeared to influence the communication. The style of opening of the consultation and use of specific phrases to start the consultation were not always as anticipated. The envisaged focus of some consultation was very different to the actual focus and there were also occasions when consultants included information or discussions that they had anticipated they would not. The consultants' assumption that they were not *able* to deal with the

psychological needs of the patient was for the most part difficult to ascertain as although in most cases the emotional needs were acknowledged they were at times not explored. This was not the case with one consultant in particular, who appeared to try to meet these needs.

Although doctors were able to reflect on and identify reasons for some of their communication, they were not always able to identify reasons for the remainder. On the basis of evidence from this study, it might be argued that doctors' self-perception of their consultation style was of questionable consistency and they are not always as patient-centred as they tend to assume. On several occasions the patient's narrative was interrupted, and cues and information given by the patient were not picked up. Doctors used strategies such as changing the focus of the dialogue, avoiding cues or disregarding certain information in order to control the consultation. How much of this was deliberate and how much inadvertent remains a difficult question and may not be answerable. However, although time limitations were given as one reason for this, the more common reason was the consultant making a conscious decision that having sufficient information to substantiate their diagnosis (which was sometimes reached before the patient was seen), they did not need, further information which they perceived to be superfluous.

It is here that the theoretical and philosophical underpinnings for my thesis come into their own, for if Goffman and Bourdieu have provided the analytical tools for framing the social significance of stereotype, one must ask if the reductive form these cognitive assumptions take is inescapable. One response is that there is indeed an alternative, and one which in different language is already embedded in the idea of the 'patient-centred clinician'. That alternative has been well explored outside medicine, by philosophers and social scientists, through the concepts of recognition and presence – both of which are relevant and significant to the relationship established with a new patient. For the majority of the consultants, the recognition and contribution of 'them self' to their clinical role was guarded and the relationship with the majority of patients existed at a level of reciprocal recognition. It may be argued that a doctor who has self-recognition and a sense of self beyond their role as a doctor is able to achieve mutual recognition and presence in their interaction with a

new patient. Recognition can be viewed as being inextricably linked with good practice. It is the ability of the doctor to adapt *habitus* and facilitate mutual recognition through respect and a desire to share the *field* with the patient. Presence takes a step beyond this and creates a space for unique understanding and sharing.

Linked with the above, doctors appear to also receive the message that 'everybody should be treated as an individual whilst also 'treating everyone the same'. Kai (2001), noted that this can often be done at the expense of promoting reflection on personal attitudes to diversity and responding to people as individuals. There was a common emphasis from the participants in this study on wanting to (or assuming they did) treat each patient as an 'individual' but conversely, also wanting to treat 'everybody the same.' Concerns regarding the tension that exists within institutions between treating everybody the same and taking into account individual identities were raised by Taylor (1994) and one may question whether these two perspectives are compatible. It appeared to not only create a tension but also to lead to the neutralisation of both the doctor and the patient (Beagan, 2000).

There were several contradictions to this expectation of treating people as individuals, even before seeing the patient.   Patient demographics were considered 'not important' apart from having medical significance. Some took little notice of the patient's name until brought to their attention, even though this is a fundamental part of one's identity and the giving and receiving of our name is often a significant ritualistic event, to which there may be attached religious or other social meaning. When the consultants focused on the patient's age they often had clear ideas about its *medical* significance to them but when asked, most denied any significance from a social perspective, even though one's age has social significance and we are often defined by our age e.g. young; adolescent; middle-aged; old. However, it was clear, once noted, that the age of the patient *was* significant. Even so, some of the doctors still doubted that the patient's age would influence communication or that their communication would be adapted depending on the age of the patient.

If no patient's name was noted, or no patient's age was considered, this could be argued as an example of all being treated the same. However, could it be argued that all were being treated as individuals?

One interpretation of 'treating everyone the same' could be that we perceive that we provide the same level of courtesy, the same access to the same treatments. As an example, a patient may fulfil the criteria for drug treatment for depression. Equality means we consider the same medications. Inequality becomes apparent when we realise that very few anti-depressant formulations are vegetarian, vegan, hallal or kosher. Does the patient compromise their beliefs in order to take the treatment (inequality)? Are they offered alternative methods of treatment, as would all patients (equality)? Are the options of treatment now the same as all other patients (inequality)? Are the options of treatment now the same as all vegetarian, vegan, hallal or kosher patients? (equality within a social group; inequality socially), (Singsit and Naik, 2001; Sattar *et al.*, 2004(b); Khokhar *et al.*, 2008; General Medical Council, 2013(a)).

Thus the paradox remains for healthcare – can we treat all equally and still attend to individuality or it that an oxymoron that cannot be fully ever resolved?

Thus far, this chapter has reflected on the challenges associated with exploring the phenomena of *a priori* assumptions and the theoretical implications of the key findings. This final section will now reflect on and explore the implications and potential applications for medical education. However, detailed consideration of how the topics discussed could actually be incorporated in our teaching i.e. the method and process of teaching them, is not included as this is considered to be beyond the scope of this thesis.

Implications for medical education

The potential implications of this research for medical education are broad and varied. Not least, it has the potential to enhance and develop professional and personal understanding of what influences interpersonal interactions between doctors and patients. As well as offering the opportunity to compare and contrast findings with previous and future studies, it also offers the opportunity to refine, define, and develop understanding through the provision of a robust,

systematic body of evidence and knowledge which may then inform not just broad inter-personal communication, but more specific contextual communication such as decision making, information giving and patient centred-care, for example. Acknowledging the need for our teaching to be evidence based, this study together with already existing and potential studies, are fundamental to communication and clinical skills teaching. Enhancing our knowledge of the existence and role of assumptions may also assist in our understanding of our own contributions to the outcome of an interaction and that the onus of responsibility is not necessarily on the other person(s) involved in the interaction.

Firstly, let us look at the value of exploring the concept of stereotyping as a normal process. As stated by McKinlay et al., (1996:769), 'despite the 'objective' medical training, physicians remain human actors, socially conditioned to engage in stereotyping, whether consciously or not'. Clearly, maintaining and acting on a positive or negative stereotype has the potential for the person to be disadvantaged and, if a patient, emotionally or physically harmed. The patient becomes 'this sort/type of patient' or a 'typical' example of the illness, and fails to be recognised as 'this person' with this illness, issue, fear etc. As things presently stand, the messages regarding the application – and even the existence - of stereotyping and assumptions is predominantly 'you don't/you shouldn't'. Valuing diversity is the emphasis and therefore any form of stereotyping is regarded as anathema. Valuing Diversity is of course an expected attribute of a doctor (General Medical Council, 2009; General Medical Council, 2013(a)) which may provide broader understanding and impact on practice if contextualised with not just valuing difference, but also acknowledging the value of 'sameness'. It should perhaps be given a broader remit so that the emphasis is not just on cultural, sexual, racial diversity (for example) or other social groupings, but also on diversity within an apparently homogenous group. Stereotyping is a way in which we simplify our social world by reducing the amount of processing or thinking we have to do, especially when meeting a new person. By stereotyping we infer that the person has a range of characteristics and abilities we assume all members of that social grouping have. It is a short-hand way of making sense of the world which has the *potential* to be helpful and benign as well as to do harm and totally

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unacceptable. By exploring the purpose of stereotyping, and embracing it as a human attribute for categorising and compartmentalising aspects of our world, it would seem more appropriate to change the message to 'you do/you will'. Learners may then be encouraged to discuss stereotypes without feeling uncomfortable or awkward about identifying their own. Of course, the implications of maintaining unhelpful/inaccurate stereotype needs to be stressed, but until there is open acknowledgement that they do exist, the pitfalls and potential benefits around stereotyping would be difficult to address.

As with stereotyping, the process of making assumptions is a natural, human phenomenon that may also have useful as well as unhelpful implications when acted upon in practice. A doctor may make assumptions about the meaning behind their communication, and the words used by their patients. They also may make assumptions about gestures, behaviour, attitudes of others and may make judgements about others on the basis of assumptions (Brookfield, 2012). If the existence, reason and purpose, as well as potential for harm of assumptions could be addressed overtly in our teaching, there is the potential to further the learners' understanding of explicit and implicit influences on their communication with patients. The medical curriculum may in some schools already include aspects of clinical reasoning, a core skill for the practice of medicine, the use of which enables informed diagnosis, decision-making and management decisions. However, I would suggest that the inclusion of a broader reflective process in the form of critical thinking would enable the clinician to have greater understanding into other aspects of their clinical practice, including their communication skills. The process being suggested is a means by which medical students and other learners can use appropriate standards by which to analyse, evaluate and learn in a constructive and creative way. It may already be that students are used to critically appraise research, for example, but are they able to use the skills to gain insight into themselves? Critical reflection by its very nature aims to transform learning by raising our own awareness of how and why our presuppositions have come to constrain the way we perceive, understand, and feel about our world; of reformulating these assumptions to permit a more 'inclusive, discriminating, permeable and integrative perspective' and of making decisions or otherwise acting on these

new understandings. (Mezirow, 1990:365; Aronson, 2010). Criticism has been directed at this study because it was felt that it is unrealistic to expect doctors to be able to analyse their own communication and that some aspects of it are too deeply implicit and tacit to draw to the surface. However, it may be that through the skills of critical thinking and/or reflection, students may gain the skills of recognising the concepts of assumptions, interpretation and inference as used in their everyday interactions with patients.

Specific to this study, the source, content and format of referrals facilitated the expression of stereotypes and/or assumptions held by the doctor before the patient was actually seen. Assumptions also influenced the referrals' perceived value as a means of reflecting the patient's current physical and emotional health. As a consequence, assumptions were made regarding what the consultant could expect and what focus their communication with the patient would take. Focusing on these aspects of reasoning and thinking, medical students and practicing physicians may gain more insight into there being the potential, from the referral information about the patient, to construct general ideas or expectations of a patient and make assumptions regarding the patient's anticipated appearance, social status or education. In this study, some expectations by the doctors were detailed enough for them to describe the person they were about to see. Based on the interpretation of the data, I perceived that assumptions were applied during the consultation – and were also identified as being applied, and influential to the consultation, by the doctor.

Exploring the potential for interpreting, or missing, patients' *a priori* assumptions may also provide medical students and other learners with some insight into why some patients behave the way they do. A behavioural studies review (Wheeler and Petty, 2001) explored the effects on the behaviour of the person being stereotyped, suggesting they may behave in a way consistent with the stereotype. Although they were not focused on the doctor-patient scenario, it is clearly of some significance that the behaviour and cognitive processes of a patient could potentially be influenced if they were being stereotyped or if they *assumed* they were being stereotyped.

This thesis argues that there is a connection between the process of being more aware of one's own beliefs, behaviours and attitudes, and their influence on inter-personal communication, and the concepts of *ipseity* (or self) and recognition, as described by Ricouer (2005). The concepts of recognition and presence are recognised by other health-care providers, as indicated in Chapter 2, but are relatively unknown to the medical profession, and not widely researched or taught in medicine, although I would argue that their value to good patient-focused care is something about which we could make medical learners aware. Much emphasis is placed on the teaching of empathy as an essential component of doctor-patient communication, but the concept of recognition – although an equally well-founded concept of inter-personal social interaction - is seldom taught. There is evidence to support the need for a doctor to recognise the patient for when doing so, the doctor is acknowledging their uniqueness and individuality in all aspects of their life. However, there is also a tension between recognising individuals' identities alongside their more universally shared rights of equality as a citizen and according to Fisher (2008:596) 'an openness to alterity – that is to difference and singularity – is integral to the rights of recognition'.

There is clearly so much more to the doctor-patient interaction than merely the creation of a relationship, or the communication that ensues. The social role of the person who helps and heals has existed in some form or another over generations. Yet, a major sociological theory that would contextualise the 'why' of the process of this social interaction between the doctor and patient, as in the concepts of field, capital and habitus (Bourdieu, 1977), may be missing from medical undergraduate or postgraduate education. I would argue ~~that~~ the sociological and psycho-medical worlds of doctor-patient interaction could 'cohabite' under the auspices of medical education. The significance to doctors and other health professionals in understanding these concepts in a medical or health related context is that they could illustrate how social values get internalised. Habitus captures how and what we are. It is structured by one's past and present, family circumstances or upbringing, one's educational background or experiences. These are aspects about ourselves that potentially influence our communication and our way of thinking. Teaching and research may be used as a means of bringing these aspects to the surface to further

increase our insight into what these influences may be and what impact they may have i.e. helping the individual see their blind spots.

If we have an understanding that there is a societal basis or level for assumptions, this may then give us more insight into why things are said or done and as a result it may be possible to anticipate them and develop strategies with which to deal with the consequences – good or bad.

Further implications

Thus far, this chapter has reflected on the implications of this study for doctor-patient interaction and medical education. However, despite the fact that this study focused on a single specialty and a specific clinical situation (i.e. prior to and during the first consultation with a new patient), generalising across different populations and professional groups is inappropriate for an interpretive study. Nonetheless, further research may wish to look at the implications and impact of *a priori* assumptions in other contexts and with other professional groups.

The existence of institutionalised racism in certain areas of policing is established, and literature exists of the presence of racial stereotyping in specific areas of health care (Minnis *et al.*, 2001). As assumptions emerge from a spectrum which includes stereotyping and prejudice, it would seem that to explore all these concepts in a wider range of health-care settings, with different specialties or professions, may provide further understanding of why they occur, and the consequences of their application. There are also many examples in health care research, as identified in Chapters 1 and 2, that gender, age and social standing (for example) have been identified as being influential in aspects of health-care provision. Further study may offer further insights in to *why* these factors were influential, and if *a priori* assumptions by the professional existed and/or were significant. There is the potential of further studies exploring different specialties, different cultures and also different professions allied to medicine such as nurses, occupational therapists, physiotherapists etc. where results could be compared and contrasted with those for physicians.

In General Practice, new patients are seen all the time, but unlike secondary care, the physician may have no prior clinical or social knowledge of the individual. Although this study explored the influence of *a priori* assumptions triggered by referral information about a *new* patient, there are also many clinical settings where patients who are known to the professional are seen. Research focusing on *a priori* assumptions in these contexts may provide further insights which could be used to contrast and compare with, or challenge, the findings of this study in order to develop a more robust body of evidence regarding the reasons behind physician communication.

Specialties where patients are, or are likely to be, age or gender specific may also be explored to see if they have their own sets of influential *a priori* assumptions. Studying these many different contexts may also help to identify whether health professionals hold certain beliefs or expectations about particular things e.g. gender, race or age which potentially impact on their clinical decision making or expectations of the patient, and themselves? Studies may also explore whether there are *a priori* assumptions particular to specific professions or specialty, or are individual, geographical, societal or cultural.

It is also important to remember that stereotyping may not always be considered negative, but may consist of attributes perceived socially as positive. Further studies may therefore provide more understanding regarding the potential *advantages* of stereotyping and assumption-making in the care of patient.

Closing comments

Exemplified by the literature (Chapter 2: Part 1), *a priori* assumptions and stereotyping is a fundamental human attribute, the purpose of which is to make the world an understandable place. From this study it can be seen that stereotyping of, and assumptions about patients by doctors exist even if the patient has not yet been seen.

However, many doctors believe that stereotyping and making assumptions about patients is wrong and that they do not or should not do it. Across their socialisation and education in medicine, the overwhelming message to doctors (in fact all health professionals) seems to be that they should be socially and culturally neutral when they enter into interactions with patients (Beagan, 2000; General Medical Council, 2013(b)). What may seem contradictory to this is that cultural competence programmes have been designed to foster awareness and openness to difference. These however, can potentially perpetuate stereotypes about what individuals from a particular culture believe or want, as well as how the doctor should deal with them (Taylor, 2003).

One may question therefore whether doctors (in fact whether all health professionals) should be made aware how stereotypes are perpetuated and what influence they may have on doctor-patient communication and treatment/management. Within the health care institutional environment, staff from many disciplines and various levels of expertise, are part of an extensive communication chain. This information environment 'supports the maintenance of commonly shared stereotypes' (Lyons and Kashima, 2003). I would suggest it is naïve for doctors to deny the potential for, or existence of, the making of assumptions about patients (or stereotyping). This study has clearly illustrated that stereotyping exists and that stereotypical terms and language are perpetuated.

This study has also tried to challenge the difficulty of accessing the implicit and tacit thoughts and actions of doctors. As a research endeavour, it has tried to understand these subtleties – and tried to provide some insight into the expression of them. Through critical interpretive thinking, it has attempted to show that through encouraging their own critical thinking, and given the time

and space to do so, the consultants may be able to access reasoning behind their communication that perhaps they previously felt unable to, or were unable to surface and consider. Also, that it may be possible to develop greater reflective powers and move from a point where we are unaware of any problems or challenges to our thinking, to being more of an accomplished thinker where our intellectual skills have become 'second nature' (Paul and Elder, 2012).

This study has demonstrated the existence, application and influence of *a priori* assumptions on doctors' communication with a new patient. In doing so, it has drawn attention to the concepts of recognition and presence, both of which have significant influence and impact on inter-personal interaction and communication. It has also raised the potential for further areas of study in the field of doctor-patient communication.

Appendices

Appendix A   Statements

Please look at this person and then complete *any 5* of the following statements:

This person is ……(young/middle-aged/old)

 This person reads the …….(choose a daily newspaper)

This person's occupation/area of work is……………………………………………………………………………………… (Choose an occupation/job)

This person enjoys…….(choose a hobby/interest)

This person listens to………(choose a radio station)

This person shops for food at……………………………………………………………………………………(choose a supermarket or type of shop)

This person votes………(choose a political party)

Appendix B   The concept of stigma in healthcare

The focus of this exploration of the literature, and the potential presence and impact of stigma, was intentionally limited to mental illness. Pragmatically, a more focused search was necessary as the results of general searches around stigma resulted in identification of a vast literature. Another reason was the specialty involved in this study includes disorders that are significantly affected by the emotional and psychological state of the patient. High levels of stress or depression and anxiety can cause the conditions to develop and flare up. Also, statistically, doctors are very likely to care for somebody with mental health problems, either as the main condition or associated with a chronic or acute illness.

Goffman (1963b:45) identified stigma as 'the phenomenon whereby an individual with an attribute deeply discredited by his/her society is rejected as a result of the attribute. Stigma is a process by which the reaction of others spoils normal identity'. His work, which emphasises the social consequences of being different, has been a significant influence on the sociological approach to stigma. He described three types of stigma: 'physical', 'tribal' and 'personal blemishes of character'. He also described those without stigma as 'normals' who use specific 'stigma terms' as a source of metaphor and imagery. Examples of this in clinical practice would be referring to a patient as 'difficult', 'typical', 'heart-sink'. (1963b:14-15) Scheid and Brown (2010) argue that in the contemporary literature, the term stigma has been used to describe what seem to be quite different concepts. One is the more familiar use of the word as an indicator of the 'mark' or 'label' attributed to an individual by society e.g. 'the schizo'. Another use is to link the label to negative stereotypes e.g. 'all schizo's are violent' and thirdly, the term stigma may also describe the propensity to exclude or otherwise discriminate against the designated person e.g. 'we don't want any schizo's' in this club'.

The overlap in meaning between concepts like stigma, labelling, stereotyping, and discrimination was recognised by Link and Phelan (2001) who defined stigma as a phenomenon dependent on the exercise of power that is an inextricable component of labelling, stereotyping, setting apart, status loss, and discrimination. There is the potential for a patient to be disapproved of,

due to personal or societal perceptions and stigmatized by association with a particular circumstance or quality. This is reflected by Finzen (1996) (in Schulze and Angermeyer, 2003:299) who referred to the reactions from society i.e. the stigma associated with having a mental illness, as a 'second illness' with which the patient had to deal. If one considers the terms 'she suffers from her nerves' or 'her nerves are bad' this is likely to generate more sympathy and less stigmatising than the phrase 'she's neurotic' – neurotic having over time grown its own stigma.

Social stigma, which Goffman (1963b) perceived to be linked with attribution and stereotype, is the extreme disapproval of (or discontent with) a person on grounds of perceived social characteristics which serve to distinguish them from other members of a society. Society may then identify the person by the stigma. Goffman (1963) also described how stigma has been used to analyse how people with certain diseases are socially evaluated in their interaction with doctors and others.

The following study has been used to draw together the concepts of stereotype and stigma. Album and Westin (2007) looked at whether diseases themselves had a prestige hierarchy and indicated that stigma may even reduce the quality of the medical treatment give. This throws a different perspective on the stereotype or stigma of patients - they may not only be stigmatised or stereotyped for having a disease but also for having 'that' disease. Album and Westin (2007) found the 'higher' ranking was associated with the disease being in the upper part of the body; vital organs being involved; being relatively pain free; curable, and predominantly affecting younger people. The lower ranking diseases were those in the lower body and those whose positioning was not known (i.e. Medically Unexplained Physical Symptoms or MUPS). Psychological problems were ranked lowest.

Appendix C   Choosing the specialty

Immediate broad choices were Primary Care, i.e. General Practitioners or Secondary Care i.e. hospital consultants and other medical staff.

Reasons for not choosing primary care physicians:

General Practitioners see far fewer new patients, and it is the communication with new patients that will form the focus of my study.

- General Practitioners would not necessarily know, until just before seeing the patient that they were in fact a new patient.

- Even when they do see a new patient, they may have minimal information, if any, about the individual before seeing them

- Appointments with the General Practitioner are made in a much more random way, and are at the instigation of the patient – this would make it very difficult to be able to judge which surgeries to observe.

- General Practitioners consultations are often composed of patients with a variety of ages, and for a variety of reasons, but could also be coincidentally composed of patients of similar ages, same gender and similar problems. This would restrict the potential for rich data.

- General Practitioners have been the subject of many studies, particularly regarding communication, and I want to focus on a field of medicine that, to my knowledge, has been the subject of little research at all, but particularly in this area.

Reasons for choosing Secondary Care:

- They have clinics specifically designated for new patients, so it will be much easier to plan the observations and interviews.

- Hospital consultants potentially may have information about the new patient from a variety of sources e.g. referral letters from General Practitioners, a fellow consultant or another health professional; word of mouth; team meetings; inter-professional discussions etc

- It will be possible to 'map' when a patient is going to attend a clinic so obtaining consent from them will be much more straightforward.

Having decided to focus my study on Secondary Care consultants, I now had to decide which speciality would be appropriate. I basically had a choice of two very broad areas, surgery or medicine. My initial thoughts were that I wanted to focus my study on general medicine, as I anticipated that this would give me

a broad spectrum of consultations to observe i.e. not age, gender or disease specific. However, following discussions with medical colleagues, it was apparent there is no such thing as general medicine but several sub-specialties. Of those available it was felt that a particular medical specialty would provide a more varied consultant group and would also enable me to observe consultations that would not be age or gender specific.

Appendix D   Intended Design_COREC Information

Stage 1 – Observation - clinical meetings
- The researcher will attend two selected, appropriate meetings where new patients are discussed.
- Observation will only take place where prior consent has been obtained from all involved which will include consultants and other medical staff.
- The factors the researcher identifies may include ways of thinking and talking about new patients, language used and beliefs and values and traditions which may be used to influence certain patterns of behaviour or ways of communicating with and about patients. The researcher will also be observing the team members for the method, manner and content of the transmission of information.
- Observation of the meetings may also provide the researcher with additional insight into the organisational processes/structures and insight into the tacit knowledge of the individuals involved, anecdotes and non–verbal communication used.
- Each meeting is anticipated to last for about 1–2 hours.
- Observations will be analysed to identify the individual and team dynamic and ways in which communication occurs and may potentially translate into clinical practice. Information obtained from this stage will be fed into the analyses of data obtained from the following three phases to provide a rich and comprehensive picture of the communication process between a doctor and their new patient.
- Details or information obtained will not enable the identification of individual patients or of individual medics.

Stage 2 - Cognitive Interviews - *Anticipated Communication*.
- One to one interviews using cognitive interviewing techniques, also known as 'think-aloud interviewing', will be carried out with Consultants and Specialist Registrars, from whom consent will have been obtained.
- The interviewee will be asked to speak out loud their thoughts whilst reading for the first time referral information regarding a new patient. This process occurs before the patient is seen.
- The referral information used will be predominantly written referral letters from General Practitioners or other consultants or medical staff.
- After speaking, the interviewee will be prompted to explain what information was significant to them, why this may be so and how they perceive this may begin to influence how they anticipate communicating with the patient. For example, the age of the individual may be significant for a variety of reasons. They may be regarded as young or old to have the condition for which they are being referred. The doctor may anticipate a particular level of knowledge, or a particular attitude to be exhibited by the individual because of their age, or indeed, the doctor may anticipate needing to use different words or behave in a particular manner because of the individual's age. Another example could be the area in which the new patient lives may have some significance – whether considered to be a socially deprived area or a particular affluent area – which may influence an expectation by the doctor they are from a particular social group and may therefore need to be communicated with in different ways.
- The cognitive interviews will be carried out in a private office, an area designated suitable and convenient to the consultant such as a private office. These interviews will be audio recorded and it is anticipated that each interview will take between half an hour to one hour.
- It is hoped that each consultant will agree to four to six cognitive interviews. To minimise the demand on the consultants at any one time, it is anticipated these interviews may be completed over two or three sessions.
- The interviews will be transcribed by the researcher who will identify themes and evidence of 'anticipated communication'.
- The analysis of data from this stage will be fed into the analysis of data from the next stage, the consultation.

tage 3 – Observation of consultations - *Actual Communication.*
- Before attending the clinic, all patients potentially involved in this stage will have received an information leaflet and a letter explaining the research.
- They will be seen by the researcher before their appointment when the researcher will give further information as required or requested, and answer any questions the patient may have. If the patient agrees to their consultation being included in the study, written consent will be obtained before their consultation taking place. All patients will be assured that whether they agree or not to be involved in the study, their clinical care will not be influenced or compromised in any way.
- If a patient does not wish to be involved, the cognitive interview regarding their referral will be withdrawn from the study and destroyed.
- The patient about whom the cognitive interview was carried out will be seen at an out–patient clinic designated by the consultant.
- The consultation will be observed and audio recorded to completely capture the communication content and to enable a comparison to be made with the data collected during the cognitive interviewing process.
- The potential number of consultations observed is anticipated to be four to six per consultant.
- The time between the cognitive interview and the consultation will be decided by the consultant on clinical grounds alone and will not be influenced in any way by the research.
- The consultations will be transcribed by the researcher to identify themes and evidence of 'anticipated communication'.
- The analysis of data from this stage will be fed into the analysis of data from the next stage, the semi-structured post-consultation interviews.

Stage 4 – Semi-structured interviews - reflection on both the Anticipated *Communication* and the *Actual Communication*
- Each consultant will be asked to identify 2–3 (50%) of the consultations observed in Stage 2 that were memorable for them with regard to the communication that took place.
- The doctor will be interviewed again to explore whether the 'anticipated communication' was reflected in the 'actual communication' of these selected consultations. If it was, how this was manifested. If it was not, why did this happen? What happened to the 'anticipated communication'?
- These interviews will be audio–recorded.
- The interviews will be transcribed by the researcher to identify themes and evidence of links between 'anticipated communication' and 'actual communication.
- The analysis of data from this stage will be fed into the analysis of data from the previous two stages.

Appendix E   Ethics Process

- **November 2006 – University research approval process**

In November 2006 the research proposal was submitted to the School where registered as a PhD student. Approval was given in December 2006 for progression to the Research stage of my study. However, this was much easier said than done!

As the study required the data collection to take place within a clinical NHS setting and involved the observation of doctor/patient consultations, several 'hurdles' had to be successfully cleared. Approval had to be obtained from the Research and Development Unit of the Trust involved in the study and Ethical approval had to be obtained from a designated Research Ethics Committee (REC) following a submission of a completed Central Office for Research Ethics Committees (COREC) application. (Since the application, COREC has been superseded by the National Research Ethics Service (NRES)).

- **February 2007 - Response from the NHS Trust**

Having chosen the NHS Trust for the site of the study, a meeting took place with the R&D contact to clarify the process of obtaining approval and for being appointed an honorary member of the Trust Staff. After a lengthy but encouraging discussion about the study and its focus, (a senior physician as research supervisor whilst on Trust property also had to be nominated) approval from the Trust was obtained very quickly, together with the Honorary Research agreement. This was provided on the understanding that appropriate R&D forms would be submitted within two weeks.

- **February 2007 R&D proposal submitted to the NHS Trust**

The documentation was submitted to the NHS Trust Research and Development Committee as agreed.

- **February; March 2007 Documentation submitted to the Research Ethics Committee**

The information and documentation required by the Central Office for Research Ethics Committees (COREC) was quite substantial and included CVs from me and both supervisors (not included in this submission). In addition to the written information and in order to provide as much information on the COREC form as possible, a considerable amount of time was also taken up in discussions with the NHS secretaries to ascertain more information regarding the process of referrals, clinic frequency and allocation. The form was submitted in February and responded to by the Ethics Committee who advised that it would be discussed at the meeting of the designated Ethics Committee in March. This meeting was attended together with one supervisor.

- **March 2007 Response from the Research Ethics Committee**

The meeting seemed to go well. There was a very positive response to the documentation submitted and a lot of interest shown regarding the study itself. All questions asked by the committee seemed to have been answered clearly. It was therefore surprising when the committee responded in the way they did. Some amendments to the information leaflets was expected but what the committee asked for regarding the actual study indicated there was an apparent misunderstanding about the focus of the study. To implement the

changes asked for would have completely changed the focus of the study. This was a real disappointment.

- **May 2007 Written response and amended documentation submitted to the Research Ethics Committee APPENDIX E**

Following the response from the committee, amendments were made to the information leaflets. More information was obtained from the clinical secretaries in the NHS Trust and meetings took place with both supervisors. The initial response to the Committee, intended to be a draft, also included a request to meet the Chair to discuss the issues raised. However, as this was considered by the Chair to be unnecessary, my response was accepted as a final one by the Ethics Committee. Nothing more could be done but to wait for the Chair of the Ethics committee to advise the final decision regarding approval of the study. If it did not receive ethical approval, the situation was back to square one.

- **June 2007 Response from Chair of the Research Ethics Committee**

Huge sigh of relief. Ethical approval has been given. It's been a long eight months since submitting the successful proposal to the School. Looking forward to finally getting the research started.

The process to this point had taken twelve months:

- **June - September 2007**
- **(August 2007 – Pilot Interview)**
- **October 2007** *(16months)*

> Data collection starts – hooray!

Appendix F   Response to the Ethics Committee

Friday 4th May 2007

Dear

REC reference number: 07/Q0906/21

Title of study - Examination of the factors which influence assumptions physicians make about patients before their first consultation and the impact of these assumptions on their communication with a new patient during their first consultation

Thank you for your letter dated 16th March 2007 following my attendance at the Research Ethics Committee review meeting on the 14th March. I appreciated the opportunity to discuss my study with the committee and also the attention given to my study and the constructive comments made by the committee.

Although I am writing to you in response to the points raised in your letter, I would appreciate this response being regarded as a draft and not my final one. Before I do submit my final response, my supervisor has asked me to request the opportunity to discuss Point 1 with you face to face. I realise this is not the usual protocol but there seems to be a degree of misunderstanding regarding the process of my study and where the emphasis lies with regard to the focus of the study and it would be much easier to discuss this with you on a personal level.

In the meantime, I have addressed the points raised to the best of my ability. I have put in italics the comments from the committee and addressed each one individually.

1. *The committee were very concerned that consent would not be obtained from patients before the discussion with the consultant and felt there was a strong likelihood that this could be distressing to patients when they eventually found out their case has been discussed before their attendance*.

I acknowledge the concern expressed by the committee and have given this issue a great deal of thought whilst developing my proposal. When discussing the information in the referral letter, although I will be aware of the information given about the patient, my focus is what this information means to the consultant. i.e. what information is significant and what role it will play in the eventual communication with the patient. Although I will be discussing the information with the consultant, it will be directly related to the subsequent consultation. I will obtain consent from the patient for my presence in the consultation and will explain the research process began when their referral was received. I genuinely would not anticipate that any patient who gives consent to be involved in the research and who agrees to me being present in their consultation will be distressed by my involvement at the referral information stage because they are consenting to participating in the research process.
Any information obtained by me at the cognitive interviewing stage about a patient who subsequently declines to be part of the research process will be destroyed. Although I will have had access to the information, I would treat this information with the respect and professionalism it deserves and would not retain any of it or repeat any of it for any purpose.
I am aware that referrals to secondary care may be seen and discussed by many individuals who are not directly involved in the patient's care, before being seen by the consultant. I am sure that patients are unaware of this, but if they were, would recognise that this is how the 'system' works. I recognise the significant difference with my involvement is that it is external to the usual system and is for research purposes. However, the research is directly linked with the care of the patient i.e. the communication that takes place between the consultant and the patient.

I would like to stress that I am a qualified nurse (and still registered) of many years' experience and have held several senior clinical positions. As such I am bound by the relevant codes of professional conduct and would never exploit my position or place patients in a situation that would cause them distress. I genuinely believe the likelihood of causing distress to a patient who agrees to take part in the research process is minimal. For those who do not wish to take part in the research, this will be respected and the process will not be discussed further with them, thus there would not be a cause for distress to them.

The committee felt that consent must be obtained from the patient before the discussion with the consultant about the referral: this would limit the researcher to non-emergency patients to give time for the consent to be obtained.
The activity that is fundamental to my study is the cognitive interview of the consultant whilst he/she processes the information in the referral letter when reading it for the very first time. The decision as to whether a patient would be an emergency or non-emergency would be made at that time i.e. when the doctor processes the referral letter. Therefore, once that decision has been made, and if the process has not been captured as part of my study, the moment is lost and is not retrievable.

The patients' status i.e. whether emergency or non-emergency, is not relevant for the purposes of my study. What is relevant is the consultant's first point of contact with the information contained in the referral letter and the processing which takes place at that very moment.

Information regarding written referrals
I have discussed with the medical secretaries the referral process i.e. when and how referrals are received, and by whom, and at what point if at all, it would be possible to obtain consent from the patients in the period between the secretary receiving the letter and the consultant reading and processing the material.
Referrals are made from a wide range of potential sources e.g. General Practitioners; secondary care consultants; nurse consultants; accident and emergency triage; other GI colleagues within the same hospital; other GI colleagues within the same trust but at a different hospital. They may be sent directly to the consultant concerned or to out-patients or to the consultant's secretary.

As there is no way of anticipating where a referral may come from or when it will be sent or received, it would not be possible to obtain consent from the patient before or at the time of the referral.

All written referrals eventually go to the consultant via their secretary.
When received by the secretary, it will then be placed in a tray for the consultant's attention. The consultant may see it immediately; within a couple of hours; within the same day; the next day or within a couple of days. Depending on the process the referral letter has been through before reaching the secretary, it could have been in the 'system' for as long as 10 days since the date it was written.

For me to know whether a patient needs contacting I would have to be told they had been referred which would mean being given access to their details and referral information in the referral letter which is what I am being asked to get consent for.

To further delay the letter being seen by the consultant in order to gain consent from the patient would be unacceptable.

The committee did not feel that this would have a negative impact on the research as the researcher had already stated that some patients would be waiting several weeks from the time of the referral to actually seeing the consultant and

therefore there would be an opportunity for consent to be obtained from the patient before their attendance.

Unfortunately, to comply with what is being suggested would completely change the focus of the study and actually make the study as intended, impossible to do.

When I explained that some patients may wait several weeks before being seen, this was in the context of my own time management and that I will not always have to attend the clinics with very little notice. However, of course, if when the referral letter information is processed, the consultant decides the patient needs to be seen promptly, I would have to be able to respond accordingly.

Information about the study would be sent to the patient immediately after the consultant had processed the information from the referral letter, irrespective of whether the patient is considered to be an urgent case or not. This will then allow the patient to read and digest information about the research before they are being asked for their consent.

Further verbal information would be given to the patient by me immediately before their consultation. They will also have the opportunity to express any concerns and to ask for any clarification before written consent is obtained from the patient for me to sit in and record their consultation.

However, I need to stress the consultation is not the main focus of my study nor is the patient. It is the consultant's communication and the relationship with, and significance to what was expressed in the cognitive interview that is my main focus.

I would not be interacting with the patient apart from explaining the study and obtaining consent.

2. *There should be a clear method for preserving patient anonymity and a clear protocol for obtaining informed consent before the patient's attendance.*

All information regarding the patient will be coded to ensure anonymity is maintained throughout the research process, from data collection to data analysis and writing up. Once the consultant has processed the referral information, all information regarding the study will be sent out to the appropriate patient. Due to the varied timescales involved, I felt it was not appropriate to rely solely upon the written information to gain consent, but to actually speak to the patient when they arrived for their outpatient appointment and obtain informed written and verbal consent at that time.

It was suggested the letter of invitation to participate, together with the information sheet, consent form and a return envelope could be sent to patients when their (non-urgent) referral is received. This letter should be sent from the consultant, rather than the researcher, to preserve confidentiality.

It was always my intention the letter of invitation would be sent from the consultant involved, and if this was unclear, I apologise. For the reasons given above, I would not expect a reply from the patient regarding consent but would obtain that before their consultation.

As explained previously, the issue about whether a patient will be urgent or non-urgent is irrelevant to the study. The status of the patient will be determined when the consultant processes the information in the referral letter. If that decision has already been made, the consultant must have processed the information. If this stage has not been captured, the study would not be exploring what is intended.

Once consent is received, then the researcher would be able to discuss the referral letter with the consultant as detailed in the protocol.

As previously explained, the activity that is fundamental to my study is the cognitive interview of the consultant whilst he/she processes the information in the referral letter when reading it for the first time. If consent is obtained in the way suggested by the committee, then the consultant must have already processed the information in the referral letter i.e. he/she will have seen and read the letter. If this process has not been captured as part of my study, the moment is lost and is not retrievable. If

the referral letter is discussed at a later date during the intervening time, the consultant will have consciously or unconsciously processed and reconceptualised the information.

Thus, the introduction letter should be from the consultant and not the researcher. It should be amended to say the consultant will incorporate the presence of a researcher rather than stating the consultant is working with the researcher.

As previously explained, it was always my intention the letter of invitation would be sent from the consultant.

The letter submitted was a direct copy from a study currently being undertaken which has ethical approval and was therefore used as a recognised and accepted model.

In preparation for the submission to the ethics committee, the structure and wording of the introduction letter was discussed and agreed with three consultants who may potentially participate in this study.

3. *The Participant Information Sheet requires the following amendments:*
a) *The language of the leading paragraph in the Patient Information Sheet should be re-written in a more neutral way, and potentially biased statements should be removed.*

This has been amended and the document is attached.

b) *X Healthcare Trust should be amended as this trust does not actually exist.*
The words 'X Healthcare Trust' don't actually appear on the above Information Sheet but are within the COREC form. As this is a minor amendment, which I have made, I wonder if the electronic version will be sufficient or am I still required to print out the complete document again?

4. *The committee require clarification on whether there are 8 consultants in the area.*
There is one Consultant based at X General Hospital, four Consultants based at Y General Hospital and five Consultants based at Z District Hospital. In addition to these ten Consultants, there are a number of Specialist Registrars who are also responsible for processing referral information and would therefore fulfil the criteria for participating in the study.

I hope I have been able to clarify what I feel were areas of misunderstanding and that you will appreciate that for me to adopt all the suggestions made by the committee in points 1 & 2 would change my study to such an extent for it to no longer be as intended.

If you still feel concerned about anything to do with my study, or require further clarification, I would greatly appreciate the opportunity to discuss these with you on a personal level.

I look forward to hearing from you
Yours sincerely
Jill Dales
IPhD Student

Appendix G   Provisional meetings with consultants

It was suggested that meeting each consultant would be beneficial in order to discuss how their participation may be possible. It was clear that secretaries were key people to get on-side as they could help turn the research plan into a reality - the 'fairy godmother to help the forlorn ethnographer' (Rock, 2001:34). From experience, medical secretaries were known to be powerful 'gate-keepers' to consultants and without their support, the study would get nowhere. They had access to the consultants' diaries and emails.   They arranged meetings; knew when the consultants had 'spare' time; when the consultants were in clinics and knew the referral system inside-out. They could also track when the patients attended clinics, which was crucial as patients whose referral information informed Stage 1 could potentially go to several different clinics.

It was essential therefore to be reactive to events and very flexible. Given other commitments, this seemed a logistical nightmare. Review interviews with the doctors after the consultations was integral to the focus of the study, and the consultants commented that unless the interviews took place within days of the clinic, they would have difficulty recalling specific encounters. For the first time, consent from the patients for their referral information to be discussed was raised as an issue. This hadn't been anticipated as necessary.

However, meeting the consultants was a very valuable process. They gave very encouraging and positive responses and some agreed strongly they were influenced by what they read in the referral information - as illustrated by the following examples: Dr Padan: *'I anticipated an elderly lady called Gladys as being 'a little old lady' but instead a very confident, well presented, piano teacher appeared'. 'Another patient was described in the referral as 'angry' - felt very apprehensive about meeting him'*. Dr Workman: *'If I read the patient is in her thirties and called Tracey, I know exactly what's coming in'*

![Newcastle University logo]

Communicating with new patients: the influence of prior assumptions

The research
This study is being undertaken as part of an Integrated PhD in Education and Communication with the School of Education, Communication and Language Sciences.

The purpose of this research is:
To study the formal and informal ways that information about patients is received by physicians, how they process the information and how their interpretation of it may influence the communication with the patient.

The objectives are:
- To expand our understanding of doctor-patient communication by focusing on information received by the doctor before a first consultation.
- To draw out the implicit assumptions, including social and clinical assumptions, which doctors bring to the initial consultation with a new patient.
- To study the significance to the receiving doctor of referral information regarding a new patient and how the information influences subsequent communication between the doctor and the new patient.
- To assess whether the source of the information and not just the information itself also influences the subsequent communication.

Background:
This research focuses on a hitherto unexplored aspect of doctor-patient communication i.e. the period during which doctors develop ideas about the patient they are to see.
Many studies have explored why doctors communicate in the way they do.
However, none explored the factors *before* a new patient is seen which may influence the subsequent communication by the doctor, or explore with the doctor (before seeing the patient) how they anticipate they may communicate with the new patient.
Many of the conclusions in previous studies were reached retrospectively, i.e. after the consultation had taken place, and assumptions were made as to *why* the doctor communicated in the way they did and *what* the doctor may have been thinking during the communication. However, this study aims to examine the pre-communication thoughts of the doctor, and how information about the patient *before* they are seen may influence the doctor's communication when the new patient is seen.

Two unique features of this proposed study are the exploration of the communication by the doctor from the very first piece of information received about the patient, and the method of data collection i.e. cognitive interviewing or 'think-aloud interviewing'.

The study has four secondary objectives:
- How and when do doctors decide what to say, and what not to say, when consulting with a new patient?
- How is the influence of information about the patient evident in the actual communication?
- What other factors, such as the doctors own assumptions and pre-conceived ideas influence their communication?
- How readily do doctors adapt their communication when the initial consultation leads them to raise their prior assumptions?.

Methodology
The study is ethnographic in design and uses a variety of methods, including observation, cognitive interviewing, and semi-structured interviews, all predominantly qualitative approaches. Ethnographic research is based on the principle that social interaction is best studied by witnessing the routine cultural contexts in which it takes place. Qualitative methods generally also explain what meanings individuals make as they engage with one another. Eliciting and interpreting these meanings is therefore a fundamental aim of this study.
Design

The study will be structured in four stages:

Stage 1 – Information sharing
- **Observation of clinical team meetings.**

With the permission of all consultants and other medical staff, the researcher will attend two selected, appropriate meetings where new patients are discussed. As this stage is for observation only, none of the individuals attending the meeting will be asked to give additional time to the researcher. The researcher will take field notes during the observation.

Stage 2 – Before the consultation
- **Cognitive interviewing, also known as 'think-aloud interviewing.'**

This will involve a selected sample of Consultants/Specialist Registrars. This process requires the interviewee to speak out loud the thoughts they are having whilst reading for the first time referral information regarding a new patient. This process will occur before the patient is seen. These interviews will be audio recorded and it is anticipated that each interview will take between half an hour to one hour. It is hoped that each Consultants/Specialist Registrar will agree to four to six cognitive interviews. To minimise the demand on the Consultants/Specialist Registrars at any one time, it is anticipated these interviews may be completed over two or three sessions.

Stage 3 – The consultation
- **Observed consultation**

The patient about whom the cognitive interview was carried out will be seen at an out-patient clinic designated by the Consultant. The consultation will be observed and audio recorded to completely capture the communication content. The potential number of consultations observed is anticipated to be four to six per consultant.

The time between the cognitive interview and the consultation will be decided by the consultant on clinical grounds alone and will not be influenced in any way by the research.

Before attending the clinic, all patients potentially involved in this stage will have received an information leaflet and a letter explaining the research. They will be seen by the researcher before their appointment when the researcher will give further information as required or requested, and answer any questions the patient may have. If the patient agrees to their consultation being included in the study, written consent will be obtained before their consultation taking place. All patients will be assured that whether they agree or not to be involved in the study, their clinical care will not be influenced or compromised in any way.

Stage 4 – After the consultation
- **Semi-structured** face to face interviews

Participating Consultants/Specialist Registrars will be interviewed to explore the communication of two or three of the previously observed consultations. Each interview will be audio recorded and will last about one hour.

Research governance

The study has been approved by the Newcastle and North Tyneside Local Research Ethics Committee,.

Individual consent will be sought from all participants in the study.

Dissemination

The research findings will be disseminated through conference presentations and publications in peer-reviewed journals. Participants wishing to be sent information about the results will be asked to leave contact details with the researcher (e.g. mail or email addresses). A database of details will be held by the researcher and results from the study, as an executive summary, will be sent to each participant for whom details are held.

At the end of the data collection and analysis, a feedback meeting will be arranged where the findings will be presented for comment and discussion. All clinicians who participated in the research will be invited to attend.

The researcher
Jill Dales
School of Medical Education Development
The Medical School
Newcastle University
NE2 4HH

0191 246 4531
07867 526178
Jill.Dales@ncl.ac.uk

Appendix I   Consultant Consent Form

Communicating with new patients: the influence of prior assumptions

Consultant/Registrar consent form

The purpose of this form is to make sure the study has been discussed with you and what is involved in taking part has been explained to you.
It is also to show that you have agreed to take part in the study

Please tick

You have read the information leaflet ☐

You are happy with what you know about the study ☐

You have had the chance to ask questions ☐

You understand that:

The interviews will be taped and listened to
by the researcher* only ☐

<u>if the researcher observes or records</u> any behaviour that might constitute a contravention of guidelines of Good Medical Practice or serious professional misconduct, such behaviour will be discussed with Dr (-) and/or Dr (-) and, if necessary, the matter will be pursued in line with Trust procedures ☐

Neither your name nor that of the patient/carer will be used
in anything written about the study ☐

I confirm that I understand the above points and give consent:

for the audio recording of outpatient consultations (subject to the written consent of patients and their relatives)
to take part in two interviews, both of which will be audio recorded

Signed……………………………………….Date……………………

Name…………………………………………

Signed (researcher)…………………………..Date……………………

Name………………………………………..

*The researcher is
Jill Dales
School of Medical Education Development
The Medical School
Newcastle University
NE2 4HH
0191 246 4531
07867 526178

Jill.Dales@ncl.ac.uk

Appendix J   Patient Invite Letter

<div align="center">To be printed on local Trust headed notepaper</div>

< Date >

< Name and Address >

Dear < Salutation >

Your next outpatient appointment is with <consultant> at <time> on <date>.

I am currently working with a researcher to find out how we can improve our consultations with patients (and their families). I am writing to ask whether you would consider taking part in this research with me.

A good way to do this research is by recording the consultations, which is what we hope to do.

The audio recorder will be set up in advance by the researcher, who will also be in the room during the consultation. The recorders we use are very small; about the size of a mobile phone, and patients and doctors often forget the recorder is there.

The enclosed information leaflet describes the study in more detail.

The researcher will see you before your consultation at the clinic, when she will be able to tell you more about the study and answer any questions you may have. She will also ask for your written consent if you agree to take part.

I would like to stress that it is entirely your choice whether or not to take part. I am happy for my patients to help with this study, but the care you receive from me <and other members of the team> will not be affected by your decision.

Yours sincerely

<name>
<job title>

Encs

What will happen next?

If you are interested in helping with the study, the researcher, Jill Dales will talk to you when you come for your next outpatient appointment. This will give you a chance to ask any questions about taking part. If you do decide to take part, the researcher will discuss a consent form with you and ask you to sign it. You will be given a copy of the consent form and this leaflet to keep.

It is entirely up to you whether or not to take part. If you do not want to be involved you do not have to give a reason. If you change your mind after the consultation, you are free to withdraw from the study at any time. If you do withdraw, you can say whether we can use any information we have already collected.

Whatever you decide, it will not affect the care you receive now or in the future.
If you have any concerns or complaints about the research, we will do our best to resolve them. Please contact:

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Newcastle University

Communicating with new patients: the influence of prior assumptions

You are being invited to take part in a research study. This leaflet explains why the research is being done and what taking part will involve. Please read the following information carefully and discuss it with others if you wish. You can then talk to the researcher before you decide whether to go ahead.

Thank you for reading this *What is the study about?*
The study aims to improve our knowledge of communication between a doctor and a new patient. We know that the communication between a doctor and their patient is a very important part of the patient's overall care. This study will try to identify how, what and why doctors communicate during a consultation.

You have been sent this leaflet because you are due to see your doctor for the first time at the outpatient clinic.

What difference will it make?
We hope that the study will increase our knowledge of how and why doctors communicate in the way that they do. We hope this will in turn help doctors be more aware of what they say to patients. We also hope that the study will help us plan our teaching of communication skills to medical students and qualified doctors. Ultimately, we hope this study may improve the communication with patients and their carers.

What does taking part involve?
The part of the study in which you will be involved is the recording and observation of your consultation by the researcher. The recorder used is very small and will be set up in advance and the researcher will sit in on your consultation. You will not be asked any questions by the researcher who will sit quietly throughout the consultation.

If you are willing to take part:
- Your name will not appear in any reports or publications about the study.
- The tape recordings of the consultation will only be listened to by the researcher.
- Anything you say during the consultation will be treated confidentially and will remain anonymous.

What will my doctors be told?
As the doctors involved are the focus of the study, a summary of the findings will be provided to them.

Who is organising and paying for the study?
The study is being carried out for a PhD in Education and Communication and is being part funded by the student and part funded by The School of Medical Education Development, Newcastle University. The study has been approved by the Local Research Ethics Committee. The researcher is based in The School of Medical Education Development, The Medical School, University of Newcastle.

Who is the researcher?
The researcher is Jill Dales, who is based in The School of Medical Education Development at the Medical School. A former nurse, Jill is now responsible for teaching Communication Skills to medical students, qualified doctors and other health professionals.

Appendix L   Patient/Carer Consent Form

Communicating with new patients: the influence of prior assumptions

Patient/carer consent form

The purpose of this form is to make sure that we have discussed the study with you and explained what is involved in taking part. It is also to show that you have agreed to take part.

Please tick

You have read the information leaflet (or had it read to you) ☐

You are happy with what you know about the study ☐

You have had the chance to ask questions ☐

You understand that:

    You can change your mind at any time without giving a reason if you don't want to carry on, ☐

    Whatever you decide, it will not affect any care you receive now or in the future ☐

    The audio recording of your consultation will be listened to by the researcher* only: ☐

    You will not be named in anything written about the project ☐

    I have understood the above points and give my consent: ☐

- or transcriber if not the researcher

Signed:_____Date:_____

Name (printed):_____

Signed (researcher):_____Date:_____

Name (printed):_____

Name of Consultant Physician

_____

Address:

_____

_____

_____

IF YOU ARE UNABLE TO SIGN THE FORM:

Signed (independent observer)_____

Name:_____

Date:_____

*The researcher is:

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Communicating with new patients: the influence of prior assumptions

Consent form: researcher's attendance at a clinical meeting

The purpose of this form is to make sure the study has been discussed with you

and what is involved in taking part has been explained to you.

It is also to show that you have agreed to take part in the study

Please tick

You have read the information leaflet ☐

You are happy with what you know about the study ☐

You have had the chance to ask questions ☐

You understand that:

 The researcher will observe the clinical meeting and take notes ☐

 <u>If the researcher observes or records any behaviour that might constitute a contravention of guidelines of Good Medical Practice or serious professional misconduct, such behaviour will be discussed with Dr (-) and/or Dr (-) and, if necessary, the matter will be pursued in line with Trust procedures</u> ☐

Neither your name nor that of the patient/carer will be used in anything written about the study

I confirm that I understand the above points and give consent:

- For the observation by the researcher of the clinical meeting and for field notes to be taken by the researcher. ☐

Signed……………………………………….Date……………………

Name…………………………………………….

Signed (researcher)…………………………..Date……………………

Name…………………………………………..

*The researcher is
Jill Dales
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Newcastle University

Appendix N   Observation of clinical multi-disciplinary meetings

The aim of attending the meetings was to provide a broader context of the speciality and the professional culture, including terminology used, comments and discussions. This is illustrative of the influence of ethnographic methodology, as ethnography seeks to amplify all contextual information wherever possible. Attending and observing these meetings allowed for the expansion, rather than contraction and narrowing down, of the definition and scope of the study.   Listening to comments also illustrated how *a priori* assumptions may be influenced by others' comments. The data (field notes) did not contribute to the analysis and findings of the study.

Two 'Breakfast' meetings held at 8.00 a.m. (where breakfast was actually included) were attended. They were attended by any specialty working with the field of medicine involved in the study. The purpose of the meeting was for consultants and others to discuss new patients about whom they were concerned or to seek advice regarding their management. Twelve people attended the first meeting which focused on issues to do with imaging i.e. ultra-sound or MRI scans or X-rays. Five consultants involved in the study, three radiologists, two radiographers and a trainee surgeon attended. Also present was a seventeen year old sixth form student on a work placement. Each meeting lasted for about 2 hours and field notes were taken which were later written up into more in-depth notes.

The focus of this thesis is on the three stages of the study. Although the observations of the clinical meetings do not relate to the patients seen in the recorded consultations or the consultations involved in the study, they played an important role in providing a much broader understanding and contextualization of the specialties involved in this field of medicine. To ensure the experiences and their value are not lost, they are described in the following section:

At the first meeting, participants' practice or behaviour, comments and discussions were interesting to observe. It was both informal with the provision of breakfast, and the way people wandered in, but provided opportunities for unexpected formality. The way in which individuals related to each other

indicated that symbolic capital (Bourdieu, 1977) differed in this environment of collective senior health professionals for example, the use of titles for some and first names for others.

The intention was to obtain consent to attend the meeting from those present (Appendix M). However, nobody took notice of there being an extra person, and due to the speed at which the discussions took place, the opportunity for introductions or explanations about being there did not arise. Therefore, the consultant designated the NHS Trust clinical supervisor during data collection, gave consent on behalf of the others.

Taking concepts from both Bourdieu (1977) and Goffman (1959), the practice and role required of those present in this environment or field would appear to be to be different than in their usual clinical settings. As expressed by Goffman (1959), when performing a role, the individual conveys the personal qualities attributed by others to this role or title which is the basis for self image and also the basis for the image others give him/her (Lemert and Branaman, 1997:35).

Bourdieu (1984) also described *class habitus* or *class unconsciousness* i.e. when individuals who share a similar position in social space also share many of the same conditions of work and life. As a consequence they were also 'inclined to develop similar lifestyles, outlooks, dispositions and a tacit sense of their place in the world' (Crossley, 2008:92). There were expressions of concern and a desire to improve the patients' health and problems. However, as described by Goffman (1963b:14-15) stigma may be a 'source of metaphor and imagery' and as illustrated by the following quotes, some words and descriptions used had the potential to stigmatise and negatively influence the expectations of another person if they were required to see the patient:

> **1:** *'Can we talk about the weirdly named Mr …'*
>
> *'… he's a highly strung individual …'*
>
>
> **2:** *'Can I talk about this odd lady … lots of psychological overlay … she's an odd lady, odd eating habits … she has a lot of odd behaviour …*

After the last quote, the person speaking then asked a colleague '*…do you want to take her on?*' who replied '*Not really*'. These dialogue examples also illustrate the potential for *a priori* assumptions being created or influenced by the comments of others.

The following comment illustrates the process of misrecognition (Ricouer, 2005) and the physical symptoms being the defining features of the patient (Raine *et al.*, 2004):

> **3:** '*… she's a DVT waiting to happen … no, she's renal failure waiting to happen … more likely a urinary obstruction waiting to happen … or a bowel obstruction waiting to happen …*'

The second meeting, the following week, focused on histology i.e. cell structures and laboratory slides. Seven people attended – two consultants who participated in the study, two consultant surgeons, a staff grade surgeon, two consultant histopathologists and a radiologist. Again, no notice was taken of an extra presence. Both meetings were very interesting to observe, with examples of social institutionalisation behaviour and speech reflecting the hierarchical positions of those present and perceptions about patients.

Appendix O   Data Collection Adaptations

All of the consultants wanted to do all the Cognitive Interviews for Stage 1 in one session and agreed to do between three and six patient referrals. As they would have the same patients to see during Stage 2 and to discuss in Stage 3, a consultant could be making a commitment to potentially eighteen separate data collection events. However, they all had preferences about how they could best make time for the subsequent stages.

Stages 1-3 varied between consultants depending on the numbers of referrals at the time of the Cognitive Interview. The number of referrals and subsequent consultations observed for Stage 2, and discussed for Stage 3, also varied for two consultants, Dr Padan and Dr Shaw. Timescales in between each stage for each patient/consultant pairings also varied. Dates were arranged with consultants to complete Stage 1, either as a stand-alone part of the study, with subsequent stages taking place later, or as part of a half or full day clinic in which to complete all three stages.

Dr Padan and Dr Schofield chose to follow the original intention of 'tracking' consultations. This meant that although Stage 1 was completed in one individual session each, patients for both of them were seen in different clinics for Stage 2. The date and time of appointments at clinics were allocated by the regional appointments centre so the only way to know when the patient was booked in was with the help of secretaries who 'tracked' to which clinics patients were booked.

Dr Padan completed four Cognitive Interviews and held clinics in the same hospital. Unfortunately, (due to being on holiday) Stages 2 and 3 for one patient could not be completed and another patient did not attend their appointment.

Dr Schofield also completed four Cognitive Interviews but clinics were held in two different hospitals. One consultation took place at the main hospital but the other three patients were seen in the same clinic at a small hospital about twenty-five miles away.

Both of these consultants chose to do Stage 3 on the same day the patients were seen and time was allocated for this. This meant having three separate

meetings with Dr Padan to complete data collection for three patient interactions and three meetings with Dr Schofield to complete data collection for four patient interactions.

Dr Kings and Dr Mason preferred to dedicate a half day to the study, both completing three Cognitive Interviews and subsequently seeing the corresponding patients for Stage 2 and for discussion for Stage 3 on the same day. Dr Workman also set aside a half day to complete Stages 2 & 3 but this took place three weeks after the completion of four Cognitive Interviews for Stage 1.

Dr Clarke, chose to set aside a full day to participate in the study and completed Stage 1 for five patients in the morning, subsequently seeing the corresponding patients for Stage 2 at the clinic in the afternoon followed by discussion for Stage 3.

Dr Allen also chose to go with the original design but found it difficult to set aside time. The secretary phoned and asked if Stage 1 could be completed that afternoon on referrals for patients who already had clinic appointments the following day. The patients concerned had not received the invitation letter from the consultant (Appendix J), nor the information leaflet (Appendix K), having been contacted by the secretary by phone and told about the research.

Dr Shaw also chose to go with the original design and the four patients about whom the Cognitive Interviews were carried out were allocated appointments on the same clinic ten days later. Of these four, one did not want the consultation observed and one patient failed to turn up for their appointment. Stage 2 for the two remaining consultations was completed and Stage 3 took place two days later.

Hi Jill

That was really interesting reading them! I hope my notes make some sense - they were mostly just my observations, but they are sort of consistent with what we discussed in Oslo.

- Inconsistencies → what he says + what he does (definately different!)

- Confirmations →

but also having read the 3 interviews the whole bit about

- Assumptions → huge assumptions made throughout

- communication threads → breakdown in comm

- Personal awareness → not really aware of his own actions + their impact

is clearer.

• There are a lot of assumptions made before a consultation even begins! That get carried through. This doctors pre-consultation assumptions affect the whole consultation + final decision

• Communication is so interesting - he has expectations about how it will be (he thinks she will ask questions) but conversely, he shuts down pretty quickly when she doesn't accept his explanation

— he kind of wants to be in control of how the consultation runs, but he doesn't really listen to everything she is saying

• Personal awareness — wasn't great, he had no concept at times of how he was interacting with the patient

• she did not seem to be an over-anxious lady (maybe this all sounds different when you've listened to the tapes) Just one that was concerned about changes in her health

• I hope this makes sense — I think you will have a clearer idea than me as you have listened to the tapes as well — but based on just that info - thats what I came up with! I hope we overlap with our thoughts + perceptions

Good luck with it all!

Denise

Dr Shaw

Dr Shaw was one of the older and more experienced consultants. He did not feel that anything other than the actual clinical information provided in the referral would influence his communication with a patient. He also felt the demographic of the patient would make no difference to his consultation style.

Jane Sanders (Patient 1)

Introduction

CONSULTATION PRÉCIS_DR SHAW/JANE SANDERS PT1

> Two of the patients seen by Dr Shaw were elderly women of similar age with similar symptoms. Their consultations progressed very differently regarding the communication by Dr Shaw. This consultation was chosen because the communication between doctor and patient was not what was anticipated. This patient was referred with continuous flatulence and Dr Shaw assumed that she would be expecting to have an *(procedure)* which he considered unnecessary.
>
> *'So (if) she comes expecting an (procedure) then (I'll) have to probably tell her that she doesn't need one. … I will not purposely raise the issue, but if she expects … thinks she needs one, at the end when I ask any questions and stuff and she says 'what about an (procedure)?'… then I would probably tell her I don't think she needs one'*

The consultation

Dr Shaw welcomed the patient into the room, explaining he had received a referral from her GP and asked her to tell him *'in her words'* about her symptoms. The patient was clearly anxious and puzzled about her symptoms but sitting quite upright, talked clearly and in detail about what she had experienced.

> Jane Sanders: *I've just got a horrendous er flatulence, it's just…continuous. It started, well, I had it on…I, personally I*

think it goes back to about a year ago when I had erm really bad flu and then I had an antibiotic and it gave me, upset my, er, bleeding of the bowels and I was really poorly.

Dr Shaw: *Bleeding?*

Jane Sanders: *Yeah. Erm, and after that I think it affected my erm…I don't know what happened. I mean I stopped…was it…I've forgotten what it was now.*

Dr Shaw: *The antibiotic?*

Jane Sanders: *Yeah.*

Dr Shaw: *Amoxicillin.*

Jane Sanders: *That's right. I was really poorly with that so once I stopped that it eventually cleared up but I just wondered if it did, I wondered if it had damaged my bowels somehow.*

She also expressed her ideas regarding what may have caused her problems. Dr Shaw listened without interrupting and picked up on her words, asking for more information or clarification as necessary. He examined her, during which he asked several medical questions:

Dr Shaw: *Don't smoke I presume?*

Jane Sanders: *No.*

Dr Shaw: *Do you drink alcohol at all?*

Jane Sanders: *Erm, I like a drink of red wine but erm…*

Dr Shaw: *No link? Doesn't make any symptoms worse?*

Jane Sanders: *No.*

Dr Shaw: *You can't think of any food which makes your symptoms worse?*

Jane Sanders: *I don't think so.*

Dr Shaw: *No one diabetic in your family?*

Jane Sanders: *No. No.*

Dr Shaw: *No one with under active thyroid?*

Jane Sanders: *No.*

Dr Shaw: *Anyone with coeliac?*

Jane Sanders: *Not that I'm aware of, no.*

and made a light-hearted comment, *'scars of the battle'* when referring to old operation scars.

Dr Shaw then offered his explanation regarding the cause of her symptoms

> Dr Shaw: *So the wind coming out this way is the wind which has to have gone down this way, okay? So what, it goes in and then it comes out. There isn't anything structurally wrong in your stomach which is making the air get through. What's probably happening is subconsciously, you're not aware of it, you're swallowing air. What we call sub conscious aerophagie. Right? If you…you make about half a litre to 750ml of saliva every day. We all do. And we keep swallowing it all the time. We are not aware we are doing it because it is happening so often throughout our life, it just happens and we're not aware. if you're swallowing more often for whatever reason, whether it's because your mouth is dry or that you are anxious or whatever, more air goes through and sits in your stomach, it distends your stomach, it makes you uncomfortable.*

The patient remained puzzled as to why this was the cause of her problem but seemed to be accepting the explanation:

> Jane Sanders: *It didn't start until I had that, so presume…presume that was just a reaction to that which…?*
>
> Dr Shaw: *Could have been but never heard of or not aware of that amoxicillin itself can cause internal bleeding but it was linked with whatever this illness was.*
>
> Jane Sanders: *Yeah, yeah.*

It was at this point the 'feel' of the consultation changed. Dr Shaw's manner didn't really change but his focus did and he seemed to switch from offering an explanation to discussing management:

> Dr Shaw: *We could do an (procedure) if you're dead keen on what…well, if you're set upon, if you think you need one. If you ask me why I think you need one, I think it would be normal.*
>
> Jane Sanders: *Yeah, okay. So you don't think I need one?*
>
> Dr Shaw: *I don't think you need one because it's…I can't think of a stomach disease which will cause just belching for such a long time.*

Dr Shaw explained the patient did not have symptoms which would indicate it was necessary. However, he continued to offer the investigation, but to alleviate her anxieties rather than it being medically indicated:

> Dr Shaw: *I could do one if you feel there's any worries in your mind that could this be anything sinister or serious and you want your mind put at rest, if you feel that way, I'm happy enough to …*

A very brief explanation about the procedure followed, after which, although she said she wasn't aware of feeling anxious, the patient agreed to have it.

> Jane Sanders: *… suppose that would … so that if subconsciously, I'm not aware that I am worrying about it …*

The remainder of the consultation was spent finalising the time, date and place of the investigation. During this time, and up to the end of the consultation, the patient continued to talk about her symptoms and her confusion about how they had come about. The patient sounded quite flustered at the end of the consultation which appeared to end quite abruptly as Dr Shaw stood up and the patient began to put on her coat:

> Jane Sanders: *Okay, right. Okay. Thanks very much. I didn't think it was anything drastic but I just can't understand why you know … as I say … it seemed to come on so suddenly. But er…*
>
> Dr Shaw: *I think this … flu like illness or whatever you had has been a trigger for it.*
>
> Jane Sanders: *Well I did have flu, I, I was really poorly. I was on bed for three weeks actually …*
>
> Dr Shaw: *Either that or the course of antibiotics has been the trigger for it.*
>
> Jane Sanders: *Yeah, okay … oh dear, right … thank you very much anyway … thank you, bye.*

Summary of this consultation

During this consultation, the patient remained puzzled about the onset of her symptoms. It appeared she was finding it difficult to grasp what Dr Shaw was

explaining. Contradictory to his assumption in the previous interview, he spontaneously offered the investigation to the patient. It seemed that the patient was still trying to make sense of the explanation regarding her symptoms when she left the room – and did not seem to be sure about the investigation either.

After she had gone, Dr Shaw commented *'There's usually an agenda …'*

Dr Kings

Dr Kings was the senior consultant and had a significant academic role. He was very supportive of the study, but did not feel that he made assumptions about patients, predominantly because of having limited time to take notice of the details about the patient.   Dr Kings was one of the few consultants who spoke mostly about the patient to be seen, rather than patients in general. He came across as more 'business-like' and focused on the task in hand.

Aden Winterton (Patient 1)

Introduction

CONSULTATION PRÉCIS_DR KINGS/JOHN WILLIAMS PT 3

This consultation was chosen because this patient was an ex-medical company representative for *(procedure)* equipment. Dr Kings assumed this suggested that he was likely to be relatively knowledgeable about (specialty specific) matters. He had been referred by a surgeon, which was significant in that Dr Kings assumed he would have to address the patients concerns. Dr Kings was also unimpressed by the actual referral from which he felt the information was inadequate:

> **Dr Kings:** … *there's a lot of information to gather from him*

There was nothing about the patient's age or address that raised any assumptions, but the previous occupation of the patient was clearly more significant and would impact significantly on his communication. The patients knowledge however was no indication of their emotional state and Dr Kings expressed that he would take patients on an individual basis. Dr Kings' comments indicated that he assumed the consultation may be more complex:

> **Dr Kings:** … *it won't be straightforward because he doesn't fall clearly into a category where it's highly likely there's nothing wrong or it's highly likely there's a problem that needs investigating, so it will require a bit more thinking and negotiating.*

The consultation

After checking with the patient he was happy to be part of the 'special clinic' i.e. research clinic, Dr Kings did not ask about the patient's present situation, but made reference to him seeing the other specialist which led the patient to explain what had happened before coming to Dr Kings clinic:

> **Dr Kings:** *...and you've been here a couple of times to see Mr Douglas?*
>
> **Aden Winterton:** *I came for a sigmoidoscopy*
>
> **Dr Kings:** *Yep*
>
> **Aden Winterton:** *and then I came back and had a brief consult chat with him*
>
> **Dr Kings:** *Right*
>
> **Aden Winterton:** *he said on the siggy there was a tiny bit of inflammation*
>
> **Dr Kings:** *yeh*
>
> **Aden Winterton:** *which he could have put down as a stomach bug but the blood test showed 95% certain it was Coeliac and that's what he told me and that I'd probably have to have the gastro done ...*
>
> **Dr Kings:** *right*
>
> **Aden Winterton:** *that's why I'm here*
>
> **Dr Kings:** *ok*

Following a request for further information from Dr Kings:

> **Dr Kings:** *... but let me get it clear in my mind when it all started and what you've been like. When were you last perfectly well? When did it all happen?*

the patient described the onset of his problems and his symptoms to date without interruption from Dr Kings, who instead made facilitatory responses e.g. 'ok'; 'yep'; 'mmm'; 'right .

A significant change in the dialogue seemed to occur after Dr Kings ascertained whether the patient had adjusted his diet to exclude gluten, and what the impact was:

Aden Winterton: *… tried as much as I can and it's helped an awful lot*

Dr Kings: *Has it?* (this was said with some emphasis – as if what the patient had said was very significant)

Aden Winterton: *Yeh – it's made a big, big difference*

Dr Kings: *In what way? What are you like now then?*

From this point, Dr Kings asked more focused medical/social history focused questions i.e. past medical history; family history; smoking, alcohol history. Dr Kings led in to this with what seemed informal language:

Dr Kings: *Ok – that's been very helpful … just a few other things then. In the past have you been a healthy bloke?*

Previously, the patient had spoken uninterrupted, but during the history taking, Dr Kings appeared to be giving him less time to talk, and at times either spoke over him or interrupted him.

Having taken the medical history, Dr Kings ascertained what the patient hoped to get out of the consultation. This also identified that contrary to what Dr Kings expected the patient had little knowledge of human anatomy or biology:

Dr Kings: *Ok……..what would you like to get out of coming here today?*

Aden Winterton: *Probably confirmation that it is Coeliacs*

Dr Kings: *mmhmm*

Aden Winterton: *and there's nothing else that's…..*

Dr Kings: *yeh*

Aden Winterton: *Coeliacs I don't see as a big major…*

Dr Kings: *no*

Aden Winterton: *I know it can lead to, I don't know much about it*

Dr Kings: *right*

Aden Winterton: *and I know it can lead to other things so obviously it is a slight worry but in terms of addressing my diet it hasn't been huge because of the types of food I eat*

Dr Kings: *yeh*

> **Aden Winterton:** *I would just like confirmation of that really*
>
> **Dr Kings:** *ok*
>
> **Aden Winterton:** *and it's nothing else*
>
> **Dr Kings:** *How much biology or human biology did you do when......*
>
> **Aden Winterton:** *Er......none........*
>
> **Dr Kings:** *not a lot*
>
> **Aden Winterton:** *not a lot........I know a little bit but not a lot. Anything you've got to tell me I'll gladly listen*

After having examined the patient, which again was introduced in an informal way:

> **Dr Kings:** *Right, if you could come through with me we'll hoy you on the couch*

Dr Kings began his explanation of his diagnosis:

> **Dr Kings:** *... when you're forty six there's a relatively small number of things that can lead to this sort of problem ... it's very rare there's anything sinister going on although occasionally that can happen ... but when you put into the picture the fact that um it's come on slowly you've lost weight you've got the blood findings that go with it and in fact the inflammation in the large bowel ... is commonly seen with Coeliac disease and your response to the dieting, even over the past three weeks is relatively dramatic so really ... it's very straightforward*
>
> **Aden Winterton:** *Right*
>
> **Dr Kings:** *For me we should double check whether you have got Coeliac disease by doing an (procedure) because that is still the gold standard*
>
> **Aden Winterton:** *yeh, ok*
>
> **Dr Kings:** *Some people would say 'oh there's enough information there to make the diagnosis, and they might be right, they might be, but I think you're always best off if your absolutely sure then there's never any doubt in the future*

Dr Kings checked the patient's knowledge of Coeliac disease, of which he had a fair understanding, before giving the following explanation:

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Dr Kings: *… it's virtually the only true food allergy so when people say they're allergic to this that and the other, it's mostly a load of nonsense, what they've got is an overreaction or intolerance. In this, it's truly an allergy to the gluten and it actually starts … it makes the cells die off early so that instead of your intestinal lining being lots of fronds with lots of absorption on the surface,*

Aden Winterton: *yep*

Dr Kings: *It goes all flat*

Aden Winterton: *Oh right, the fronds are flat*

Dr Kings: *The fronds disappear and they just become flat – and when you start to avoid that, it allows the gut to recover*

Aden Winterton: *Mmhmm*

Dr Kings: *… and slowly those fronds will grow back and they will increase the area in your gut to absorb your nutrients.*

Aden Winterton: *Right – and that's how you start putting on weight*

Following the discussion and explanation regarding the likely diagnosis, the patient agreed to an appointment for (procedure).

Summary of this consultation

- ❖ It came across as quite straightforward, which is not what Dr Kings had anticipated.

- ❖ It was quite a calm consultation, during which the patient did not seem to be concerned at the prospect of having Coeliac disease.

- ❖ It came across as a functional consultation. It served the purpose for which it was intended.

- ❖ Although appearing mutually respectful there appeared to be no sense of engagement other than 'the patient' providing the problem and 'the doctor' providing the answer.

- ❖ The use of words like 'bloke' and 'hoy' by Dr Kings were perceived as friendly informality as well as words considered appropriate for a person of a similar age to him.

- ❖ Although Dr Kings assumes he speaks to patients the same, irrespective of age, it was considered unlikely that he would refer to an elderly patient as a 'bloke'. (The word 'hoy' or 'throw' is more colloquial).

❖ The consultation changed after about nine minutes and it seemed that Dr Kings made an intentional move to change the direction of the dialogue.

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