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THE FUNCTION OF NORMS IN DOCTOR-PATIENT COMMUNICATION

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by

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Abstract

The main purpose of this study is to provide deeper understanding into doctor-patient communication. The emergent focus in this study is on the role of norms and how they function within the discourse of the doctor-patient relationship. A discovery of three major types of injunctive norms, explicit, implicit, and understood, was made. Each major category was defined according to the attributes assigned throughout the analyses: explicit injunctive norms were found to be those that are stated directly by the physician. Implicit injunctive norms were defined as norms indirectly, or not overtly, stated by the physician. Understood norms were those that the patient acknowledged s/he should do, although there is no indication that the patient had indeed adhered to those norms. That is why they were thus Understood Norms rather than labeled personal norms.

Explicit and implicit norms were broken further down into more specific categories. Since Understood norms had so few examples, it was not further subdivided. The implicit norms were subdivided into Implicit Norms as Suggestions, Implicit Norms as Questions, and Descriptive Norms Used as Questions. It was posited that since Implicit Norms as Questions were the only type of norms that elicited patient accounts, perhaps doctors should ask more questions versus making suggestions or directly stating what the patient needs to do, in order to gain patient compliance. Since questions are more face-threatening in that they require an answer, they may help function in moving patients from the pre-contemplative stage of behavior change to the

contemplative stage, at the very least. Finally, three models, one for each major type of norm, were derived.

The most groundbreaking part of the study involved the investigation of patient accounts in normative behavior. To date, there are no known models of doctor-patient communication which include any type of norms and accounts. “Bad behaviors” stemming from patients ignoring injunctive norms were considered norm violations in this study; therefore, approaching compliance from a norms and account perspective in future studies may increase understanding and awareness of patient behavior and lead to testable models of interaction. This study produced several models depicting the use of explicit and implicit injunctive norms; the hope of this researcher is that the models can lead to predict what types of injunctive norms are most effective in patient compliance.

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Statement of the Problem

Introduction

Clear communication between doctor and patient is one of the keys to successful medical treatment, playing a role in a patient's diagnosis, patient compliance, and recovery (Mack, Hilden, Watterson, Moore, Turner, Grier, Weeks, & Wolfe, 2005; Nayak, Pradhan, Reddy, Palmer, Zhang, & Bruera, 2005). This communication may even be life-saving. Thus, any study resulting in outcomes that improve communication not only contributes to communication theory but also is useful for increased patient satisfaction and more importantly, better patient health.

The process of understanding doctor-patient communication must begin by examining the nature of the "relationship," or interaction. Typically a great deal of information is exchanged despite minimal levels of contact and low levels of relational engagement. Doctors acquire intimate knowledge about the patient from bathroom visit irregularity to sexual dysfunction to STDs and other health problems—more intimate information than shared with almost any other individual. These shared details may require and even generate an enormous amount of patient trust, another important quality of the interaction. Take, for example, a typical health visit. In a typical health visit of 15 to 20 minutes, a huge chunk of patient history and symptoms must be shared and communicated accurately so that the doctor can make a diagnosis and/or offer the best care and solution possible for the patient.

The communication dynamics of information exchange, therefore, are interesting on the basic level of communicating (clearly) and understanding (accurately) the nature of the visit. The communication process however becomes a vehicle for deeper study

whenever more sophisticated strategies are used by either doctors or patients. For example, doctors often use broader questions in the beginning of the medical interview and more focused questions closer toward making the diagnosis (Kaplan, 2003; Stein, 1986). Patients, on the other hand, sometimes use hedges and disclaimers along with excuses, justifications and apologies when giving accounts of their behaviors, especially when they exhibit “bad behaviors” such as overeating, smoking, excessive drinking, etc. (Helme & Harrington, 2004). Patients additionally employ emotional and psychological strategies (Salmon & May, 1995). Since both patients and doctors frequently complain about misunderstandings, uncovering and studying these strategies can help improve communication and advance our understanding of communication in the medical context.

Overview

History of the doctor-patient relationship

Society has witnessed a huge transformation in health care practices, medical advances, and doctor patient-communication. History documents the replacement of whiskey with anesthetics along with life-saving antibiotics to cure illnesses that were formerly seen as “terminal.” Better diet, exercise, and other preventative or health maintenance strategies have received favorable attention. Anyone who can recall living 80 years ago can say with certainty that our health care system today saves lives and prevents the onset of many diseases and other health problems. But has doctor-patient communication been enhanced at the same rate? Or does communication appear to be clear but remain just as confusing, causing the participants to misunderstand, misconstrue, and mistake what the other person has said?

In the last one hundred and fifty years, the doctor-patient visit in America has undergone extreme transformation (Hashimoto & Haddad, 1988; Schuster, 1984). During the Civil War Era, patients did not see physicians for annual check-ups or wellness visits. The typical doctor-patient interaction occurred when the doctor rode his horse to examine the patient exhibiting signs of extreme illness. Because the doctor's medical training was barely the equivalent of six weeks' worth of theoretical lecture followed by another six weeks of exactly the same lecture materials, the care given was not steeped in extensive scientific knowledge. Moreover, attendance was not a requirement; many doctors-to-be missed half or more of their classes. Perhaps even more importantly, little if any lab work or hands-on-training occurred (Ludmerer, 1985). In short, the "training" consisted mainly of an apprenticeship with a doctor if the student was fortunate, and many students did not even receive this type of instruction. Therefore, twelve weeks after their education began, the "medical students" were awarded certificates to practice medicine and use the title "Doctor."

In addition to very little schooling and training, another drawback of the health visit 150 years ago was that they were infrequent, and therefore little information was exchanged between doctor and patient. The communication relationship was very asymmetrical in that patients looked to doctors similarly as do children in a parent-child relationship. In other words, doctors assumed the parental role of "knowing what was best" in order to care for the patient. "Good" patients obeyed the doctor by getting rest and taking recommended medicine. Being "bad" patients may included ignoring the doctor's orders; but of course, there were no studies to determine patient compliance rates. Today, although medical training has improved drastically, communication

between doctor and patient has not progressed at the same rate. There are still many problems within the doctor-patient interaction.

Today's health care visit

Certainly doctors now compared to those in historical accounts spend more of the health visit talking with patients about diagnoses and prognoses, likely because of the knowledge gained in practicing medicine. However, the length of health visits has been shortened drastically in the past 20 years, mostly due to the HMO demands facing healthcare facilities (especially general practice clinics), even though longer visits have been linked to more participatory decision-making and patient satisfaction (Adams, Smith, & Ruffin, 2001). In fact, a common practice among general practice centers is to schedule only ten to fifteen minutes per patient and to “double-book” and even “triple-book” patients (Murray & Berwick, 2003; Dexter, Macario, & Traub, 1999; Meza, 1998). This means that two (or three) patients might be scheduled for a 10:00 a.m. appointment, especially if one of the slots is for a follow-up or immunization visit. The rationale is that follow-up visits are usually shorter than new symptom or first-time visits because the hope is that the earlier problem has lessened or disappeared. Visits for vaccinations or tests are even shorter because nurses generally administer the tests or injections and doctors spend even less time with these patients.

Reasons for Communication Problems

Patients often are dissatisfied when they have to wait to be seen, doctors seemed rush for time, and/or they do not feel the doctor is using good positive affect or effective communication skills. Regardless of type of visit (new, multiple-problem, or follow-up), if patients are dissatisfied, there often are residual problems. Despite these

preferences, even in apparent contradiction of them, the doctor's set agenda in a typical fifteen-minute visit with a sick patient may include an attempt to make an accurate diagnosis and propose a plan for improved health such as exercise, medicine, or diagnostic testing (Korsch & Harding, 1997; Smith, 1996). Under pressure from the clinic and HMO or insurance company paying the clinic (and therefore the physicians) to see as many patients per day as possible, the doctor has to conduct the necessary exam very quickly but efficiently and ask "good" questions in a short amount of time. This protocol does not leave much room for patients' questions or concerns, let alone time for doctors to address health maintenance issues such as proper diet, exercise, use and abuse of prescription and other drugs, etc.

In addition to time constraints, the interview process itself provides a second reason these questions and concerns often go unheard: patients are frequently interrupted without having finished their initial description of their symptoms. Some researchers have found that only one in 51 patients in the same study was able to even *finish* the opening statement at all (Beckman & Frankel, 1984). Moreover, physician interruptions of patients do not occur just at the beginning of the visit but throughout the entire interaction (Irish & Hall, 1995; Parsons, 1951; Szasz & Hollender, 1956; West, 1984a). Researchers have argued that it is far more common for physicians to interrupt patients than the opposite (Parsons, 1951; West, 1984a). The prevailing thought has been that the physician interrupts the patient primarily to control the interview, steering the dialogue to reflect the doctor's agenda of diagnosing and caring for the patient (West, 1984a; West, 1984b). Yet, many times patients are interrupted when explaining something they feel relevant to their health. Unfortunately, these interruptions often

stop patients from revealing information vital to diagnosis and health status (Mishler, 1984; Waitzkin & Brit, 1993). When patient stories are cut short, the narratives including information about the patient's general health can be lost. Moreover, psychosocial issues and these effects on the patient and even information about the patient's health compliance practices often go unheard.

More recent studies have shown completely opposite findings: the patient engages in interruptions more than the doctor (Irish & Hall, 1995). In fact, Realini, Kalet, and Sparling (1995) found that overall, patients interrupted 55% of the time and 75% of these interruptions produced new information. Interestingly, Rost (1989) found that more frequently patient interruptions correlated positively with patient satisfaction but more often physician interruptions correlated negatively.

Communication Problems

The dilemma of limited time for the health visit is compounded by the increase in patient demands (Surman & Cosimi, 1996). Research has shown repeatedly that while some doctors withhold complex information or other specific details from patients, the vast majority of patients want all information, positive or negative, given to them (Afifi & Alavaro, 1994; Beisecker, 1990; Daltroy, 1993). Concurrently, with the onset of medical breakthroughs, patients in general have become more involved in their own health decisions (Stevenson & Scambler, 2005; Edwards & Elwyn, 2004; Thornton, Edwards, & Elwyn, 2003). For example, mass media, especially radio and television, spotlight health shows as well as campaigns for improved health and prevention of disease. Some radio talk shows and television networks like Discovery Health Channel™ dedicate their airways solely to health and medical issues. Additionally, a recent model

in the health field, communication skills training has helped those attending workshops and instruction sessions gain more confidence in asking questions and demanding more information from their doctors (Cegala, Marinelli, & Post, 2000; Cegala, McClure, Marinelli, & Post, 2000). As patients become more capable of discussing their health issues, time restrictions can cause doctors to thwart these attempts.

In addition to troubles with doctor-patient information exchange, another problem is actual physician communicator skills. Patients do not appreciate being treated in a “less-than-friendly” manner (Buller & Buller, 1987; Burgoon, Pfau, Parrott, Birk, Coker, & Burgoon, 1987) and prefer the physician to exhibit an affiliative style of communication rather than authoritative one (Buller & Street, 1992; Street & Wiemann, 1987). Despite satisfaction studies showing that patients want “to be listened to,” be active in their decision-making, and “be treated like a person” (Arborelius & Bremberg, 1992; Berger, 2002;), the reality is that a large number of physicians are abrupt and lack empathy (Bellet, 1991; Ellingson, 1998; Squier, 1990; Suchman, Markakis, Beckman, & Frankel, 1997; Zinn 1993).

Health Insurance Issues

Another factor that has helped to shape doctor-patient communication is the health insurance industry. It is estimated that Americans annually spend over one trillion, one-hundred forty-nine billion dollars in national health expenditures and millions of dollars on personal health care (like prescription drugs, dental services, nursing home care, etc.); projections for 2006 have national costs at one trillion, eight hundred billion dollars and one billion, six hundred dollars on personal health care (Statistical Abstracts of the United States, 2000). These high costs are significant because of the relationship

between high health care costs and HMOs. That is, Americans participate in HMOs often over other insurance plans for healthcare coverage in hopes of offsetting individual costs such as deductibles and other out-of-pocket expenses (Parente, Feldman, & Christianson, 2004; Goldman & Zissimopoulous, 2003). However, HMO members complain of the difficulty in securing appointments with a specialist because a referral from their general practitioner is required. With HMOs creating the norms for patient flow, it has become standard practice to wait longer to see general practice doctors. Patient satisfaction studies show that waiting time is one of the most dissatisfying components of the health visit (Meza, 1998). Additionally, obtaining a referral may take days. Even after obtaining a referral, it still may take days or even weeks to get an appointment with the specialist. Some HMOs run their own clinics, and a portion of these have been testing and implementing an “open access policy,” which enables patients to see their physician on the requested day. However, the reality is that the majority of HMO-run clinics operate on less than preferable circumstances, particularly in wait times and inconveniences related to referrals (Radel, Norman, Notaro, & Horrigan, 2001).

Patient Waiting Times

Patient waiting time may seem a nuisance at worst. However, it has been suggested that patients frustrated with long waiting periods are less likely to disclose as many details about their health than they would otherwise. While long waiting periods clearly can impact the communication interaction between doctor and patient, graver problems can arise. A major study of emergency room waiting time demonstrated that extended waiting times in emergency rooms is one of the main reasons patients leave

the ER waiting areas without being seen by a clinician (Moshin, Bauman, & Ieraci, 1998).

Money

In addition to shorter health visits, physician interruptions, long waiting times, and increased patient demands all affecting the communication in the doctor-patient visit, healthcare out-of-pocket costs may actually deter patients from showing for scheduled appointments or from making appointments at all until symptoms are so bad that they are compelled to seek medical care. These “costs” should be considered carefully as problematic for patients because out-of-pocket costs continue to escalate to the tune of about five hundred dollars annually for those under 25, about two thousand dollars annually for the middle-aged group, and around three thousand dollars annually for the elderly (Barer, Hertzman, Miller, & Pascali, 1992; Statistical Abstracts of the United States, 2000).

While some data 15 years ago pointed to 16-20% of annual incomes being spent on healthcare (Clinton, 1992; Miller, 1990; Roemer, 1991), today’s projections are closer to 26% for preventative care and 60% toward curative care (*Financial Times*, 2004). According to the National Institute on Health (NIH), the Fiscal Year 2005 Budget Request for Health initiative dollars was \$1,055,666,000 just on initiatives, grants, and programs (NIH Justification Narrative). The latest reports show that as of 2001, the U.S. spent 1.4 trillion dollars on annual healthcare spending (*Washington Business Information*, 2003). Further, medical expenditures are projected to consume 37% of the gross national product (GNP) over the next three decades (Gibson, 1994) although right now expenses consume about 5-6.5% of the GNP (*Health and Medicine Week*, 2004).

Finally, while healthcare expenses are skyrocketing, it also is estimated that billions are spent each year on health education and research including HIV, heart disease, cancer, and diabetes, to name a few diseases. Despite the surge of monies spent on healthcare costs and the growing number of health education programs, many patients remain non-compliant to physician instructions (Donovan & Blake, 1992; Vermeire, Hearnshaw, Van Royen, & Denekens, 2001; Waitzkin & Britt, 1993). Because of non-compliance with specific eating and exercise instructions as well as prescription medications (including not taking the proper dosage or adhering to the frequency as instructed), researchers estimate that additional expenses in repeated or follow-up doctor's visits and different prescription medications cost taxpayers an additional several billion dollars each year (Hausman, 2001).

Background and Training of Doctors

Finally, medical school training is another major contributor to miscommunication between doctor and patient. Mishler (1984) argued that the doctor's perspective is derived from the biomedical, scientific model as the "voice of medicine," while the patient's perspective is rooted not in science but in the experience of pain and symptoms as the "voice of the lifeworld." Their differing perspectives, one making a clinical diagnosis from second hand symptom information, and the other recalling the actual experience of the pain and affliction, create two distinct worlds. Excellent communication is imperative for the two to be able to understand each other, to overcome the "cultural" differences, and for the doctor to provide adequate care for the patient. While, theoretically, doctors should be able to understand the patient's perspective through skillful questioning, the reality is that medical schools focus mainly

on the biomedical model of diagnosis of problems and “fixing the problem” rather than on interviewing and interpersonal communication training. Additionally, medical students and residents in Balint¹ groups do sometimes role-play and simulate interviews (Smith, 1996); however, very few medical schools incorporate communication courses into their curricula. Therefore, 3rd and 4th year medical students are expected to develop communication proficiency through their clinical rounds and by adopting the behaviors of their resident and physician advisors. Unfortunately, without classes in interpersonal communication skills training, new practicing physicians are often not adept at effective patient discourse.

So far the argument has been aimed at showing how and why doctor-patient communication is complex and easily misconstrued in the health visit. The rest of the chapter focuses on the importance of good doctor-patient interactions.

The Need for Strong Communication Skills

A patient’s confidence in communicating with the doctor wanes when a physician has erred in making a diagnosis or prescribed an ineffective treatment. A patient’s confidence is shattered, however, when a physician makes a grave mistake. News shows such as *Date Line* and *20/20* have broadcast horrific accounts of patients awakening after surgery only to find the wrong limb had been amputated or their appendix removed rather than their gall bladder. While most patients do not experience such acute slip-ups, they may still feel dissatisfied, as evidenced by the huge number of patient complaints to insurance companies, responses on patient satisfaction surveys,

¹ Balint groups are small groups of medical students or doctors who engage in activities such as role-playing (i.e., doctor and patient) in order to become better familiarized with the medical interview. Balint groups are typically used in residencies to encourage more effective doctor-patient communication by practicing and simulating a doctor-patient interaction.

and the rising number of patient-initiated lawsuits (Hickson, Clauton, Entman, Miller, Githens, Whetten-Goldstein, & Sloan, 1994).

Regrettably, patient dissatisfaction with the health visit often reaches beyond the physician's communicator style. Research shows it is common for patients to leave feeling frustrated and without having their concerns or questions addressed or without receiving adequate information (Cherkin, Deyo, Street, Hunt, & Barlow, 1996; Counsell, Geddis, & Smith, 1993; Mingo, Herman, & Jasperse, 2000; Mossman, Boudioni, & Slevin, 1999). Worse, patients sometimes walk away from the interview without understanding or even identifying the next step in the treatment or diagnostic plan of action (Bond & Hussar, 1991; Cochrane, 1993; Cochrane, Horne, & Chanez, 1999). Unquestionably, this research underscores the importance of physician recommendations and reminders as well as the salience of preventative health; take, for example, general practice physicians reminding middle-aged women to obtain annual mammograms (Metsch, McCoy, McCoy, Perevra, Trapido, & Miles, 1998). Research also highlights the need for providing nutritional information to patients regardless of the reason for the appointment (Kotte, Battista, DeFriese, & Brekke, 1988; Wechsler, Levine, Idelson, Rohman, & Taylor, 1983). Yet Gemson and Elinson (1986) found that only 6% of general practitioners recommend annual check-ups for all their patients.

Communication should be of utmost importance to physicians, given the staggering numbers of non-compliant patients. One study demonstrated that 77% of the participants misunderstood the doctor's instructions about frequency of medication dosage alone (Hanchak, Patel, Berlin, & Strom, 1996). This figure does not even touch the total estimate of patient non-compliance. In fact, researchers estimate

conservatively that only one third to one half of patients is fully compliant with physician instructions (Donovan & Blake, 1992; Waitzkin & Britt, 1993). One reason for patient non-compliance includes not understanding why taking medication may be necessary, even after feeling better. In other words, patients frequently are not educated about the dangers in skipping or refusing to take medicine. They are simply told to “take the medicine as directed.” Additionally, patients often miss appointments because they are unaware of the importance of follow-up visits.

Conclusion

The communication process that is vital to successful health care delivery is ripe with problems that are both structural (e.g., visit length, medical training) and interpersonal (e.g., doctor’s social skills, patient knowledge). As a result, there is much room for improvement in the communication process between patient and doctor. It would appear that more useful dialogue and better understanding of the entire problem, symptoms, diagnosis, and prognosis between patient and doctor, even in spite of time and other constraints, would seriously decrease missed appointment scheduling and guesswork about “doctor’s orders.” Until doctor-patient communication problems find resolution, many doctors will continue to be frustrated with patient non-compliance; and many patients will continue to be dissatisfied with the communication process and may be left without necessary information to aid in their decision-making processes. More important than mere dissatisfaction with the visit or frustration with non-compliance, improved communication between doctor and patient should mean better use of the health visit, and ultimately, more efficiency in the doctor-patient interaction.

The complexities of doctor-patient communication will remain until there is more study of the actual dialogue itself. A foundation for demystifying some communication problems would be to adopt a goals perspective in examining the interaction. This approach would seek to answer what kinds of goals both doctors and patients have for the health visit and how the communication process helps in the advancement (or preclusion) of these goals.

This study is designed to investigate actual communication strategies in order to better understand reasons for inaccurate or erroneous information exchange patient between doctor and patient. Most studies of the doctor-patient relationship have relied on patient recollection (self-report). Some video taped studies have investigated specific nonverbal behaviors and how they contribute to communicator style and outcomes such as patient satisfaction and/or compliance. However, no study to date has closely examined verbal strategies used by doctors and patients to accomplish their goals for and during the health visit. This study's objective is to provide more insight into these areas.

Literature Review

Introduction

The review of literature of the doctor-patient relationship is organized into five main areas. Part One begins with a macro view of the social setting of doctor-patient communication and is followed by a micro view. Part Two focuses on the relational aspects of doctor-patient communication, including background, process, and outcome variables. Part Three describes the importance of communication competence in general and specifically within the doctor-patient relationship. Part Four details the coding traditions used in doctor-patient studies and points to problems with extant research. Lastly, Part Five provides a summary of the chapter and offers research questions for the present study.

Part One: A Macro View of the Doctor-Patient Relationship

From its origins to the recent past, people characteristically have viewed the structure of the doctor-patient relationship as asymmetrical. In other words, the primary assumption held the doctor in authority, possessing the medical knowledge to help improve or heal the patient. For decades, this standpoint went unquestioned. Recently, however, patient advocates have found that empowering patients can lead to mutual decision-making in the medical interview and therefore more successful outcomes. The following sections trace the perspectives on the relationship structure and how these views have “evolved” and changed, especially during the past 75 years.

Asymmetrical Approaches

All of the views under this section portray the doctor-patient relationship in terms of the doctor as authority and the patient as the less powerful entity. The most familiar

and controversial depiction comes from the work of Parsons. Intellectual adversaries of Parsons agreed with the asymmetrical aspect but upheld other key differences; those distinctions also are included in this segment of the chapter.

Parsons' initial position. The functional approach to the doctor-patient relationship was championed by Parsons (Latham, 2002; Parsons, 1951; Turner, 2006; Vanderstraeten, 2000). Parsons claimed that the primary reason for a health visit is for the patient to receive medical aid. According to the functional approach, the doctor's sole purpose is to heal the patient. Patients, in turn, act in the "sick role;" they require help but medically are unable to determine their own diagnoses. Therefore, they must visit the doctor.

The "sick role" creates a patient's reliance on a doctor for health improvement. By being ill, patients put themselves into the subordinate position of an asymmetrical relationship (Black, 1961; Parsons, 1951; West, 1984). Concomitantly, the functional approach assumes physicians "hold the key" to improved health; thus, they exercise control over patients.

Individuals other than Parsons have championed the sick role perspective. For example, West (1984) defended this view several decades after Parsons had arrived on the scene by delineating three ways in which physicians control patients. First, patients cannot get well without medical help; they need the care provided by the doctor. Second, physicians possess technical/medical knowledge necessary to treat the patient, considering the time spent in medical school and medical settings, receiving the necessary training. Third, the *prestige* (separate from medical knowledge and skills) of training and education distinguishes doctors from patients, "giving them the upperhand"

in the medical interview. In terms of the basic law of supply and demand, patients have needs (or demands), doctors have the resources to supply the demand, and doctors also have the status to go along with “selling” the supply. In short, the physician has more control than the patient.

Parsons’ asymmetrical perspective on the doctor-patient relationship followed this pattern: the patient passively answers questions when asked, and the doctor actively cares for the patient, sometimes asking the patient for a response. Moreover, some researchers have used the analogy of a parent-child relationship: the doctor is the “parent” and the patient is the “child.” That is, the doctor takes care of the patient, gives the patient instructions, and punishes the patient when the instructions are not followed.

Mutual Participation Model. Several years after Parsons published his position, Szasz and Hollender (1956) argued that Parsons’ doctor-patient perspective was too limiting. While they agreed with Parsons’ asymmetrical concept, they insisted that the patient’s severity of psychological symptoms was related to the patient’s degree of dependence on the doctor. If a patient visits the doctor for a minor illness, that patient’s ability to be more active in decision-making was greater than that of the patient with severe problems. Therefore, patients, particularly those with minor problems, need guidance rather than specific orders. However, patients with more serious and/or terminal illnesses/diseases may suffer from many more psychological symptoms (e.g., fear and dependence) and therefore need to be told specifically what to do. This model has been labeled the *Mutual Participation Model* (MPM). The MPM seems to be the most applicable in cases of preventive medicine where the patient is otherwise in good health (West, 1984a).

Several years prior to beginning the current study, this author had worked on another study which entailed conducting four focus groups. The focus groups each consisted of 6-12 participants; these four focus groups were part of a larger study of approximately 12 focus groups altogether of the same size. The purpose of the study was to determine major patient goals and expectations for doctor visits. In over 15 hours of audio recorded conversations, the same theme “I just want to get medicine” emerged more frequently than any other goal, thus illustrating the MPM (Barnett, 1999). Several of the participants described an appointment for a cold or for allergies during which they reported they had told their doctors their sole purpose was to get medicine. The focus group members noted that they were not interested in establishing or maintaining a relationship with the doctor. However, these same focus group participants indicated that when they visited the doctor for more serious illnesses, they wanted to “be listened to” and wished “for the doctor to spend more time with [them].”

Parent-child metaphor and other models. Other scholars deviated from the MPM and modified Parsons’ “parent-child” metaphor. Wolinsky’s (1980) expanded metaphor represents stages: infant-parent, adolescent-parent, and adult-adult.” The underlying assumption seems to entail that the first two stages are asymmetrical and the third stage is more symmetrical. This is similar to a traditional family structure in which parents serve as overall decision-makers in the welfare of their young and adolescent children. When children become adults themselves (and are out on their own), they are able to have a more symmetrical relationship with their parents. Thus the metaphor seems to presuppose that for the largest part of the patient’s life, s/he has a more symmetrical relationship with the doctor than in childhood or adolescence.

Philosophical problems arise from this view. First, it would appear that there are four, not three, stages in a person's development; Wolinsky did not account for the older adult-parent stage. Older adults often become dependent on their adult children to care for them. Dependency pushes them into a stage different from their years as independent adults. Moreover, if the relationship is more asymmetrical in this stage, it would seem that the doctor (parent) would assert authority over the patient's compliance. No research to date shows that doctors are more authoritative with older adults. Further, research does show that adolescents and not seniors are often the least likely to comply with the doctor or even visit the doctor just as they are likely to rebel against other sources of authority (Fitzgerald, 2001; Staples & Bravender, 2002).

Another problem with this metaphor occurs at the third stage. Wolinsky's metaphorical last stage was adult-adult, allowing for the assumption that the doctor-patient relationship "progresses" until the structure is more symmetrical, excluding an older adult (patient) – parent (doctor) stage. In addition, senior adult patients (See "Age" under Part Three for additional information) are likely to visit the doctor as much or more than young children. Older persons, particularly ones with disabilities or impairments, are often accompanied by a friend or relative. The companion serves in a parental role just like a parent would with his/her child. The companion (friend or relative) needs to understand the problem(s) and what is prescribed for a treatment plan because the older person might not comprehend or remember what is said (Nussbaum, 1998). Unlike seniors and young children, adolescents and healthy younger adults may visit the doctor only for annual physicals, if that. Observation at health clinics demonstrates the majority of patients are infants, young children, and older adults.

Perhaps the only time the doctor-patient interaction comes close to a symmetrical construction is when the patient is a young or middle-aged adult, closer in age to the doctor than at any other time.

The Functional Approach's Doctor-Patient Relationship

Parsons' major claims. In response to critics of his earlier writings, Parsons wrote *The Social System* in 1951. In this book, he rendered the doctor-patient relationship as a small but major part of the larger structure of societal relationships. That is, the doctor-patient relationship was one of function just as is an auto repair shop. Repair shops are necessary when a car is not working properly. Likewise, according to Parsons, a patient's primary "relationship" with the doctor occurred whenever the patient was not well. Patients did not need physicians (or a "relationship") in times of good health.

The Social System drew much criticism. Critics of Parsons asserted that a patient's perception of the doctor's health care practices were influenced by other relationships (e.g., family, fellow church affiliates, friends, even nurses and aides in the medical office) (West, 1984). Critics argued that there were many influences other than the doctor on a patient's health and health decisions. They also disputed Parsons' idea that illness serves a purpose in society to "weed" out and prevent over-population. While Parsons saw illness or disease as a departure from the norm of good health and as a way to "eliminate" the less healthy in society, other writers believed that illness was not a natural cleansing process.

The functional approach to the doctor-patient relationship structure

As Parsons became increasingly aware of opposition to his views, he responded to his critics with arguments concerning responsibility by comparing the doctor-patient relationship to that of a professor-student. Parsons reasoned that the professor guides the student in learning. Therefore, even though the student may learn on his/her own, the professor is responsible for the student's learning, for s/he has to evaluate the student's knowledge and competence (through grades). As applied to the doctor-patient context, the doctor undertakes responsibility for the patient's wellness and is the true evaluator of the patient's health through physical examination.

Parsons continued to advocate that the relationship's "essential asymmetry" was necessary for the patient's health improvement. He identified specific symmetrical relationships in society. The first, he said, is the free market system in which everyone in theory has an equal chance or opportunity of realizing the "American Dream." Second, in voluntary or democratic organizations, people are elected to leadership positions. In other words, everyone supposedly has an equal opportunity to run for political or civic offices. Finally, Parsons saw that symmetry in social relationships affords people the chance to acquire friends, romantic relationships, and other social networks (Black, 1961).

Interpretations on relationship structure and the functional view

There have been other suggested interpretations of Parsons' theory of structuring the doctor-patient relationship. Black argued that Parsons' description of the patient is like that of an employer who "employs" the doctor for service, although the doctor expects the patient to be compliant and loyal (not go to another doctor). In

return, the doctor will render his/her service to the patient. The “employer-employee” relationship differs from a more recent “consumer-service provider” view (Friedler, 1997). Functionality is the key to understanding the differences between these two models. To illustrate, if the patient is sick; the doctor treats the illness. Very simply, the doctor is “employed” to treat the patient. However, in the “consumer-provider” relationship, the implication is a partnership between doctor and patient regarding the patient’s health (Paper, 2002). That is, patients have more control in this latter model. From a legal standpoint, Rothhouse (1999) contended that now, more than ever before, patients have opportunities to research a doctor’s background and experience including employment history, medical training, and even malpractice. Yet with regard to functionality, Parsons advocated that doctors operated within the realm of social control. That is, patients were not able to heal themselves and therefore needed the doctor. “Need,” accordingly, is more highly emphasized in the functional approach. In contrast, the modern “consumer-service provider” perspective, linked with HMOs in particular, operates under the assumption that patients have needs but are not fundamentally “needy” (Battistella & Burchfield, 2000). Instead, they pay the doctor (clinic) to provide the service of improved health. Having health needs differs greatly from “being needy.”

Problems with the Functional Approach

Understanding the historical changes in construction of the doctor-patient relationship necessitates exploring the functional approach to the relationship as well as its criticisms and alternate views. The following sections summarize these perspectives.

General problems

Adversaries of Parsons disputed his view of illness, saying the angle was too general and one-dimensional; illness could take many forms and affect individual patients differently. One of the main adversaries of this view, Freidson (1970) argued that until the average patient's construction of his or her illness was fully realized, researchers could not truly know how illness functions as part of the social structure.

Interruptions and the functional approach. Another problem with a strict (and uni-dimensional) asymmetrical approach involves interruptions. Researchers have argued that whenever the doctor interrupts the patient, it is a display of dominance; and whenever there is dominance, the relationship is asymmetrical (Cline & Cluck, 1984; Parsons, 1951; West, 1984). Doctors, however, insist that their interruptions during patient talk are necessary, especially if the discourse seems tangential to the problem or illness (Waitzkin, 1991; Waitzkin & Britt, 1993). Even scholars disagree on medical visit interruptions. Some researchers insist that physician interruptions not only violate the patient's right to speak, but also that "...[s/]he is also systematically cutting off potentially valuable information on which [s/]he must [herself/]himself rely to achieve a diagnosis" (West, 1984a; West, 1993). That is to say, physician-initiated interruptions can actually impede the doctor's information gathering. By contrast, patient-initiated interruptions may facilitate the history and symptom taking.

More pronounced problems

Gender issues and the functional view. A few years ago, physician/researcher Rotor and her colleagues performed a meta-analysis on medical studies of the doctor-patient relationship and found that although patients do not have a male or female

preference regarding their primary physician (Rotor, Hall, & Aoki, 2002), gender differences influencing the communication process remain. Differences in the way doctors and patients communicate are part of the functional approach's power structure claim although there are variables other than the doctor's authoritative position that can inhibit communication in the health visit. In another meta-analysis, Irish and Hall (1995) concluded that gender differences contributed to communication difficulties. For example, as stated in the previous paragraph, physician interruptions can hamper patient communication about complaints and symptoms. West's research (1984a; 1984b) significantly supported the claim that male doctors interrupted their patients far more than the patient interrupted his/her male doctor. However, there was no evidence that the interruptions accomplished positive results. Moreover, female doctors were interrupted as much or *more* by patients than the other way around. In direct contradiction, Irish and Hall (1995) found in a small sample study that patients interrupted physicians more than physicians interrupted patients. The study outcomes pointed to patient interruptions as a means of clarifying or making a statement; whereas, the physicians interrupted to ask a question. Further, another study showed that patients initiated interruptions fifty-five percent of the time, slightly more than the rate at which doctors interrupted the patients (Realini, Kalet, & Sparling, 1995). Yet Rhoades, McFarland, Finch, and Johnson (2001) in a recent large study found that male residents interrupted their patients far more than female residents, and both male and female residents interrupted female patients more often than they interrupted male patients.

Considerable research has explored conversation interruptions used by males as a form of dominance over females (Beattie, 1981; Ferguson, 1977; Natale, Entin, & Jaffe, 1979; West, 1979; West, 1984a; West, 1984b; West, 1990; West, 1993; West & Zimmerman, 1983; Zimmerman & West, 1975). Several decades ago, a notable study showed that male doctors interrupt their patients much more than patients interrupt male doctors (West, 1984b); reverse findings held true for female doctors. That is, patients interrupted female doctors as much or even more than female doctors interrupted patients (West, 1984a). Perhaps surprisingly, the gender of the patient in the above studies was not a significant variable. More recent studies indicate that the gender differences in doctor-patient interruptions have narrowed extensively (Irish & Hall, 1995) just like in other social circles, where significant gender differences in interruptions could not be found (O'Loughlin, 2002; Turner, Dindia, & Pearson, 1995).

Today's time dilemma and the functional approach. Parsons did not consider another important issue in his writings: time restrictions. As noted in Chapter One, today's health visits dictate less time with individual patients, so doctors are continually faced with decisions to maximize the visit. If Parsons could have envisioned our healthcare system today with managed care and HMOs not to mention other major health organizations putting pressure on doctors, perhaps he would have not have held onto such a generalized position on the doctor-patient relationship structure.

In summary, research indicates that gender does have some bearing on understanding control in the doctor-patient relationship. All the available literature indicates that doctors interrupt with more questions than do patients. Patients are put on the defensive and limited in the topic matter; therefore, patients are rarely in a

“power position” when trying to achieve their objectives. Unfortunately, there seems to be nothing found in Parsons’ theory to account for influence of background variables such as gender, ethnicity, age, education level, and socioeconomic status, etc.

Parsons’ perspective on the doctor-patient relationship positions it as one of functionality and necessity within the social structure. It is important to examine the details more specifically because for several decades, Parsons’ view helped guide and shape the way society looked at the medical context.

A Micro Look at the Functional Approach

Parsons’ social relationship model consists of five “patterns” which are “namely, achievement, universalism, functional specificity, affective neutrality, and collectivity-orientation, in that order” (Parsons, 1951, p. 454).

Achievement. Parsons described achievement as the idea that the “modern medical practice is organized about the application of scientific knowledge by technically competent, trained personnel” (p. 454). Medical competence is perhaps the most important key to a successful patient health outcome. There do not appear to be any disagreements about this aspect of the model.

Universalism. Universalism is interpreted by many of Parsons’ critics as the idea of treating all patients the same rather than as individuals with singular problems. It seems that some critics, however, have interpreted Parsons’ words literally rather than by context; worse, others show evidence of reading other critics’ reviews, and tend to rely more on those interpretations rather than going directly to Parsons.

It is true that within the context of the health visit, Parsons did not view the role of the patient as a person or individual (Robinson, 1999; West, 1984a). However, Parsons

clarified what he meant by “universalism” through the example of a physician having friendships and relationships with family where s/he is very “particularistic” because of the context. At the time Parsons was writing, prevention was seldom practiced in the medical setting. Intervention, or patients going to the doctor when sick, cast all patients into this “sick role.”

The concept of universalism remains contrary to the more modern “customer-provider” metaphor or even Parsons’ work relationships in a free market. To explain, a more recent approach stipulates that patients are individuals with individual needs; each has a socioeconomic, socioemotional, and physical context (Gulbrandsen, Fugelli, & Hjortdahl, 1998; Vermeire, Hearnshaw, Van Royen, & Denekens, 2001). Further, West (1984b) argued that there are cultural and gender differences in attitudes and responses to physical symptoms and pain. To predict that an individual will behave in a certain way due to circumstances is to strip that person of all elements of identity.

Function specificity. Function specificity refers to keeping the relationship within the sphere of medicine. Parsons’ textbook example of the physician making specific inquiries illustrates the specific function of the interaction. For example, if the patient does not wish to answer the questions or agree to a recommended procedure or health change, it is up to the doctor to provide “proof” that it is necessary. If the doctor cannot answer medically why the information is important, the patient should refuse to tell the doctor. Interestingly, on one hand, this perspective restricts the relationship in terms of physical conditions/problems and does not seem at all expansive in socio-emotional and/or quality of life issues. Yet, Parsons’ example of the patient refusing to answer the

doctor is empowering to the patient. This detail appears to conflict with an asymmetrical view.

Affective neutrality. Parsons advocated affective neutrality, or the idea that the doctor should remain emotionally detached to the patient. He explained that affective neutrality was what established the physician's attitudes within "limits" of the doctor-patient interaction; or, that is, what is professional and what is inappropriate. Parsons gave the example of the male physician stepping out of the exam room while the female patient undressed but that the male physician would become significantly embarrassed if the female patient chose not to wait until he left the room to start undressing. The embarrassed physician would not experience the same emotional reaction if the female patient undressed while on the exam table. Thus, not only is a doctor's professionalism important, it also is important for the physician and patient to understand and follow contextual norms.

Collectivity orientation. Parsons defined this concept as the vulnerability of the patient by sheer position of being the patient and thus sick. While some scholars consider him to have set up only four parts of the social relationship model (Robinson, 1999), Parsons in his own writing clearly outlined five. Parsons described collectivity orientation as the notion that a sick person is in a vulnerable position in just being sick and needing a doctor. Therefore, it is the doctor's responsibility to protect the patient against exploitation because of his/her helpless state.

Summary of Parsons' Social Model and Problems

The first assumption of Parsons' functional approach is that each person is to be treated the same within the social structure. Aside from treating patients differently than

one would treat friends/family members, it is difficult to understand how doctors would be able to treat patients similarly. Everyone is unique. What if a young woman's first gynecologist does not "handle her with kid gloves" and help her to relax? She likely would be more nervous during her next visit or may even avoid it altogether. However, the same doctor probably would not treat a thirty-something, sexually experienced woman the same way that he would treat the young, inexperienced patient. The older, sexually experienced patient undoubtedly would perceive the physician as exhibiting condescending behavior. Yet Parsons maintained that "affective neutrality" should be maintained regardless of the patient's health issue/problem. His social relationship model states that the doctor should not become emotionally involved with the patient. But saying this and actually practicing it can be two different things. Patients say they want to be listened to and treated like a person (Barnett, 1999; Osborn, 2000; Falvo & Smith, 1983). The recurring term "person" seems to carry the connotation of treating an individual with specific and particular needs and health concerns. Despite the fact that Parsons was writing about "role structure" with regard to the doctor-patient relationship and not individual patients, practicing "affective neutrality" does not lend itself to the kind of immediacy many patients would like.

Another problem with Parsons' construction of the doctor-patient relationship involves the communication process. According to Black (1961), Parsons assumed that if the actor's orientation within a situation is known, predictions can be made about that individual's behavior. However, Parsons intimated that researchers cannot truly understand the discourse; he alleged that meaning from words spoken within the doctor-patient context is interpreted as a resource but not as an "object of investigation"

(West, 1984a). In other words, meaning is created in the health visit situation, and analyses of transcripts at any point afterwards cannot accurately portray the gist of the doctor-patient relationship in real time (in context as it is naturally unfolding). Yet a number of articles have focused on the social construction of meaning in medical contexts (Ellingson, 1998; Mishler, 1984; Waitzin, 1991; West 1984a; 1990; 1991). These scholars maintained that language helps to explain medical as well as interpersonal complexities created by the situation itself. For example, Emerson (1970) found that gynecologists used definite articles rather than possessive pronouns to refer to a patient's body parts. To illustrate, instead of informing a patient about "her/your vagina" a doctor would say, "the vagina." The use of indefinite articles helps to keep meanings from involving sexuality and ultimately serves to protect both patient and doctor from embarrassment. Ironically, Parsons would likely agree that the indefinite pronoun "the" bolsters affective neutrality.

At the heart of the asymmetrical approach to the doctor-patient relationship, there are power issues that cannot be dismissed. There appear to be three main types of power/control relationships. The first type of power, as Parsons argued, lies in the structure itself of the doctor-patient relationship. A patient with moderate to acute symptoms/problems is dependent upon the doctor to properly diagnose and treat him/her. Here, the patient who is in need of aid goes to the doctor. Because of the patient's dependence on the doctor's medical experience, the doctor is the one in control of the situation. The "power" is most easily seen through the structure of the medical interview. Typically, the doctor asks the patient questions and the patient answers. The questioning may start out as open-ended "Why are we here today?" or

“What seems to be the problem?” However, the questions progressively become more specific as the doctor tries to rule out what the problem is *not*. For example, the question, “Do you have burning with urination?” requires a “yes” or “no” response.

Not only does the doctor control the format of the medical interview but also interrupts the patient more frequently than the other way around (Rhodes et al., 2001; Street & Wiemann, 1987; West, 1979; 1984a; 1984b; 1990). Recent research seems to suggest that there are not as many interruption differences (i.e., male physicians interrupting patients more than female physicians) as was once thought (Irish & Hall, 1995; Realini et al., 1995). However, there is still the large disparity in type of interruptions that supports a power dimension. In other words, physician interruptions are typically probes, re-statements, questions, or clarifying comments, to name a few possibilities; whereas, patients tend to interrupt more often with statements and clarifying comments. These reflect power differences because the doctors’ interruptions direct the flow and orientation of the interaction, while patients’ attempt at elucidatory comments and symptom descriptions do not change the direction of the discourse.

Researchers portray the doctor as having more “power” in the doctor-patient relationship (Street & Buller, 1987; 1988; Street & Wiemann, 1987; West, 1984b; 1990). A symmetrical view of the relationship is not as common. For example, if the patient is an adult and is intelligent and concerned with good health practices, there is an adult-adult relationship more closely “equal” in dynamics than if the patient were a child, elderly adult, or a mentally challenged person. Parsons and others espousing the functional approach may have contended that the patient still is not “medically competent” like the doctor. However, this author reasons that patients who investigate

their health concerns and go to the doctor visit armed with information regarding their problems are in a more symmetrical relationship with the doctor than those patients with less knowledge or intelligence.

Another consideration is severity of (i.e., the patient could get well with over-the-counter, or OTC, medicines), the relationship becomes more equal because the patient's overall quality of life has not been threatened. Especially if the patient has taken some initiative him/herself to try to determine possible causes for the health issue, the patient may assume more responsibility for his/her own health, freeing the doctor from such responsibility. This relationship of mutual responsibility typifies the Consumer Model, positioning the patient in a more equal relationship with the doctor since the patient is demanding a service from the doctor and the doctor is providing that service. This approach is exemplified by a female patient returning to the (male) doctor for a re-check on a problem, interrupting the doctor much more frequently than the doctor interrupted her, and doing most of the talking (Barnett-Theodori, 2001). The patient told the doctor she wanted to stay on one medicine for her depression but wanted to try something else for her cold sores. Evidently assuming responsibility for her health, she told the doctor that she was in the process of finding a new therapist and discontinuing visits with her former therapist. In fact, she had already made arrangements to "interview" several new therapists. In actively taking charge of her own health care needs, the patient seems to be on "equal footing" with the doctor, thus supporting the argument that there could be symmetry in a doctor-patient interaction.

A third type of power structure found in the doctor-patient relationship, at least in theory, is also asymmetrical—where the patient, not the doctor, is in control of the

interaction. The example in the last paragraph probably would not fall into this category because that patient seems to be on an equal footing with the doctor. She is active and responsible for her health needs, but she is still reliant on the doctor to switch her cold sore medication and to continue to prescribe anti-depressants. In a patient-controlled relationship, the patient would not merely take an active role in the interaction but actually would *control* the interaction. For example, perhaps the doctor is just starting a practice and has a strong need for patients in order to earn a living. The doctor may comply with the patient's wishes (e.g., demand for antibiotic for a sore throat versus the common cold virus without exploring other options or conducting tests to determine if the patient really does have strep throat).

At this present time in published doctor-patient communication research, the third type of power structure has not been found, although the author of this project through her research makes the argument that such a power-structure does indeed exist.

Summary of Part I

Despite his controversial ideas, Parsons helped lay the groundwork for communication theory by advocating communication as the foundation for all social relationships. Communication is not only the foundation for these relationships, researchers have argued, but communication also *is* the relationship (Duck, 1988). Communication of information exchange between patient and doctor is critical for history taking, symptom sharing, diagnosis, and prognosis. Without good communication, doctors may be unable to provide quality care. It is therefore necessary to explore what variables affect the communication within and more importantly, the outcomes of, the doctor-patient visit.

Part Two: The Doctor-Patient Relationship

Part Two reviews literature on the doctor-patient relationship, not according to its structure (both in and out of society) but from three aspects of the interaction. In other words, there are unchangeable variables, which are really personal characteristics or traits of patients and doctors. In this study they are referred to as “Background variables.” Age, gender, ethnicity, and degree of patient illness are examples of Background variables. Process variables comprise those influences on the interaction which are changeable, especially with interventions such as doctor workshops or even patient empowerment training. Process variables include interactant knowledge, communicator style, and interruptions. Outcome variables are those variables that result from the communication. They include satisfaction, compliance, and behavior change.

While there are numerous variables having at least some salience to the doctor-patient interaction, the current review is not exhaustive. Instead, this section captures the variables most often examined in studies. Additionally, the variables discussed here are the ones found not only in doctor-patient studies in medical journals but ones most emphasized in doctor-patient discourse studies.

Background Variables

Background variables are those variables, which doctors and patients bring to the doctor-patient interactions, including gender, ethnicity, age, and type of patient illness at the time of the health visit. Gender, ethnicity, and age are traits which are *part* of the patient and which cannot be changed regardless of the communication interaction or outcomes. Therefore, nothing can alter many of these background variables, but

they nonetheless have been shown to exert influence over the communication interaction.

Gender². Gender/sex differences in doctor-patient communication have been the focus of countless studies. Several decades ago, Wallen, Waitzkin, and Stoeckle (1979) studied doctor-patient interactions and concluded that male physicians offer more explanations to female patients than they do to their male patients even though they spend equal amounts of time with patients of both sexes. This may indicate that the females studied received more useful knowledge about their diagnoses and treatment options than did the males (Waitzkin, 1984; 1989).

A prominent difference found between male and female doctors involves interaction time with patients. Female doctors spend more time in face-to-face interaction with patients of both sexes than do male doctors, quite possibly suggesting that patients have more time with female doctors in which to ask questions and have their questions answered (Weisman & Teitelbaum, 1985). Roter and her colleagues (2002) showed support for this statistically significant gender difference, finding that female general practitioners (GPs) typically spend an average of two minutes longer with patients than do male GPs. Finally, in line with that finding, Kaplan, Gandek, Greenfield, Rogers, and Ware (1995) discovered that male patients had the least participatory visits (or the least participation in the decision-making process) with male physicians as compared with male patients seeing female physicians or female patients seeing a physician of either sex.

² In this review, “gender” will be the term used to discuss male/female differences found in doctor-patient studies because much of the literature does not distinguish biological sex (“sex”) from sex roles (“gender”).

Gender differences also are evident in interruptions. Since this was already discussed in Part I, the author will summarize here the majority of the outcomes of gender influences in doctor-patient studies. Results of various studies point to the minimal significance of the patient's gender, although the doctor's gender tended to be important. In a meta-analysis, researchers found that female doctors are interrupted more than male doctors, and male doctors interrupt their patients more than do female doctors (Irish & Hall, 1995).

In addition to interruptions, gender differences also in the doctor-patient interaction are manifested through the actual manner of communication. In an observational study of 648 routine medical visits (69 participating physicians) including audio tapes of the interactions along with both physician and patient questionnaires, female patients during the health visit appeared to be more active and emotionally involved than were the men (Hall & Roter, 1995). Perhaps surprisingly, this same study provided support for significantly greater physician awareness of male rather than female satisfaction. Hall and Roter (1995) suggested one plausible explanation: female patients may not have presented easily detectable nonverbal cues indicating satisfaction. To explain, women mask their feelings more than do men (Eckman & Friesen, 1984); therefore, outward smiling might hide true feelings of dissatisfaction.

Finally, in a study of physician gender effects, Roter and colleagues (2002) found that female doctors talk more actively, work on more partnership relationships with patients, and are more emotion-focused than their male counterparts. Not all studies, however, produced significant sex differences regarding manner of communication. In a study of nonverbal behaviors between physicians and patients, no support was found

for sex as an influence on nonverbal communication (Street & Buller, 1988). However, Street and Wiemann (1987) became aware that women were more satisfied (than men) when they perceived their doctors were more involved and more expressive but that they became more dissatisfied (than men) when they perceived their doctors were low in involvement and expression.

Role playing in the doctor-patient relationship is yet another way in which gender differences are highlighted. Cline and Cluck (1984) alleged that when a patient is female, passive, and silent, she embodies the “helpless female” role that has permeated our culture through history, films, literature, and even religious beliefs. Therefore, when the doctor is male and, by virtue of the interaction, the only one in control, “a double jeopardy” situation is created for the patient. In other words, she can be subjected to the power and domination of the doctor because, first, he is male and, second, because he is the doctor and she is “sick and helpless.” A different role might be the one a female doctor plays with male patients. A female doctor may have to act tough in order to achieve credibility with her male patients, particularly those older male patients who have not been exposed to female doctors most of their lives or male patients with a male-dominated cultural background.

Gender has shown to influence the doctor-patient relationship in terms of interruptions, expression of emotions, and time spent with patients. To summarize, female doctors are interrupted more than male doctors, but male doctors interrupt patients more than do female doctors. Female doctors spend more time with patients in general and spend more time fostering a closer relationship and encouraging patients to

be more active in decision-making. Female patients in turn report appreciating emotional expressiveness of physicians more than male patients.

Age. In addition to gender, age may influence doctor-patient communication. Nussbaum (1998) pointed out various differences in the younger patient-doctor and older patient-doctor interactions. First, the context of the older patient often includes a companion (e.g., spouse, son or daughter, or friend). The doctor may engage in additional or equal amounts of dialogue with the person who accompanies the senior, particularly if the companion is younger and if the senior has hearing difficulties or memory failure. Second, often the senior patient is significantly older than the doctor, and this could mean very different attitudes toward prevention and treatment ideas. Third, Nussbaum (1998) contended that older patients often ask questions less frequently, give less detailed information, and are less assertive than are younger patients. And finally, older patients typically have more health problems, including chronic diseases, longer medical histories, and move much more slowly than a doctor's younger patients. These factors can greatly impact the dynamics of the doctor-patient context, especially when many appointments are scheduled in fifteen-minute blocks of time (Nussbaum, 1998).

There are physiological considerations associated with aging. Nussbaum, Hummert, Williams, and Harwood (1995) reported on physiological changes in the older patient (over 55) that are likely to impact the medical encounter including slower movement and reaction time along with and hearing loss. Nussbaum (1998) showed that age-provoked changes can contribute to patronizing talk by doctors. However, just because an older patient may not hear very well or have a slower response time, a

patient may still be mentally competent and able to detect a doctor's pejorative tone, which in turn can affect the way they respond to (or do not comply with) the doctor's advice.

It should be noted that a doctor's communication style with older patients does not inevitably reflect patronization. Some physicians act less domineering and more responsive to mid-age (ages 30-55) adult patients, using more back channels (i.e., head nods, verbal "uh-huhs," etc.) and engaging in more equal turn lengths (Street & Buller, 1988). While it is impossible to interpret if there is a condescending tone accompanying the nonverbal behaviors described by Street and Buller (1988), research shows that a patient's age affects the doctor's manner of communication.

Another concern regarding age involves competition versus cooperation tactics. That is, younger people tend to engage in more competition tactics than older people, who tend to engage in more cooperative tactics (Bergstrom & Nussbaum, 1995). For doctors, this effect could have implications for understanding older patients. A study conducted at 11 senior centers suggested that patient self-efficacy may warrant more attention from doctors (Maly, Frank, Marshall, DiMatteo, & Reuben, 1998). Boosting the senior's sense of being able to "cope" might have an impact on the patient's health and recovery, producing speedy and lasting results.

Age might interact with other individual difference-level variables. In fact, age was studied along with other variables to determine their combined effects on the doctor-patient relationship. Beisecker (1990) reported that age, education, and yearly income correlated with question asking; that is, younger, more educated, and higher income persons asked more questions of their doctors. In addition, Waitzkin (1984;

1985) found no difference in the relationship between education levels (poorly educated versus more educated) and status (lower class versus upper class) in overall desire for information. The idea that generally patients want as much information as possible during their health visits may help doctors avoid assumptions. In other words, because lower class patients reportedly have not asked for information, doctors may believe that the patients did not want it; however, studies report that patients want as much information as possible (Terry & Healey, 2000; Smith & Hoppe, 1991).

In summary, older people rarely attend a health visit alone but instead are accompanied by a son, daughter, spouse, or friend. An additional person adds to the complexity of doctor-patient communication dynamics. Additionally, older patients are not always receptive to new ideas, especially from doctors who are much younger. Older patients usually ask fewer questions yet have more health problems and needs. Finally, senior patients tend to be more cooperative than competitive, which is good for the doctor when trying to gain compliance but is not necessarily good if patients fail to report health concerns or issues if afraid that their concerns are too time-consuming or burdening for the doctor.

Education. Education level itself is an important predictor of health visit outcomes (i.e., patient satisfaction, clearer prognosis, etc.). Both a high level of patient education regarding the patient's health problem(s) and more years of formal education of the patient have been shown to produce increased satisfaction outcomes. Hall, Roter, and Katz (1988) reported that a high amount of physician-given patient education vis-à-vis the patient's health concerns was correlated to high levels of patient satisfaction. College degrees also affected outcomes such as satisfaction levels. In

one study, educated patients, defined as those with college degrees, tended to be less satisfied than those not having college degrees (Anderson & Zimmerman, 1993).

Cultural Context. Cultural background, including race and ethnicity of the doctor and patient, are important to the medical encounter (Ferguson & Candib, 2002; Griffiths, Kaur, Gantley, Feder, Hillier, Goddard, & Packe, 2001; Shapiro, Hollingshead, & Morrison, 2002; Skelton, Kai, & Loudon, 2001). Hofstede's (1980) research seems to indicate that members of collectivistic cultures strongly associate their identity with group affiliation, and they tend to exhibit high context in their communication. This means that individuals from collectivistic cultures tend to rely heavily on the situational norms and the relationship of the parties themselves in order to find meaning within the verbal messages. On the other hand, members of individualistic cultures tend to have low context in their communication messages, signifying that reliance is on the explicit meaning of the words rather than on the context itself.

Scholars have theorized about the implications of cultural contexts on the relationship itself. Take low vs. high context cultures. Low context cultures derive more meaning from verbal communication (e.g., words) than from cultural norms. For example, if a business breakfast meeting is supposed to start at 8:00 a.m., it would be unacceptable for someone to show up at 8:30 a.m. On the other hand, in a high context culture where more meaning is derived from the cultural norms, a breakfast meeting that is announced to begin at 8:00 a.m. might have persons arriving at an acceptable 10:00 or 10:30 a.m. Further, McCalman and Canary (1998) hypothesized that individuals from a low cultural context (LCC) would be more likely than those from a

high cultural context (HCC) to adopt consumerist roles. These researchers suggested that an LCC society tends to be more individualistic and equalitarian.

Regarding an LCC cultural context in the medical interview, the patient acts as consumer, trying to make the best investment and purchase to suit his/her needs in order to maintain or improve health. This metaphor points to a seemingly symmetrical relationship. Conversely, HCC individuals should be more accustomed to hierarchical structuring, thereby giving the doctor situational authority. These patients likely would adopt a traditional structuring in the medical interaction, viewing the doctor more in an authority or parental role as compared to LCC patients. However, contrary to expectations, in their study, McCalman and Canary (1998) found no significant differences between HCC and LCC patients regarding perceptions of being in the “sick role.” But as predicted, the study’s outcomes showed significant statistical support ($p < .001$) for LCC patients’ identification as a consumer. Here, context/culture explained 9% of the correlations. Further, McCalman and Canary (1998) found that LCC (vs. HCC) patients reported more satisfaction with health care providers, and HCC (vs. LCC) patients reported that they felt health care providers were less immediate, less receptive, more dominant, and more formal.

In summary, culture plays a fundamental role in communication contexts. In doctor-patient settings, culture can influence the outcomes. This becomes increasingly important when doctor and patient are from different backgrounds and try to understand one another. In the scenario of a traditional Hispanic male patient and a Euroamerican female doctor, the patient may have difficulty complying with the doctor because in his culture, men have more authority than women.

Recent research has probed the area of cultural sensitivity within the medical arena. Conclusions suggest that society may be culturally insensitive to ethnic minorities, (Canlas, 1999; Deville, 1999; Glanz, Resch, Lerman, & Rimer, 1996; Gorelick, Harris, Burnett, & Bonecutter, 1998; Gray & Stoddard, 1997; Heaton, Taylor, Burr, Dumois, Loewenstein, & Kaye, 1996; Ito, 1999; Jacobson, Thomas, Morton, Offutt, Shevlin, & Ray, 1999; Kaplan, Gandek, Greenfield, Rogers, & Ware, 1995; Pousada, 1995), the indigent (Jacobson, Thomas, Morton, Offutt, Shevlin, & Ray, 1999; Mechanic, 1992), and the less educated (Jacobson, Thomas, Morton, Offutt, Shevlin, & Ray, 1999; Kaplan, Gandek, Greenfield, Rogers, & Ware, 1995; Pousada, 1995). This insensitivity may produce distrust; and historically, minorities have had more distrust in the medical profession. Therefore, affirmative action may be a necessity within the medical context (Canlas, 1999; Deville, 1999). Trust, researchers have argued, is essential for the doctor-patient relationship, and trust for minorities may be strengthened by having a doctor of the same ethnicity. In fact, Gray and Stoddard (1997) showed that minority patients were significantly more likely than non-minority patients to report having a minority physician for a doctor. This is particularly significant for Hispanics, who have reported having a Hispanic physician 19 times more often than non-minorities.

Distrust and a preference for doctors of the same ethnicity are two reasons for researchers to continue studying cultural sensitivity in the doctor-patient relationship. Other reasons to continue research exist. Some studies have shown that minority patients have different needs because they have differing levels of knowledge than non-minority patients and that they have differing decision-making styles, particularly if an

individual is both a minority and less educated (Glanz et al., 1996; Jacobson et al., 1999). Additionally, health illiteracy, whether related to education or language differences, is widespread and under-researched. What is known is that low levels of health literacy exist for minorities and are even more prevalent among the indigent, inner city African-American population. To illustrate, a randomized control study underscored the need for simple literacy: a simple low-literacy education tool increased pneumococcal vaccination rates and doctor-patient discussions about the vaccine for older, less educated (and lower literate), indigent minorities (Jacobson et al., 1999). Pousada (1995) pointed out that significant differences in the socioeconomic, cultural, and language context, especially for Mexican Americans, Puerto Ricans, and Cuban Americans, can complicate the doctor-patient relationship. Tearing down these barriers through understanding Hispanic-American social dynamics and values is vital to successful doctor-patient outcomes.

Most importantly, there are cultural implications for the ways patients and doctors communicate about very serious illnesses. Heaton et al. (1996) showed that knowledge levels about the drug AZT (the drug zidovudine that has been used in HIV cases to try to prevent transmission, particularly in pregnant women to the fetus) differed among racial/ethnic groups. Trust in health care providers, opinions on whether testing should be voluntary, and even attitudes toward the drug AZT itself was different among racial/ethnic groups. Further, according to the Centers for Disease Control (CDC), as of 2001, 50% of those with HIV are African-American, while Whites comprised only 29%. Latinos constituted 19%, and 2% of those currently infected are of some other ethnic background. The confounding effects of gender and race on health

are also significant: of all females with HIV, 64% are African-American, while only 17% of females are White and 17% are Latino (CDC, 2001).

Context of the visit. The context, or nature of the visit, is a background variable impacting the doctor-patient relationship. The patient brings his/her problems/symptoms to the medical interview. In addition, there are differences in the type of medical practice, particularly with the emergence of managed care.

While nature of the visit influences outcomes, there is not much research on whether first time visit versus a return or follow-up visit varies significantly according to outcomes (especially patient satisfaction). Street and Buller (1988) found no significant differences in the first visit versus repeat visit, particularly in nonverbal exchange. Further, in addition to variables directly related to the communication interaction, there are factors outside which have been shown to impact doctor-patient communication. Beisecker (1990) found that situational variables such as type of illness, reason for visit, and physical features of the clinic (i.e. cleanliness, parking situation, etc.) and even time in the “waiting area” influenced process variables, including how patients communicated with their doctors.

While little is known about first-time visit versus repeat visit, research has explored patient illness level and/or nature of visit and impact on outcome. Two large studies conducted by Hall, Milburn, Roter, and Daltroy (1998) with sample sizes of 1,114 patients and 2,649 patients showed that less healthy patients are more dissatisfied with their health care: Poor health status directly produces dissatisfaction, and dissatisfaction is produced through the mediating effect of the doctor’s behavior. Another study showed that a patient's medical condition had a positive correlation with

patient satisfaction (Patrick, Scrivens, & Charleton, 1983). These researchers found that the level of disability or illness along with other factors, such as sex, social class, medical conditions, self-rating of health, social support, and other life events, were related to one or more measures of satisfaction. In fact, the study further showed support for the patient's health status and external influences (e.g., cleanliness of the clinic, friendliness of receptionist, and waiting times) as better predictors of satisfaction than even the manner of the doctor's caring for the patient. Interestingly, according to this research, improved doctor-patient communication may not be the key to increased patient satisfaction.

Type of health plan (e.g., membership in an HMO versus a fee-for-service) is a final background variable. Some studies have shown that there are differences between HMO enrollees and non-enrollees regarding satisfaction levels. Tudor, Riley, and Ingber (1998) investigated enrollees receiving Medicare from both HMOs and fee-for-service organizations and found that both groups reported satisfaction overall. However, the HMO enrollees were more likely to be satisfied with the costs of their health care and in getting their care at one facility. On the other hand, non-enrollees reported higher levels of satisfaction with the interaction with their doctor. Nonetheless, another study also examined satisfaction with overall care between HMO enrollees and fee-for-service patients and uncovered other outcomes (Schmittdiel, Selby, Grumbach, & Quesenberry, 1997). The logistic regression model showed no other single variable, patient demographic or socioeconomic characteristics, health values, health beliefs, or physician demographics (or even physician specialty) predicted high overall patient satisfaction with the exception of choosing one's doctor.

Process Variables

The second category of variables were named “process” because they not only are ones the patient and doctor bring to the medical interaction and are influential regarding outcomes, but also they can be altered through the communication interface, unlike background variables. That is, these variables are often changing (i.e., increasing or decreasing), depending on the communication between participants.

Trust. Research has considered both initial as well as emergent trust. A patient brings a level of trust to the interaction based on a general view of doctors. Research shows that past experiences, including relationship quality, significantly predict loyalty to one’s doctor (Safran, Montgomery, Chang, Murphy, & Rogers, 2001).

However, more importantly, patient trust in the doctor develops during the interaction and can continue to enrich or challenge the doctor-patient relationship over time. Within the interaction, however, it is feasible that trust can increase or decrease over time. Consequently, trust can fit as a process variable. Most importantly, establishing patient trust in the doctor-patient relationship is essential for positive outcomes (Adams, Schmidt, Sanders, Larkin, & Knopp, 1998; Anderson & Dedrick, 1990; Canlas, 1999; Deville, 1999; Gerbert, Caspers, Bronstone, Moe, & Abercrombie, 1999; Heulton et al., 1996; Kamholz, & Mellow, 1996; Meeuwesen, Schaap, & van der Staak, 1991; McCalman & Canary, 1998; Sharpe, Chalder, Palmer, & Wessley, 1997; Tang & Newcomb, 1998).

The importance of trust in the medical encounter cannot be overstated. Trust is one of several elements in primary care that has a significant positive relationship with compliance, patient satisfaction, and improved health status (Safran, Taira, Rogers,

Kosinski, Ware, & Tarlov, 1988). Sharpe et al. (1997) found that in cases of Chronic Fatigue Syndrome (CFS), physicians often became frustrated with the process of eliminating all other possible causes of the patients' problems, thereby increasing the challenge of making the diagnosis meanwhile losing patient trust. The researchers argued that in cases of illnesses and diseases that have been stereotyped by society (i.e., homosexuals constitute the major group contracting the HIV virus), it is of absolute importance to establish mutual trust between patient and doctor. Another group stereotyped by society, depressed patients, carries a stigma of laziness or uselessness. According to Kamholz and Mellow (1996), older people are sometimes susceptible to clinical depression than other age groups. They studied depressed geriatric persons and concluded that older depressed patients are more likely to recover if they develop trust in their doctor.

A link seems to exist between patient trust in the physician and outcome variables (e.g., satisfaction and compliance). Further, doctors can augment their patients' trust through specific behaviors. For example, participants in a focus group study offered that trust and thus confidence in the doctor could be greatly enhanced if physicians would be more open to giving to patients as much information as possible about their health status (Tang & Newcomb, 1998). In fact, in another study, patients reported greater motivation in adhering to a plan of treatment and high satisfaction levels; both were correlated with increasing trust in the doctor (Safran, et al., 1998). As noted earlier, McCalman and Canary (1998) investigated context/culture, role expectations, degree of failed expectation, and relational messages to see which ones best predicted patient trust and satisfaction with the health care provider. A stepwise

multiple regression showed that failed expectations explained 68% of the variance on trust and receptivity an additional 9% of the variance. These researchers also hypothesized there would be a negative correlation between patients' unmet expectations of their doctors and trust in those doctors. They found strong support for this hypothesis. Implications from these findings point to fulfilled patient expectations as crucial to the development of patient trust.

Establishing patient trust through better physician-patient communication not only depends on amount of information-giving but also on communicating ethical reasons for trusting the doctor. That is, the patient needs to understand that the doctor is acting in the patient's best interest while being attentive to patient needs (Meeuwesen et al., 1991), including affective behaviors such as nonverbal and verbal interest in the patient, expressions of empathy, and words of encouragement. Although one implication is that better physician-patient communication will enhance trust, to date, studies have not shown that trust leads to better health outcomes (Buller & Buller, 1987; Lane, 1983; Woolley, Kane, Hughes, & Wright, 1978) just as there is little to no correlation between satisfaction and compliance (Bartlett, et al., 1984; Burgoon, 1992). In fact, perhaps more frustrating, improved patient satisfaction with the doctor has not been shown to significantly help the patient to improve his/her health outcomes (Putnam, Stiles, Jacob, & James, 1988; Putnam, Stiles, Jacob, & James, 1985). Throughout the past 30 years or more, the relationship between patient satisfaction and health outcomes is puzzling to researchers. While it seems a logical conclusion that higher levels of patient satisfaction (and trust as well) will result in compliance and thus improved health, the evidence does not significantly reveal satisfaction as an intermediary influence.

Finally, while psychosocial health is enhanced through variables such as trust, there does not seem to be any hard evidence to support a relationship between patient trust and improved physical health. Psychosocial health issues include facets of a patient's life not necessarily directly related to physical health but definitely have moderate to major impact on one's life. Such issues include relationship conflict (with family, friends, and/or relational partners), verbal/emotional abuse, physical/sexual abuse, alcoholism, drug dependency, work-related stress, school problems, financial worries, eating disorders, and the like, to name just a few. Unfortunately, there is still a dearth of studies focusing on doctor-patient communication and patient psychosocial health.

Empathy. Empathy arguably might be grouped with the background variables because many patients feel the doctor should bring an empathetic quality to the medical encounter (Bennett & Alison, 1996; Hellstrom, 1998; Kaplan, 1998; Lipkin, 1996). However, like the patient's trust in the doctor, doctors display empathy through both verbal and nonverbal behaviors. These actions are elicited and conferred *during* the interaction. Scholars have clashed over whether empathy is merely a communicator style that some physicians practice or an integral part of the interaction (Bennett & Alison, 1996; Hellstrom, 1998; Mechanic, 1998), particularly in the delivery of bad news (Bennet & Alison, 1996).

Doctors' display of empathy has been linked to satisfaction outcomes, especially in the effectiveness of therapy and treatment plan (Kaplan, 1998; Lipkim, 1996) as well as in improving patient health (Squier, 1990). Bensing (1991) found a weak but statistically significant relationship among the behaviors of nonverbal attention, verbal

empathy, and encouragement and patient satisfaction. Further, research on physician motivation supports the idea that doctors strategically and purposefully employ empathic communication in order to satisfy patients (Branch & Malik, 1993; Platt & Keller, 1994; Suchman, Markakis, Beckman, & Frankel, 1997; Zinn, 1993). Additionally, a link between empathic communication and patient expectations for the interaction has been found (Kravitz, et al., 1996).

The doctor's display of empathy is important in the development of the doctor-patient relationship. In theory, it is a teachable skill (Bellet, 1991; Branch & Malik, 1993; Gerard, 1999; Platt & Keller, 1994; Roter, Rosenbaum, de Negri, Renaud, DiPrete-Brown, & Hernandez, 1998; Suchman, Markakis, Beckman, & Frankel, 1997) although research to date has not widely demonstrated the teaching of empathy in the medical community. To illustrate, in a study of fourth-year medical students, a survey was used to measure empathy (Moorhead & Winefield, 1991). The research design was pre-test and post-test with the intervention consisting of training in communication and in counseling. Low rates of empathy were recorded before and after the training. No significant increases in empathy occurred in the post-test. However, contrary findings revealed that despite communication skills training provided for the medical students' contact with cancer patients,³ empathy, listening, and listening to patients' wishes regarding medical decisions were important to those who received the communication training, even for as long as two years following the training (Klein, 1999).

Clearly patients are more satisfied when doctors effectively communicate with them, and communicating well can be learned through actual training in demonstrating

³ It is necessary to note that the communication skills training was done in a research study, not as part of the medical school training itself. Most medical schools to date still do not have interpersonal communication skills training.

empathy (Mathers, Jones, & Hannay, 1995). Despite the myriad of studies supporting the charge that doctors *can* be trained to be more empathetic, few medical school curricula include developing interpersonal communication skills (Klein, 1999; Thistlewaite & Jordan, 1999). Furthermore, just because empathy *can* be learned does not guarantee that doctors will develop an empathic style in communicating with patients.

Information Exchange. As already mentioned, good information exchange is not only a tool to increase patient trust but is also crucial to the development of the doctor-patient relationship (Cegala, Coleman, Warisse, 1998; Cegala, McNeilis, Socha McGee, & Jonas, 1995). First and foremost, doctors need to ask patients questions in order to diagnose. Second, patients have a need for information concerning the problem as well as treatment. How that information is exchanged can affect outcomes of the interaction including doctor and patient satisfaction as well as patient adherence to the doctor's prescribed regimen. Giving the patient more information and spending less time reading the patient's chart were positively correlated with higher patient satisfaction (Hall et al., 1988). In their review of the literature, Steptoe, Sutcliffe, Allen, and Coombes (1991) highlighted studies in which patients received a good deal of clinician-delivered information but still reported wanting more. Patient perception of receiving appropriate levels of information about health concerns was linked to greater patient satisfaction (Woolley, Kane, Hughes, & Wright, 1978).

Doctors control the power in the doctor-patient visit. That is, doctors can manage how the information is exchanged in the medical interview by continuing to ask the patient questions during the interaction and interrupt when patient responses became

tangential (Beisecker, 1990). However, the interview does not always follow this format closely. Patients also volunteer information on their own as well as interrupt doctors. Tuckett and Williams (1984) suggested that patients can control the encounter by actually *limiting* the information they provide. In turn, doctors can discourage patients from asking questions by telling patients they do not need to worry or by emphasizing that their patients should concentrate on complying with the treatment plan (Beisecker, 1990).

It is impossible to describe the process variables in detail within the doctor-patient context without including outcome variables, because part of the process entails understanding the outcomes. While it is clearly evident that process variables in part do determine patient outcomes (e.g., compliance, satisfaction), research has not sufficiently shown whether any or all of them influence the outcome of improved or maintained patient health.

Outcome Variables

Outcome variables are the results of the health visit. They are influenced by the other two sets of variables, background and process. Outcome variables also may influence each other as well. The variables described below include satisfaction, compliance, and behavior change.

Satisfaction

Some researchers may argue that patient satisfaction is not and should not be the focal goal of the doctor; getting the patient well is and should remain so (Burgoon, 1992). However, satisfaction *is* salient if a relationship between satisfaction and compliance can be established. Some research offers mixed findings regarding patient

satisfaction and compliance (Post, Cegala, & Miser, 2002) while other research supports a weak relationship between the variables (Buller & Buller, 1987; Buller & Street; Street & Buller, 1987; 1988; Street & Wiemann, 1987). Schall, Evans, and Lottinger (1998) proposed that the weak link and conflicting findings were due to the use of satisfaction scales that measure dissimilar types of satisfaction (i.e. general satisfaction with the waiting time and the cleanliness and the physician altogether versus satisfaction with the physician-patient interaction only). Additional research shows a significant relationship between satisfaction and health outcomes, particularly among older patients (Ostir, Simonsick, Kasper, & Guralnik, 2002). If patient satisfaction affects compliant behavior, and in turn, if the compliant behavior is a major factor in the patient's improved health, then the doctor's behaviors influencing patient satisfaction are important.

Physician general communicator style and patient satisfaction. A number of studies (Arborelius & Bremberg, 1992; Bensing, 1991; Barlett et al., 1984; Buller & Buller, 1987; J. Burgoon, Pfau, Parrott, Birk, Coker, & M. Burgoon, 1987; Cardello, Ray, & Pettey, 1991; DiMatteo, 1979; Korsch, Gozzi, & Francis, 1968; Ong et al., 1995;; Steptoe, Sutcliffe, Allen, & Coombes, 1991; Street & Buller, 1987; Woolley et al., 1978) have unearthed support for a relationship between a doctor's friendliness and patient satisfaction with the visit. Affiliative style (e.g., communicator style showing a friendly, empathic, and supportive demeanor versus an authoritative manner) is important. Street and Buller (1987) found that doctors spoke much longer in turns than patients, doctors touched patients much more than the converse, doctors produced more vocal back-channeling (e.g., "Uh-huhs," "Okays," etc.) than patients, and doctors and patients

exhibited about the same number of gaze behaviors. Satisfaction was linked with the “control” behaviors such as length of speaking turn, touch, and back-channeling. Although Street and Buller (1987) hypothesized a negative relationship between perceptions of physician dominance and outcome satisfaction, the data did not support this.

Other studies have looked at a wider range of physician behaviors. For example, Barlett, Grayson, Barker, Levine, Golden, and Libber (1984) showed a correlation between general physician interpersonal skills including a broad range of characteristics such as politeness, minimal interruptions, explanations of treatment options, shows of empathy, respect toward the patient, and treating the patient as a person. Treating the patient like a person was the most common factor that emerged from a series of focus groups (Barnett, 1999). Patients emphasized an important goal was respect from the doctor. A doctor’s respect for the patient has been linked to higher patient satisfaction rating. Ben Sira (1976) noted that patients report higher levels of satisfaction when they are “treated as people.” Such was the case in the Bartlett et al. (1984) study in which patients wanted to be “treated with respect,” which was correlated highly with satisfaction. In addition to its relationship to satisfaction, general physician communicator style has been linked to coping style (Humphrey, Littlewood, & Kamps, 1992). Better coping skills are related to better health outcomes for both patients (Sobel, 1995) and for their caregivers (Hooker, Monahan, Shifren, & Hutchinson, 1992).

Verbal communication and patient satisfaction. Doyle and Ware (1977) expected that effective communication would promote positive affect, which would then lead to patient satisfaction. In their meta-analysis of 41 independent studies, Hall et al. (1988)

found that “social conversation” was linked to satisfaction. Also, Hall et al. (1988) found a strong relationship between “positive talk” and satisfaction. More social conversation, more positive talk, and less negative talk also were correlated with high patient satisfaction in Hall et al.’s (1988) meta-analysis. Furthermore, people are more satisfied with certain types of verbal communication. For example, the elderly favored a more direct verbal style from their physicians rather than role-playing (Vieder, Krafchick, Kovach, & Galluzzi, 2002). Interestingly, in a review of 14 verbal communication and 8 nonverbal communication studies, Beck, Daughtridge, and Sloan (2002) found that verbal behaviors such as empathy, reassurance, support, humor, positive reinforcement, and others were positively related to health outcomes. Finally, patient satisfaction with the doctor-patient interaction can be explained in part by just a few verbal communication variables. Rowland-Morin and Carroll (1990) discovered that the use of silence or latency time, language reciprocity, and reflexive interruptions explained 27 percent of the variance in patient-reported satisfaction.

Non-verbal communication behaviors and patient satisfaction. Nonverbal as well as verbal communication is essential to better understanding of the doctor-patient relationship. Some scholars agree that nonverbal communication accounts for far more meaning than words alone. In fact, nonverbal communication has been shown to greatly impact patient outcomes, chiefly satisfaction (Buller & Buller, 1987; Street & Buller, 1987; 1988; Street & Wiemann, 1987). Additionally, just as with the verbal communication studies and health outcomes, Beck and colleagues (2002) found that nonverbal communication behaviors, including head nodding, direct body orientation, mutual gaze, and unfolded arms and legs were positively related to health outcomes.

Additionally, Irish (1997) maintained that there is little research on how physician nonverbal communication functions in the older patient's interview. The review suggests that to date research indicates the importance of three outcomes important to older persons—which are satisfaction with care, quality of life, and health outcomes—but also explains the relationship of these outcomes to the physician's use of nonverbal cues has not been examined. The suggestion that health improvement could be an outcome of more attention to nonverbal communication in the physician-older patient interaction merits attention.

Overall, doctors tend to reciprocate patients' adjustments in response latency, pauses during speaking turns, body orientation, and interruptions as well as compensate for patients' turn lengths and gesture rates (Street & Buller, 1988). Some scholars have maintained that these reciprocal behaviors may be an extension of a doctor's sympathy, especially when a patient discloses symptoms. Another approach to physician caring posits that empathic doctors will sit on the edge of their chairs bent in the direction of the patient, nodding and contributing frequent "Mmm-hmm's" as encouragement for the patient to continue the "story." By contrast, empathy appears to be absent when doctors merely reciprocate the patient's body language and other nonverbal cues (pauses, response latency, interruptions, etc.). Patient response is not only reciprocated by doctors but also is affected by physician expressiveness. To illustrate, in an older study (Friedman, Prince, Riggio, & DiMatteo, 1980), physicians without nonverbal expressiveness did not have the proportion of satisfied patients that the expressive physicians reported.

Other variables found to influence patient satisfaction have included openness and warmth (Burgoon et al., 1987). Buller and Buller (1987) confirmed that a physician's affiliative style is related positively to satisfaction but that dominant styles related negatively to satisfaction. Additionally, in several studies of information delivery, a physician's nonverbal display of positivity and friendliness was shown to predict more positive patient-reported outcomes (Ben-Sira, 1976; Sharf, 1990). Moreover, Bensing (1991) noted that patients are sensitive to nonverbal "leaks" from the doctor. Moreover, Friedman and DiMatteo (1990) claimed that nonverbal communication is much more important than verbal communication; and detection of emotion, deception, and inaccuracies is dependent on good reception and interpretation of a patient's nonverbal behaviors. In fact, doctors appear to be more responsive to patients with varying levels of anxiety (Street & Buller, 1988).

While there seems to be no argument that nonverbal communication carries more weight than the words actually spoken, exactly how *much* emphasis should be placed on nonverbal meaning is subject for debate. To illustrate, Bensing (1991) found in his observation study that only 7% of emotion is communicated verbally; 22% relies on voice tone, and 55% is transmitted through eye gaze or contact, body positioning and other nonverbal cues. This is reflective of the familiar 1967 nonverbal study (Mehrabian & Ferris) that found that meaning is communicated verbally (7%), vocally (38%), and facially (55%). Some scholars have suggested that these numbers are inflated ⁴, saying the study lacks "external validity" (Burgoon, Buller, & Woodall, 1989; Lapakko, 1997). That is to say that while there is no denying the magnitude of

⁴ Mehrabian's data findings have been the subject of heated debate but have nonetheless caused individuals to focus on the impact of nonverbal communication and its meaning along with the meaning attributed to verbal communication (i.e., words).

nonverbal communication, perhaps the percentage of meaning found in words versus the other components of a message is higher than earlier reported. Researchers do agree that nonverbal communication is important in the doctor-patient interaction (Burgoon, Buller, & Woodall, 1989; Friedman & DiMatteo, 1990; Hall, 1984; Street & Buller, 1988).

Another way physician nonverbal communication affects patients is in their anxiety levels. While there is a dearth of information available on the effects, to date researchers have found that high anxiety patients have reported greater satisfaction with more involved, expressive and less dominant doctors. On the other hand, lower satisfaction was reported with less involved, less expressive, and dominant doctors than patients with lower levels of anxiety (Street & Wiemann, 1987). Additionally, Buller and Street (1991) found that doctors used less “task touch” with more anxious patients than with the less anxious patients.

One of the most powerful of doctor nonverbal communication behaviors is eye contact. Unfortunately, there is little known about the effects because patients’ perceptions of physicians’ eye gaze behaviors have not been widely studied. Of the few studies conducted, one details unexpected outcomes. Robinson (1998) audio taped and video taped 86 doctor-patient consultations from a British general practice health clinic. While previous research demonstrated patients perceived eye gaze away from them as a negative expectancy violation behavior, he found the opposite: patients understand and expect averted eye gaze during the interview, especially when consulting the patient’s chart. Robinson connected his findings to the satisfaction

literature by citing previous studies that indicate a negative relationship between doctor's (lack of) eye contact and satisfaction.

Compliance

Although satisfaction has already been discussed in the sections pertaining to physician communicator style as well as background/situation variables, this section focuses on the definition of patient satisfaction according to the literature and how this outcome is related to another outcome: patient compliance. The patient-centered approach to the doctor-patient interaction involves the patient taking responsibility for his or her own actions. This seems to be especially true with psychosocial issues. The research of Meeuwesen et al. (1991) revealed that physicians should view patients suffering from psychosocial complaints through a "patient-as-person approach" versus an "illness approach." This means that the communication does not revolve around the illness of the patient but is connected more to what can be done to help the patient recover. Although this approach to the interaction is newer and under-supported by research, Stewart's (1984) study of 140 physician-patient interactions using bi-variate analysis showed that the physician's patient-centered behavior was related to self-reported patient compliance and satisfaction, while overall patient behavior and compliance were not related. Some studies also have reflected positive outcome assessments based on patient-centered behaviors. For example, Bensing's (1991) study of 103 physician-patient consultations revealed a strong correlation between patient-rated positive assessment of the consultation and the physician's approach to the interaction as patient-centered.

The ironic dilemma facing researchers is the relationship between satisfaction and compliance. To illustrate, common sense would support the idea that the more satisfied patients are, the more likely they are to comply with doctor's orders. Earlier studies (Francis, Korsch, & Morris, 1969; Korsch et al., 1968) confirmed this hypothesis. However, today few studies support a direct or very strong link between these two variables (Burgoon, 1992; Lane, 1983; Speedling & Rose, 1985). In a meta-analysis of 41 studies, Hall et al. (1988) found only a minimal relationship between satisfaction and compliance. The only strong evidence of a statistically significant link between satisfaction and compliance is in a particular sector of the health community. Patient satisfaction in the dental office has been related to compliance with the dentist and with improved oral hygiene behavior, which ultimately leads to improved patient health (Zimmerman, 1988).

The concept of compliance has not been explained satisfactorily in one theoretical framework. Not complying with doctors' orders could indicate a way for patients to assert their independence and power (Rodin & Janis, 1979). Of course, non-compliance may have little to do with patient satisfaction. Donovan and Blake (1992), in a similar vein, argued that patients do not necessarily throw out the doctor's advice in some "irrational act of non-compliance." Rather, they argued, patients often weigh the costs and benefits of adherence to the instructions and make their compliance decision based on their perception of whether or not adherence is more beneficial, overall. Other feasible explanations for patient non-compliance revolving around time, energy, lack of resources, and absence of motivation have stemmed from the Health Belief Model (HBM) along with Fishbein's Theory of Reasoned Action and Ajzen's Theory of Planned

Behavior (Trafimow & Trafimow, 1998). As an illustration, research has shown that according to the HBM, family members can serve as either barriers to or facilitators of the patient's compliance status (Cameron, 1996; Shepard, 1975). Other factors such as divisions of labor or roles within the family structure can impact adherence, and even what "group" one belongs to (e.g., the elderly, the children, the independent adult, the disabled, the very sick person) can affect compliance levels (Aluf, 1989; Becker & Green, 1975).

One problem for researchers in understanding the compliance issue remains in not knowing and/or not understanding a patient's goals. The above examples and theories can be attributed to conscious awareness regarding compliance. That is, patients knew that they had not adhered to doctor's orders and yet knowingly excused or justified their behaviors. The opposite is unintentional non-compliance. Svarstad's (1976) study showed that patients often made errors in amount of medicine taken because they misunderstood the doctor or could not read the doctor's written instructions. Perhaps more salient, in a study done at an emergency department at a major hospital, 22% of the patients were there because of non-compliance with prescription medications; incredibly, the average costs for the non-compliance was \$576.61 per patient (Olshaker, et al., 1999). In total, about one third to one half of all patients are non-compliant with physician advice and/or medications (Donovan & Blake, 1992). This non-compliance is due in part to increased patient decision making and in part to too much information about times and dosages. In one study (Hanchak, Patel, Berlin, & Strom, 1996), researchers found that 77% of the participants misunderstood the doctor's instructions about frequency of medication dosage.

Another quandary in developing a theoretical model lies in conflicting definitions of the word “compliance.” For example, some research has shown about one third of patients are non-compliant with medical instructions (Davis, 1968), while other studies (Ley & Spelman, 1967) have indicated that about one half of all patients are non-compliant to some degree. Depending upon the definition of “compliance” put forth by the researchers at the onset of the study, not taking medicines at all, not taking medicines as directed (times per day), not exercising, not exercising as regularly as instructed, not making dietary changes, not making all recommended dietary changes, and so forth all constitute varying degrees of non-compliance, yet they are all lumped together in most studies.

Satisfaction and Patient Recovery

In cases of a serious illness, substance abuse, or emotional health issues, satisfaction could be vital to recovery. Bensing (1991) conducted a study with 12 general practitioners that included a total of 103 consultations with patients suffering from hypertension. Two groups were formed: Those rated “high” in psychosocial care and those rated “low” in psychosocial care. Bensing hypothesized that knowing the type of communication style of the physician as well as the nature of the overall communication between physician and patient would predict which group of patients ranked in the high category. Results of the study indicated a weak but statistically significant relationship between patient satisfaction and other variables including nonverbal attention, verbal empathy, and encouragement. Psychosocial care patients reported higher levels of overall satisfaction and in particular, satisfaction with the recovery process.

Although there is a plethora of prescriptive as well as theory-based studies focusing on prevention of illnesses and diseases, Waitzkin and Britt (1993) claimed that few studies actually looked at the dialogues between physicians and patients to see how talk about non-compliance and self-destructive behaviors actually develops. Waitzkin and Britt (1993) developed an interpretive method of analyzing the narratives they claimed were embedded within the socio-cultural context of medicine. They found that the discourse of health care reinforces the ideology of medicine such as “professional surveillance”—the physician policing the behaviors of his/her patients and individual control. The researchers concluded that changes in the health care discourse (doctor-patient communication) must be first changed in the social context of medicine.

Compliance and Behavior Change in Patients

Behavioral changes are likely to be made in the health care setting over other settings (e.g., home or the work place) because patients can develop a trustful relationship with the doctor and believe the doctor’s interest lies in helping them. It may be easier for a patient to hear from the doctor rather than friends or family that he needs to lose weight or that she needs to take insulin daily. Also, while many people may not wander into a weight loss center or diabetes support group, patients *do* see a doctor occasionally for illnesses or routine exams. That continuity in the healthcare relationship with the doctor may serve as an impetus for the patient to acquire the intervention needed for behavior change.

Some research indicates a chain reaction occurring as the doctor assumes the role of behavior change agent. First, the physician intervenes and tries to get the patient to give up negative behaviors and/or adopt positive acts. In doing, so the patient

will exhibit more compliance in changing behavior patterns. As the patient becomes more compliant, the patient's health will improve. An older smoking cessation study (Heszen-Klemens & Kapinska ,1984) was conducted to investigate the doctor's role as a change agent. The findings revealed that a doctor's emotional attitude toward the patient, the doctor's directness, and a patient's activity level (i.e., patient inclination towards exercise or taking medicines) influenced compliance. The literature suggests patient compliance is best achieved when physician advice or physician counseling is combined with other variables. For example, Hebert and colleagues (1992) set up a smoking cessation study with several experimental groups: those receiving physician advice only, those receiving "patient-centered counseling intervention," and those receiving the counseling intervention plus Nicorette® gum. The last category of patients had the highest rates of quitting smoking. Further, a meta-analysis of 39 controlled studies using multivariate analysis predicted and confirmed that the highest level of patient compliance would come from intervention strategies that included physicians along with non-physicians employing multiple intervention modalities and delivering individualized advice (Kottke, Battista, DeFriese, & Brekke, 1988). Other research supports higher levels of patient behavior change when there is a combination of physician advice along with the patient's self-motivation to achieve better health. Janz, Becker, Kirscht, Eraker, Billi, & Woolliscroft (1987) confirmed that physician advice along with patient reading of a clinic distributed self-help manual was the most effective means of compliant patient behavior change. While not always clearly defined or included in study design, patient motivation (e.g., perception of self-efficacy and

success in behavior change) should be conceptualized as a variable in behavior change.

Summary of Part II

Part II reviewed the recent literature on background variables found to impact the doctor-patient interaction. These background variables include gender, age, education level, culture, and context of the visit. Additionally, process variables, or factors that can arise within the communication context such as communicator style, information exchange, and trust were reviewed and found to significantly impact the doctor-patient interaction. Both background and process variables influenced outcome variables such as satisfaction, compliance, and behavior change. In particular, physician nonverbal communication along with positive talk and direct information giving were shown to strongly influence patient satisfaction in older people, which in turn, was linked to improved health outcomes in the elderly.

Unfortunately, the outcomes to date on patient compliance are uncertain. What is known is that when patients do not adhere to physician advice (and thereby prolong poor health), doctors become increasingly frustrated. Even if patients are satisfied with the doctor's communication skills, the literature reveals that patient satisfaction is not a strong predictor of compliant behavior. There has not been a study to date that has satisfactorily explained patient non-compliance.

Part III: Communication Competence

One area of extreme importance in human communication studies is the level of communication competence exhibited by the participants. The sophistication of strategies used in interactions reveals pertinent information about the communicators.

Identifying the degree of competence in communication of those being studied moreover can indicate specific strategies, which in turn, can reveal goals of the individuals. Understanding communication competence in the doctor-patient interaction and the variables involved illuminates the study of physician and patient goals.

Considerable research in the last several decades has focused on communication competence in interpersonal relationships. Regrettably, the competence literature has not targeted physician-patient relationships but interpersonal relationships in general, including romantic associations and friendships. What follows are a review of the competence literature and then a review of the few studies on doctor-patient competence.

Introduction: A Brief History

The study of competent human behavior and normalcy in some form has intrigued people throughout time. According to Wine (1981), there were three early models used to help explain personal actions. During the Dark Ages, the demonological model was used in an attempt to explain unusual behaviors or a declaration of heretical beliefs. The name, indicative of possession by demons, was a widely held belief during the Spanish Inquisition and therefore the “abnormal” behaviors of anyone disagreeing with church doctrine were explainable by this model. Centuries later, the demonological model was replaced by the medical model. This model attempted to address both physical and mental aspects of a person’s health. Therefore, anomalies in human behavior could be attributed to something faulty in the body itself (i.e., poisonous substances or genetic defects) or something actually wrong in the mind itself. This model was prominent until the 1950s. Finally, this model was modified by

the teachings of Freud and other psychoanalysts from the late nineteenth century to the first part of the twentieth century. A mental health model, or what has come to be known as “social competence” model, was born.

Social competence, however, is not the only term used to designate one has a handle on psychological/social skills. Spitzberg and Cupach (1984) list “psychosocial competence,” “communicative competence,” “conversational competence,” “social skills,” and “interactional competence,” to name a few. Spitzberg and Cupach (1989) additionally named and discussed interpersonal competence in relation to “communication competence, linguistic competence, social competence, social skills, heterosocial skills, interpersonal skills, assertiveness, maturity, psychosocial adjustment, mental health, executive competence, referential competence, organizational competence, efficacy motivation, rhetorical competence, marital competence, infant competence, and autonomy” (p. 76).

Competence

Communication competence is an essential part of human relationships. To understand how communication competence is operationalized, it is necessary to differentiate among a few of the “competences.” As Spitzberg and Cupach (1984) suggested, communication competence is the real measure of a quality relationship; a display of competence is essential in achieving interpersonal objectives. They defined communication competence as the ability to enact certain roles as dictated by society and to possess particular socially acceptable skills. They also suggested communication competence is narrower in focus in a communication situation; that is, communication competence should be used to refer to exchanging appropriate

messages within the distinct interaction context. “Interpersonal competence” then might be more suitable for specifying task accomplishment and achievement of instrumental goals. Spitzberg and Cupach (1984) further maintained that identity management, empathy, and role taking, all constructs of strategic communication, are indispensable skills in interpersonal competence.

Another distinct competence type is linguistic, or grammatical competence. Chomsky championed the notion of grammatical knowledge (i.e., language and sentence structure) facilitating usage, thus indicating competence. As Spitzberg and Cupach (1984) explained, linguistic and communication competence are both message-focused, not outcome-focused. To clarify, these two forms are concerned with how people actually interact with one another and use strategies, roles, the situation, and of course, actual wording. Interpersonal competence, however, is outcome-focused. In the definition used in the preceding paragraph, interpersonal competence is rooted in accomplishing tasks and other goals, particularly instrumental goals. The measure of interpersonal competence hinges upon “products” resulting from the interaction. One of the most common of these products or outcomes is satisfaction.

Relational Competence

Understanding relational competence can help illuminate provide insight into doctor-patient communication. Relational competence is based on the process itself like linguistic and communication competence as well as on outcomes (i.e., interpersonal competence) such as satisfaction or dissatisfaction, further intent to interact or not interact, and ability to engage in high-level decision-making. Perhaps the most important tenet of competence is that all normative judgments are to be

suspended when judging relational competence. Perception of competence by the interactants is the essential key in determination of competency (Spitzberg & Cupach, 1984).

It seems highly reasonable that relational competence above all other competence terms listed above would be of utmost significance in the therapist-patient relationship considering that the talk between therapist and patient is what mediates the patient's emotional/mental health issues (Spitzberg & Cupach, 1989). Likewise, communication competence should be critical to the nature of the relationship between the general practice physician and the patient when taking into account that without competent communication, a patient's health outcomes may suffer. If a patient does not sufficiently communicate symptoms to the doctor, a misdiagnosis could result, and improper treatment could delay proper prognosis of the real problem and, of course, proper treatment.

If a patient does not understand the physician's instructions regarding medication, or if the doctor does not provide adequate information regarding patient's self-care, the patient likely will have less than satisfactory health outcomes. Scofield and Yoxheimer (1983) among others have investigated components of medical competence; however, after an exhaustive search in communication, medical, psychological, and sociological journals, this author can find little experimentation in interpersonal or relational competence and clinical outcomes. While research still has not successfully linked patient outcomes to interpersonal or relational competence, there are attributes of competence that should be noted. The next section describes attributes of relational competence.

Attributes of Relational Competence

In defining relational competence, Spitzberg (1993) discussed dialectic pairs that aid in characterizing what is known about competence with respect toward motivation, including the two common pairs: appropriateness vs. effectiveness and politeness vs. assertiveness.

Appropriateness vs. effectiveness. Appropriateness is used to signify adherence to socially established rules. Effectiveness, on the other hand, refers to goal accomplishment and some degree of outcome reward. As will be shown through the following examples, these two concepts may be in conflict with one another. Since both appropriateness and effectiveness are the two main components of relational competence, each will be discussed in terms of assessing degree of competency.

Effectiveness requires less in-depth explanation and examples because it seems to be more understandable. Put simply, effectiveness with regard to relational communication competence means goal accomplishment. A high level of effectiveness shows that the communicator has realized desirable outcomes. According to Clark and Delia (1979), these goals fall into three basic categories: instrumental, relational, and self-presentation. Instrumental goals point to resource acquisition. These goals can be to obtain basic needs such as food, water, shelter, and safety; or they can fall under “wants” such as abundance of wealth or the realization of life dreams. In the context of a staff meeting, the chair’s communication can be deemed effective if she covers everything on her agenda and all issues are resolved.

Another category of goals, relational, refers to goals that an interactant has for a certain relationship. To illustrate, let us say that Individual A yearns for an increase in

intimacy in his relationship with Individual B. Individual A might invite B over for dinner and a movie. During the movie, A might put his arm around B, and perhaps following that, other outward behaviors may indicate an ensuing increase in intimacy. Individual A has been effective in his attempt to increase intimacy in his relationship. Finally, self-presentation is an additional goal category. Most of the time, people try to portray an image that is likeable, ethical, and mentally astute. For example, when getting to know someone, it is common to compliment others and display positivity in an effort to present oneself as likeable.

All three types are present in any type of interpersonal communication situation; within each type, there can be several goals. For example, at a staff meeting a department chair may have the instrumental goal to review the university policy about long distance telephone call abuses. But another instrumental goal might be to get input about a proposed change in graduate admission policy. Sometimes these goals can conflict with relational or even self-presentation goals. A department chair may have the instrumental goal of addressing telephone abuse. However, she may also be embarrassed to attend to a seemingly trivial topic whenever there are other issues such as probationary faculty review. Her self-presentation goal of not being perceived as fastidious and hard to please may conflict with the instrumental goal of trying to please her dean, who has insisted she discuss this issue.

Appropriateness is tied to social rules and norms and assumes accessibility to knowledge concerning them and how they function in particular contexts. Rules are usually written out in texts, such as law books, school and university handbooks, workplace policy and procedure manuals, and operating instructions, to name a few

examples. Some rules are even stationed as readable signs. For example, sometimes the wording “No Smoking” will be written on the glass door of a restaurant. Some rules, however, are implicit and not written out anywhere; they are generally accepted as the guidelines to acceptable behavior within a particular setting. Most people refer to these as norms. Examples of norms may include not interrupting others until there is a natural pause in the flow of conversation or not to begin eating in a restaurant until everyone at the table has been served.

People can expect to incur retribution in the way of warnings, threats, and even punishment if they are caught breaking rules. That is, if an individual is stopped for speeding by a police officer, the chances are good that the person will receive a warning or greater punishment. People should also anticipate being reproached if social norms are violated. That is, if someone continuously interrupts her friends when socializing, she may not be invited to hang out in the future. Or if someone constantly cuts up in study group, he may find himself without study partners (and tutors) before the next test.

Because appropriateness hinges on following rules and norms in a given situation, competency level must be judged according to consideration of those rules and norms. And these norms help people determine what behaviors are obligated by social situations, what behaviors are preferred over others within a particular social situation, and which behaviors are strictly prohibited in specific social situations (Shimanoff, 1980). Competency is increased when high levels of both effectiveness and appropriateness are displayed, and people generally are satisfied with the communication interaction when there is mutual communication competence. When

there is a low level of communication competence in a specific situation, the potential for conflict is great.

Competence and Conflict

Sometimes conflict causes us to step outside our social rules. An individual could be effective in pursuing goals but be communicatively incompetent because appropriateness is low. For example, if someone becomes so angry that he yells at his relational partner in a restaurant, his primary goal may be to win the argument. Therefore, he may be effective in stating his agenda. The communication would be effective but inappropriate (e.g., yelling in most public places is socially unacceptable).

Another possibility is that our goals might conflict with others' goals. If both communicators' opposing goals are pursued (i.e., Person A wants to get Person B to go to a concert and Person B wants to watch "Big Brother"), the pursuit results in consequences in which at least one person will not have goal accomplishment (Person B goes to the concert and forgoes watching "Big Brother").

Another form of conflict, internal conflict, can occur if the person's goals are not conducive to the social context. For example, say Person A wants to reveal his feelings for Person B. This desire is a goal, and the level of effectiveness is determined by whether and to what extent A reaches his goal. If A does indeed tell B how he feels and B understands, A is perceived as an effective communicator. If, however, A tells B how he feels during the same conversation in which B is crying because her beloved poodle has just died, A is displaying inappropriate behavior. Thus, competence is low. On the other hand, A could have tried to tell B during a romantic dinner celebrating their 1-year dating anniversary that their love was very special and that he wanted to marry her. If

B continued to eat her meal and comment on the strange weather they were having, A's communication was obviously appropriate but ineffective. Competence is low again. Only if both appropriateness and effectiveness are realized together in the same context is A considered communicatively competent and without internal conflict.

Politeness vs. Assertiveness. This dialectic component of competence comes from the notion of exhibiting politeness and courteousness to the other individual and at the same time balancing assertiveness about the messages communicated. In short, this dialectic pair is the crux of Brown and Levinson's (1987) politeness theory, which asserts that most individuals do not pursue their instrumental or relational goals aggressively, especially in an attacking manner. The perspective of the individual analyzing the communication is of utmost importance. While outside viewers may see aggressive behaviors as a means to an end and therefore competent, relational partners may not share this belief (Lowe & Storm, 1986). Especially in a relationship where communication is valued (e.g., high levels of both effectiveness and appropriateness), aggressive behaviors would likely be viewed as negative and as a display of incompetence.

Neither displays of aggressiveness nor politeness need to be genuine. That is, politeness could involve some level of deception (Spitzberg, 1993). For example, telling a partner that her new hair cut looks good (politeness) might not actually convey how one feels. Was communication competence achieved? Arguably, the appropriateness of such a remark, particularly if the other partner asked if her hairstyle looked good, was high. The remark may also be effective in allowing the partner to feel good about her hairstyle choice. If the remark were both appropriate and effective, then it would seem

that communicator competence was achieved. However, the deception used in order to be communicatively competent must be noted. Some scholars might argue (Spitzberg, 1993; Spitzberg & Cupach, 1989) that the deception used detracts from the maximum level achievable in communication competence.

Evaluating communication competence becomes even more complex when motivation and intention are considered. Some behaviors indicative of communication incompetence are intentional; for example, some people intentionally are impolite. If the intention of the communicator is to be rude to someone else, then is competence achieved by a display of “non-appropriate” behavior? Of course, the behavior may have been inappropriate but perhaps effective if the goal was to prevent future contact with the other person. When mediating variables other than intention are considered such as gender, ethnicity, and societal norms, true levels of competence become harder to discern (Spitzberg, 1993).

Communication competence in addition to medical capability is an essential part of our doctor-patient relationships. A relationship can be enhanced through a better understanding of what being communicatively competent means and what variables affect competence. Being more communicatively competent for the physician can mean knowing when to let the patient talk and when to ask more closed questions in the diagnosis. For the patient, a higher level of competence can translate into a better and faster diagnosis. Much is at stake in the doctor-patient interaction; improved communication competence for both parties can only be a win-win situation.

Summary of Part III

The review of literature in Part Three explored communication competence. Specifically in the doctor-patient relationship, communication competence affects outcomes such as patient satisfaction and compliance. More importantly, miscommunication could lead to a misdiagnosis and wrong or delayed treatment.

Part Four: Coding Schemata

It is important to understand the history of coding schemas as they relate to doctor-patient studies since this study's plan was to use a grounded theory, rather than a priori coding schema, to analyze the data. Additionally, this section was written at the insistence of a former committee member who felt it imperative to justify a grounded theory approach.

While a plethora of communication coding schemas can be found in the literature, few coding systems were designed for specific analysis of the doctor-patient relationship. Of those few, the most widely used in studies include the verbal response mode (VRM) (Shaikh, Lynne, & Stiles, 2001) and the Roter interaction analysis system (RIAS) (Roter & Larson, 2002) as well as other "un-named" coding methods (Sala, Krupat, & Roter, 2002). Robinson (1999) pointed out four criticisms of coding schemata found in the doctor-patient literature.

First, coding schemata do not capture the contextual or related-sequential elements but only the action itself. This is problematic because often actions and responses are related to the context surrounding them and/or related to prior or future responses/actions. Additionally, until recently, most doctor-patient studies relied on audio tapes of the interaction. While information was useful in conceptualizing theories

to test in the interaction, nonverbal communication was omitted. For example, on audio tape there may be long silences/pauses between a patient's question and the doctor's answer. A plausible explanation is that the doctor is ignoring the patient or at least thinking about the patient's problems and therefore not answering immediately. However, video tapes have revealed that the doctor often receives more questions while sitting at the desk writing than during the examination period. For example, the doctor may prefer to write down all important notes first, even sacrificing answering the patient right away, to ensure that s/he has not missed anything in writing.

A second aspect refers to how the coding schemas are divided into turns. Some schemas consider a whole sentence as one unit; others break it into one turn-constructive unit (TCU) by idea. However, sometimes a response or question is only one word (e.g., a patient's "yes" or "no" response); other times it is built on related phrases following the initial answer. There is no set formula; however, coding schemas force the breaking up of conversation in that way. Robinson (1999) pointed out that Waitzkin and Stoeckle's 1976 study coded patient questions as turns only if they included a "who," "what," "when," "where," "why," or "how" word; and Putnam, Wolf and James' (1979) study coded patient turns as disclosure only if they included the personal pronoun, "I." Strict adherence to rules leaves out a chunk of material that could be classified under these categories. The method of a content analysis demands coding in this fashion. Running categories through a computer program to check for frequency of use must be uniform. However, if a person asks a question by raised intonation at the end of what a declarative sentence is grammatically, this sentence would not be included. For example, the patient may ask, "My ears look OK." Perhaps the

transcriptionist included a question mark after “OK.” Perhaps s/he did not. For the Putnam et al. (1979) study, it would not have mattered. However, listening to the raised “OK” at the end of the sentence as well as situating the patient’s sentence within the context would indicate that s/he is actually asking a question.

The number of categories within coding schemata constitutes a second criticism (Robinson, 1999). To illustrate, Bales (1950) worked with Parsons in developing the IPA (Interaction Process Assessment) scale, which had 12 categories for social action. This type of coding limits researchers to only 12 different types of actions, thereby, prohibiting the discovery of additional types of action. In response to that early thinking, some researchers created numerous categories for their studies. However, this creates a statistical problem because if there is/are 0 or only 1 (or with some statistical procedures, few) codes in a particular category, it is tough to run analyses and make general claims because of low numbers within an individual cell. On the other hand, whenever a researcher collapses some similar categories into one category in order to run a statistical function, there is the loss of some unique characteristics. Also, if the researcher left a large number of categories, it is possible and often probable that a social action may fit into several different categories. If the researcher’s goal is to determine the category for the behavioral response, too many categories can present difficulties.

Third, when applying coding schemas to interview data, one is using a deductive approach because the guidelines are already there. Also, one is looking for specifics (according to whatever coding schema one is viewing) and therefore missing some of the talk. In qualitative research, one method to use is grounded theory. A priori

knowledge about specific categories is not preferable. Rather, a continual comparison of one transcript to another or sections of transcripts with other transcript sections allows categories to emerge. It would seem that this method would be invaluable if the goal of the research is to analyze the data itself and let the data generate a coding schema rather than applying an established coding system that may or may not fit the data.

A fourth criticism involves the idea that one coding category represents a single meaning/action. However, research shows that when people communicate, often within a turn or sentence, several meanings may be conveyed. Baxter and Montgomery (1996) gave several examples, including an “over-compensatory fit.” To illustrate, a wife comments, “I am going to be late getting home from work on Friday,” to which the husband responds, “I can’t make dinner Friday because I already promised Fred and the boys I’d have a drink or two with them at happy hour.” On one level, the wife may just be making descriptive disclosure; on the other level, the wife could be hinting that the husband should plan to make the dinner. The husband’s response may be uni-level; maybe he is interpreting the wife’s statement to contain the deeper level meaning and wants her know that he is unable to prepare dinner. Or, the husband may not wish to make dinner because lately her nagging about him not doing anything around the house is driving him crazy; therefore, his response is a reason for not participating in household chores (because meeting his friends for happy hour is not a necessity).

Fifth, Robinson (1999) cited Stiles (1989) in disputing the correlation coefficient being utilized in measuring the impact of social actions’ effect with process variables (i.e. communicator style, information-giving, doctor’s use of technical wording) on

outcome variables (i.e. satisfaction and behavior change). For example, two patients could visit a doctor for the same illnesses. However, both patients might not require the same level of information or even affection/attention. Robinson (1999) argued that while one patient might respond positively to a huge amount of information by the doctor, another patient might respond neutrally, and yet another patient might even respond negatively. The doctor's communication may not have varied at all from one patient to the next; however, each patient's psychosocial health may have triggered the variation in patient responses. Already established coding schema cannot account for variations dependent on contextual elements.

Conclusion

With all the research on background, process, and outcome variables along with communication competence influencing doctor-patient relationships, research still has not offered much in terms of how communication between doctor and patient is operationalized. Factors can be identified that produce certain outcomes, but how these outcomes are communicated and how doctors and patients communicate about the outcomes is relatively new territory. While more recent research has probed into doctor and patient expectations (Cameron, et al., 2000), nothing has been developed regarding patient goals and how patients and doctors both communicate about these goals. Yet these goals seem necessary for better understanding of the communication process. Understanding the variables which effect the communication process such as the background variables and even the process variables, can definitely impact the outcomes for both doctor and especially patient. Since this has been shown to be true, it follows that understanding the goals of each interactant can aid in understanding

where and why there are miscommunications. Additionally, one problem for researchers in understanding the compliance issue remains in not knowing and/or not understanding a patient's goals. Both intentional non-compliance (decisions for time, lack of energy, family concerns) as well as unintentional non-compliance (misunderstanding doctor instructions) could be better understood and receive more attention by doctors if patient and doctor goals were clearer. Therefore, the first two research questions are asked,

RQ1: What are patient goals for the health visit?

RQ2: How do patients and doctors communicate about patient goals for the health visit?

Knowing and understanding communication variables such as how process variables (i.e., levels of trust and empathy) and communication competence are developed and utilized in the doctor-patient interaction can be enhanced through learning about patient and doctor goals and the strategies used by both participants in the health visit. Since it is unknown what strategies patients and doctors use to uncover and try to accomplish patient goals, the third and final research question is presented,

RQ3: What communication strategies do patients and doctors utilize in order to uncover and attempt to accomplish patient goals?

Chapter Three: A Grounded Theory Methodology

Introduction

A grounded theory approach was selected as the overarching perspective from which the overall research plan was developed. As noted in Chapter 2, physician-patient communication is a relatively understudied area without an organizing theoretical framework to guide future work. The grounded theory approach allows the framework to emerge from the data. While related theories could have been used, they have not as yet been successfully applied to this subject area and thus it was determined to take a broader-based approach. For example, the goals framework described in Chapter 2 (need cite) has been used to study communication interactions such as prosecutor-defense witness discourse (Pomerantz, 1994) and in relational partner communication (Tracy & Coupland, 1994) but has not been used in physician-patient discourse analyses. So goals, which appear to be central to understanding physician-patient interaction, will be used as a “sensitizing construct” in a grounded approach.

This approach to analysis was chosen because little is known about goal accomplishment, change, or abandonment in the doctor-patient interaction. While there have been recent studies with an emphasis on understanding goals as a means to effective message interpretation, none of the contexts studied has been the general practice physician-patient interaction. The main purpose of this study was to look at discourse as a means of accomplishing or transforming goals, and the research focused on how this process occurs, how the doctor functions in relation to patient goal-seeking attempts, and how patients try to negotiate their own goals. Because of the

discrepancies in goal schemas (See Chapter 1) and because physician-patient communication is uncharted territory for goal understanding, grounded theory was preferred as the best methodological selection.

Theory vs. practicality. Grounded theory dictates that the researcher “enter the field with complete openness” (Glaser, 1978, p. 44). This means that researchers remain aware of their own biases and work to keep them in check, while attempting the broadest possible description of events. In fact, being open to this degree, according to Glaser (1978), has advantages, including being more sensitive and receptive to emergent ideas than those who go into the field with pre-set ideas and perspectives along with having “less ideational baggage to give up or correct” (p. 44). It is never possible to enter the research field with total openness, and in this study there were factors which further limited this approach. These unforeseeable constraints included very rigorous Institutional Review Board (IRB) guidelines; adherence to the requirements of three different IRBs; and many differing ideologies among the principal investigators, dissertation committee members, and members of various IRBs. To illustrate, one IRB alone required a prospectus with detailed methodology and a complete listing of references for the literature review, which typically is not even finished in a qualitative study until *after* the analyses are completed.

In order to satisfy the requirements of the three IRBs as well as committee members and the doctors providing entry into the field of study, it was necessary to remain focused on the main goals for the study: Collecting the data in a two-three month time frame, protecting human subjects’ rights, and maintaining a good working relationship with dissertation committee members as well as the doctors and nurses

recruited to help with the study. To give just one example, an ex-committee member whose method of data analysis is solely qualitative had insisted on distribution of a Likert-scaled survey instrument, which he designed, to all the patients agreeing to participate in the study. The problem was that the instrument was not based on any other previously tested instrument. The doctor who gave this researcher entry into the “field,” or clinic, was dissatisfied with the survey because of its lack of validity. Additionally, the medical doctor became increasingly displeased with other changes made by the one university IRB to the study proposal approved by the IRB at the other major university and indicated at one point that these changes would make it impossible to conduct the study at the clinic where she practiced. Because she was integral to the data collection, this author relayed this information to the IRB at the first major university. She convinced the members of this IRB to forgo some of their modifications since the other university IRB had approved the same study proposal that IRB at the first university wanted to amend for the third time. Moreover, this researcher additionally persuaded the ex-committee member (who at the time of data collection then served as a regular member of the dissertation committee) to drop the requirement for the quantitative survey.

Another shortcoming in writing Chapter 2 was doing so before collecting the data. This route caused some loss of “theoretical sensitivity” as Glaser (1978) wrote. To example, Chapter Two, the review of the literature, needed to be written fully in good draft form to be submitted as part of the proposal to satisfy the clinic’s IRB as well as the Texas state university IRB *before* the data collection could begin. Nonetheless, as much as possible, immersion into the goals literature, the presumed framework for the

analysis, was avoided. The purpose of this chapter is to inform the reader of the process whereby the author set out to begin theoretical development. That is, this chapter provides a brief overview of the inception of a grounded theory concept, the purpose of grounded theory, a condensed overview of some important concepts in grounded theory, and an explanation of how grounded theory is used. Very importantly, this chapter in no way is intended to serve as a summary of a grounded theory perspective but as a roadmap so that the reader can more easily conceptualize the analysis, results, and discussion which follow this chapter.

A Grounded Theory Approach

With the publication of *The Discovery of Grounded Theory: Strategies for Qualitative Research*, by Barney Glaser and Anselm Strauss (1967), both qualitative and quantitative approaches to data analysis had a new and exciting direction. That direction was an innovative way to accomplish theory generation.

History of Grounded Theory

Glaser and Strauss (1967) noted that one purpose for their ground-breaking book was to provide a rationale for an alternate approach to theory development that is grounded in data. Functionalists such as Parsons and Merton used a deductive approach; they did not give as much credit to theories that literally emerged from the data of a research study. Therefore, a book detailing how to proceed with inductive theory generation grounded in the data was necessary. This book influenced the social sciences in such a way that today, a grounded theory approach is perhaps the most widely used methodological design in qualitative research.

Another reason Glaser and Strauss helped to develop a grounded theory perspective was due to general biases against qualitative research. The book helped legitimize current qualitative work of the day and provided a model and justification for future endeavors such as this one. In the 1960s there were sociologists who believed that qualitative research could not adequately be verified and, therefore, was not as important as quantitative research. Glaser and Strauss (1967) wrote that the book “should help students to defend themselves against verifiers who would teach them to deny the validity of their own scientific intelligence” (p. 7). In fact, a third purpose was not only to legitimize qualitative research in general but to show the merits of a grounded theory approach. They wrote, “One canon for judging the usefulness of a theory is how it was generated—and we suggest that it is likely to be a better theory to the degree that it has been inductively developed from social research” (Glaser & Strauss, 1967, p. 6).

Theory generation involves a lengthy, rigorous process. A data set is read, coded, analyzed, re-coded and reduced in order to arrive at the answers to the research questions. If the grounded theory method is employed throughout all stages of analyses, then a grounded theoretical model is created. Hypotheses or an actual theory are products of this model construction. Glaser and Strauss (1967) promoted the inductive model in which theory is used to generate testable hypotheses. It is clear from their writings that Glaser and Strauss believed there was just as much merit in a theory derived from the data as compared with a theory driving the data. While others may debate the strengths and weaknesses of both, it is not the purpose of this project to argue that one viewpoint is better. The questions that the researcher asked before the

study began and throughout the data collection and analyses seemed to be best answered through qualitative means.

Purpose of Grounded Theory

The main purpose in using a grounded theory methodology in data analysis is theory generation. Similar to the scientific method, the first step is observation, followed by asking research questions or formulating hypotheses, and finally, sifting through data in order to answer the questions and thus organize the findings into a theory. One important distinction, though, between a grounded theory approach and the traditional scientific method lies in the process of verification. In the scientific method, the outcome of a study is to confirm or reject a hypothesis. In a grounded theory approach, hypotheses “emerge” as one is saturated in the data. As one continues to compare new data with data already collected and coded (in short, the “constant comparison” approach), hypotheses are either verified or supported as part of the *process* of analysis rather than as an *outcome* of the analysis. In other words, research questions and hypotheses are developed and answered /supported or not supported along the way as one “wades through the data.” This process is anything but linear. More on the analyses used in this project is explained in this chapter’s subsection entitled “Utilization of Grounded Theory.”

Grounded Theory Concepts

As mentioned above, a grounded theory approach assumes an inductive perspective to data analysis. This means a researcher does not start with an a priori coding or category schema that s/he intends to use in data analysis. The first step includes formulation of research questions followed by development of categories that

hopefully will help to answer the questions. By approaching the data in this fashion, one does not need to worry about supporting a hypothesis. Strauss and Corbin (1990; 1998) explained that the negative case, an exemplar that does not conform to previous coding, actually can be good because it can be very instrumental in explaining anomalies.

Openness is encouraged in the inductive approach. Openness implies that the researcher considers or inspects whatever emerges as salient in the data. Of course, the key is recognizing what is salient; but in inductive research, this process is part of the analytic task rather than part of the research design. The rationale is to allow the data to direct the analyses. For example, a researcher who predetermines through hypotheses that gender is an influencing factor in power dynamics goes into the study with that mindset and will look primarily at gender and power. A researcher with a deductive approach enters the field asking, "What are the underlying dynamics in this situation?" If power and gender emerge as salient, the researcher can ask about the underlying dynamics of the relationship along with consideration of context.

Another important concept in a grounded theory approach is theoretical, or purposive, sampling. While quantitative researchers typically use random sampling, qualitative researchers often employ theoretical sampling, which targets particular individuals in environments where the phenomena being studied are most likely to occur (Glaser & Strauss, 1967). This enables the researcher to understand more about the process. Denzin and Lincoln (1998) add that a focus on the negative case is key, aiding in understanding the circumstances in which *X* occurs. Thus, specific populations where the process or phenomena occur *must* be studied. Concomitantly, the purpose

of this method is to discover categories and properties and to find relationship patterns which can be used to formulate or build theory. Glaser (1978) indicated that theoretical sampling could be used as a way of checking on the emerging conceptual framework rather than for verification of pre-set hypotheses.

Grounded theory also dictates that there are patterns of action and interaction between and among the data. What this means is that in discovering the process, not just in stages and phases but within the whole process, a researcher must look for reciprocal changes in patterns and relationships with regard to changes of condition, whether external or internal to the process. Changes in conditions are not controlled for but targeted; this is a huge difference between quantitative and qualitative results. However, conditions must be explained via the emerging patterns, and the patterns must be able to be traced back to the data.

Finally, Glaser and Strauss (1967) said that a grounded theory must meet the criteria of “fit” and “relevance.” “Fit” means that a theory grounded in data must apply to the data set used. That is, the theory must be able to explain what happened, predict what will happen, and interpret what is happening. “Relevance” is a term that has been used by other grounded theorists (Eisenhardt, 1989; Miles & Huberman, 1984) to indicate that the theory has credibility. Unlike quantitative researchers who can boast validity and reliability, qualitative researchers must show how the theory and analyses were derived from the data and how the analyses answer the research questions. This ensures trustworthiness (Miles & Huberman, 1984). For example, let us say that a researcher has listed some categories and properties of the categories as s/he is becoming immersed in the data, and then stumbles upon some text that “almost” (but

not quite) fits into one of the categories s/he has created. Not all the properties that s/he has listed are appropriate for the newly coded text. It is imperative that the researcher not try to force the data into the category by allowing a code to be represented by properties, some of which do not depict the actions/behaviors of the text. The researcher should either make a new category for the code or revise properties of the older category to include the new code without dismissing older codes.

Utilization of Grounded Theory

As Glaser (1978) wrote, theoretical sensitivity is the idea that one enters the field with as few predetermined ideas as possible. This way the analyst is able to remain “sensitive” to the data without existing hypotheses and biases to distract. In addition, Glaser (1978) wrote that one should not, on the other hand, go into the field “blind.” In other words, researchers should be steeped in the literature of the field if possible in order to be familiarized with the variables to be used in the study. However, while being knowledgeable is important, the researcher should not be so entrenched in a predetermined position that s/he already knows for what s/he is searching. Glaser gave the example of being sensitive to issues of gender, class, race, or power. If a researcher is preoccupied with these issues, s/he will “look” for them in the data. That is not truly a grounded theory approach. While qualitative researchers cannot separate themselves from their data, they should not let their biases determine their findings. For example, this particular researcher became involved in doctor-patient research because her own mother has had a history of health issues including over a dozen surgeries. Because some of the doctor visits included positive communication and others led the mother to tears of frustration and feeling belittled, this researcher decided to investigate

doctor-patient communication in order to try to understand some of the primary communication problems. It would be easier for the researcher to transcribe the doctor-patient conversations and adopt the stance that when miscommunication occurs, the problems often are due to doctors talking over the patients' understanding level and/or exhibiting condescending manners. However, that would not be fair to the study and this researcher needs to be open to miscommunication issues on the patient side as well. Therefore, the onus is on the researcher to ask *good* research questions and let the data speak to them in finding answers to the questions.

A researcher embarking on a grounded theory approach cannot help but use the idea of constant comparison (Glaser & Strauss, 1967). Constant comparison involves coding the data. What is currently being coded (and how and with what codes) is continually put side by side what has already been coded. As this is accomplished, lists of categories and their properties are compiled. New text is then checked for properties to see if the properties fit into a previous category. Assignment may result in redefining the category. If the text does not fit into any of the existing categories, a new code is assigned; and its properties are listed. In other words, this process is not a linear design but a cyclic process. This process is continued until no new concepts/codes are found. When one reaches the point of finding nothing new, we say that the researcher has "reached saturation." That is, a researcher could go through any number of additional transcripts or open-ended questions, but the continued process at this point will add little if anything to the categories and properties listed.

Specific coding techniques used in employing grounded theory to this project can be found in Chapters 5 and 6⁵.

⁵ It might seem prudent to include a brief discussion of the coding approach here. However, at the beginning of Chapter 5, the reader will note that several different coding schemata were developed in the course of the analyses and that there was a complete shift in focus from the original research questions to the new research questions which emerged from employing the grounded theory methodology.

Chapter Four: Collecting the Data

Introduction

The field of Communication has been criticized for its atheoretical perspectives (Berger, 1997; Berger & Bell, 1988), and this criticism extends to physician-patient communication (Epstein, Campbell, Cohen-Cole, McWhinney, & Smilkstein, 1993; Street, 1992). Most theories guiding research in Communication Studies originated in other disciplines including psychology, sociology, anthropology, ethnographic studies, and even history and political science (Berger, 1997). If Communication is to be taken seriously as an independently recognized field with its own theories and conceptual views distinguishing it from other fields of study, some changes need to be made. Rather than being the pill all other disciplines swallow, dissolve, and digest, serious contributions need to emerge as well from *within* our discipline, working their way outward to other areas of study instead of continually being on the receiving end from other disciplines. One way for Communication Studies as a discipline to develop its own theoretical framework is to ground its theories in descriptions of communicative processes. Therefore, one way to develop or add to existing theory is to approach a study inductively through a grounded theory approach.

The nature of the current study is, in fact, inductive. This approach has allowed for more independence from a-priori coding categories applicable to physician-patient interactions (PPIs). This is not to say that already existing coding schemata have been completely dismissed or that there has been an attempt to discount seminal groundwork in this area. Contrarily, several studies (See Chapter 3) have proven to be invaluable (and informative) in the beginning stages of conceptualizing theoretically what is known

and especially, how much is not known, about PPIs. The literature review, nonetheless, provided a conceptual framework (e.g., physician-patient communication patterns) to initiate the study; but because so much about PPIs has been left unexplored and under-investigated, this study is predicated on allowing the data to produce a theoretical framework for the study collection rather than hypothesizing these conclusions a priori based on limited knowledge.

In this study, goal accomplishment in the PPI was approached from a different angle. First, the communication interaction itself was viewed as the focal point of analysis in order to learn more about how patient goals emerge and are accomplished, how they are altered and thus accomplished, or how they are in some form left unaccomplished. Second, a “guide” (the pre-interaction survey) of patient-reported goals was used as a roadmap through the analysis. Patients listed their pre-interaction goals, and these goals were searched for in the transcripts. While emergent goals, those arising during the discourse, were anticipated and coded, the survey also was useful in guiding analyses. Secondly, the survey helped determine if patient goals were or were not accomplished. Had each patient not indicated what s/he wanted to get out of the health visit, the task in understanding how patient goals are negotiated throughout the interaction would have been more complicated. To avoid speculation and guess work, the patient-reported initial goals for the health visit were used to help describe how these goals unfolded during the interaction.

The study contained three parts: A pre-PPI survey, and audio taped doctor-patient interactions/exams⁶, and a post-PPI survey. Each part is explained more fully in the appropriate subsection. Additionally, two types of participants were necessary to conduct the study: physicians and patients. Physicians participated in the second part of the data collection only by way of the audio recordings of PPIs (with consenting patients). Patients participated in all three parts of the study by filling out a pre-interaction survey, having his/her PPI audio taped, and filling out a post-survey.

Background

The study was conducted in a major university city in the South. While the population is primarily white, Hispanics constitute more than twice as many non-Hispanic Whites. The ethnic breakdown in Bryan/College station is as follows: 46% Hispanic; 21% White, non-Hispanic; 19% African-American, 12% Asian; and 2% Other. Because the targeted sample for the study was small (N = 50-60), an ethnically diverse population was not the target.⁷ Instead, it was expected that language and/or large cultural differences between patients and physicians would problematize communication. At this time there was no interest in understanding those dynamics because in an initial study in a new research area (accomplishment of patient goals through looking at discourse), it is more important to understand the communication process itself in accomplishing (or impeding) those goals. However, only physicians

⁶ For an entire year the plan was to video tape, at the insistence of an ex-committee member. It took a full year to obtain IRB approval due to demanded revisions of one or more of the IRBs. The revisions were full of added safeguards designed to help protect patients.

⁷ It was expected that some patients would be African-American, Hispanic-American, Asian-American, etc. They were not to be excluded from the study.

and patients who were native speakers of English were included because the complexities of medical interviews involving second languages.

Physician Recruitment⁸

Physician criteria. Physician participants in the study were part of the Division of Family Practice at a large clinic in a major city in Southeastern Texas. There were 14 doctors who comprised this division; 10 of the 14 were physician participants.

Meeting one. My study partner, a general practitioner at the health clinic, and this researcher attended a monthly (Division of Family Practice) staff meeting at the clinic prior to the data collection. During this meeting, the purpose of the study (e.g., to better understand the communication process that occurs between physician and patient), was presented along with the procedures to be followed and method of analysis. Additionally, it was explained to the doctors the advantage of participating in the study was that they would gain a better understanding of patient goals and wishes (what patients want) for the interaction itself and for health maintenance/improvement. The physicians were told that after analyses were completed, the medical doctor and researcher would share with them the findings regarding the communication process within the PPI and what was learned about how the communication between the doctor and patient affects patient goals. Moreover, the physicians were told that at a later date, the findings regarding the actual process of communication and how it links outcomes (i.e. satisfaction and compliance) to initial goals or wishes would be shared. Finally, the doctors were informed that such an understanding can promote a more

⁸ See Figure 4.1 for Physician Demographic Information found at the end of the chapter.

positive relationship and may lead to more positive patient-reported outcomes such as higher satisfaction ratings with the physician and with the interaction.

The division chief in charge of the staff meeting invited the two partners to come to a future staff meeting after the analysis of the study was completed in order to announce the results. The invitation was accepted; it was added that an individual's results (e.g., a specific patient's satisfaction responses) would not be presented in order to protect patient confidentiality. However, the doctors would be provided with aggregated results of satisfaction data from the take-home surveys to requesting physicians.

During the meeting, it was explained that each physician and his/her patients were to be targeted for one half-day. That is, only patients seeing one particular doctor on a given half day would be recruited. It was anticipated that utilizing only one doctor's patients on a targeted morning and/or afternoon would help to maintain a tracking system for patients as they arrived, minimizing disruptions of normal work flow and routines. These procedures were meant to avoid placing undue stress on clinic workers. On a typical morning/afternoon, a physician sees 12-14 patients. It was expected that 6-7 patients would participate.

Physicians were told that their participation was strictly voluntary and that they would be able to withdraw from the study at any time prior to publication of the findings. Withdrawing from the study would include stopping the audio recorder and/or video recorder at any time during a PPI if the physician or patient or both became uncomfortable or if the recorders hindered the information exchange. A physician could

also withdraw at any time, prior to the day in which s/he was scheduled to have his/her PPI video recorded or even afterwards.

At the staff meeting, the researcher verbally asked for volunteers for the study. She then distributed a sign-up sheet on which volunteering physicians were asked to sign their name under one of three columns, “Yes I’m Interested,” “I’ll Think About It,” or “Not Interested.” No physician signed under the “Not Interested” column; four signed under “Yes I’m Interested,” and eight signed under “I’ll Think About It.”

Meeting two. The medical doctor and researcher attended the August family practitioner staff meeting (Division of Family Practice) near the end of the month at the clinic. At this meeting, the staff physicians were reminded of the upcoming study and thanked them for allowing this study. The nature of the study was briefly re-explained and then all interested physicians (those who had indicated “Yes” as well as those who were “thinking about it”) were solicited to sign consent forms if they were still willing to participate.

The next day the two researchers decided to forego video taping and just audio record the interactions instead. Several days after that, the researchers met with every doctor who had signed the sheet indicated they would participate or think about it (n=12). Ten of the twelve doctors agreed to participate. The consent forms were explained in detail, and the primary researcher went over the potential risks, benefits, and rights found on the consent forms. Since most of these doctors had been participants in a previous study in which their physician-patient interactions (PPIs) were video taped, it was not difficult to convince them to agree to have their PPIs audio taped.

The doctors were already familiar with potential risks. Nonetheless, all were consented and reminded of each potential risk and benefit of participating in the study. After having their rights explained, each participant laughed when reading the part of entitlement to medical coverage.

Moreover, if the doctor's name were used during the interaction, a pseudonym would be substituted in the transcripts and write up of the results. It was explained that no personally identifying information would be used when writing up the results for publication. Patients would be contacted from the targeted medical interviews and obtain written consent. It was emphasized that if a doctor or patient should change his/her mind even after giving written permission to participate in the study and after having had the interaction audio taped, the audio tape would be destroyed. The material on the consent forms was reiterated to the patients; that is, the audio tapes of the PPIs and the patient surveys and both patient and physician consent forms would be kept in a locked filing cabinet in the researcher's locked office at the Texas university. The tapes will be marked, "GET WRITTEN CONSENT FOR FUTURE USE." These tapes will remain in their own boxes apart from data collected from other research studies. Ten doctors agreed to participate and signed consent forms.

Protection for All Patients at the Clinic

Typically each doctor in the clinic was allotted 3-4 examination rooms. Since some doctors only practiced part-time and/or were not in every day (some were professors at the medical school affiliated with the clinic), they didn't necessarily have their "own" exam rooms. So each morning before seeing patients, staff put the doctors' names on their assigned doors for that day. Usually, the doors were side by side,

across the hall from one another, or at the very least, in the same corridor. As patients are seen and then vacate an exam room, a nurse assistant inspects and makes sure the room is ready for the next patient and then proceeds to call the next scheduled patient from the waiting room. The patient is taken to another waiting area for vital signs and then finally to an examination room to wait for the doctor, who is in one of the other exam rooms.

In order to accommodate the study, two exam rooms would be assigned per doctor per day for those patients who agreed to participate in the study; one-two rooms would be regular exam rooms for patients who did not agree to participate in the study. All of the nursing staff had to note which two exam rooms in which they would place the audio recorder and make sure the doctor's third (and fourth) allotted exam room was reserved for non-participating patients. Patients who were asked to participate in the study (either during the investigator's phone call or the morning of the taping) but refused would be escorted into an exam room without an audio recorder. Nurse assistants also had a list of those patients who had given consent over the phone to participate. They would be escorted into exam rooms with cameras and asked again if they would participate in the study. If they agreed, the primary researcher was called back to the exam room to go over the written consent form with the patient and to obtain a signature. If the patient refused to consent, the audio recorder would never be turned on.

Physician Debriefing

Doctors participating in the study would be contacted upon completion of the analyses. In a staff meeting at the clinic in the future, the researchers would present

general, overall results of the study. Each doctor would meet individually with the doctor upon request to give him/her the aggregate results of the patient satisfaction (Take Home Health Survey) questionnaire in order to protect patient confidentiality.

Patient Recruitment

Patient criteria. The first criterion was that the patient participants be age 18 or older due to the legal issues involved with minors participating. Second, returning patients only were targeted, not those who were visiting the physician for the first time. New patients were not to be included in the study because they typically require a history-taking and lengthier overall diagnostic testing not typically found in returning patient consultations. For this reason, all the audio taped PPIs involved “established” patients of a particular doctor so that differences in physician communicator or examiner style did not reflect new versus “established” patients.

A third criterion was that patient participants needed to be fluent speakers of English. Several reasons existed for this criterion. As a note, most of the transcription was done by the primary researcher although research assistants were hired to help with some of the transcription of the audio tapes. Since neither the research assistants nor the researcher spoke a second language, it would have been more difficult in transcribing a foreign language or one that included heavily accented speech. Errors due to language barriers could affect the transcription and more importantly, lead to incorrect analyses. Therefore, it was believed it was better to avoid potential problems by requiring that patient participants be native speakers of English.

Finally, a variety of patients were targeted patients with chronic (recurring) illnesses, patients with new chief complaints, or those needing a physical exam were

targeted. Patients who had scheduled several weeks or more in advance as well as patients who had scheduled only 1-2 days in advance were included.

Explanation of Study, Consent, and Pre-PPI Survey

Patient participants were recruited with the help of an assistant at the medical clinic. The assistant, whom will be called Deanna, and the researcher, met prior to any patient contact. In the initial meeting, it was explained that the plan was to be in the health clinic every Tuesday, Thursday, and Friday morning and/or afternoon for at least several weeks beginning in September. The plan was to target only one physician's patients per given morning/afternoon.

A compliance requirement of the clinic meant that initial verbal agreement to participate had to be obtained by a clinic employee. Therefore, Deanna first accessed the patient appointment schedules and identified a wide range of patient "problems" according to the criteria established. For example, one of the first meetings Deanna and the researcher had occurred on Friday, September 1, 2000; Dr. Doe's patients for the starting day, Tuesday, September 5, 2000 were the target. It was agreed that on the night before or Friday night before if the appointment fell on a Monday, Deanna would access patient appointment schedules. First, she looked for patients who were scheduled to have an appointment with the targeted participating physician. Next, she made a list of all the prospective patient participants who fit the criteria, excluding patients under 18, those she knew were not native English speakers, as well as first-time patients of Dr. Doe. All others she put on her list.

Next Deanna gave the list to one of the appointment clerks on Monday morning. (The appointment clerks typically call patients the day before their scheduled health visit

as a reminder.) Deanna instructed one appointment clerk to phone each of the patients on her list because it would be easier for just one clerk to make the reminder call and include the following script:

“Scott and White is involved in a research study at the clinic about patient goals for their health visit. Ms. Theodori is the primary researcher. Would it be OK if Ms. Theodori calls you to explain more about the study to you?”

Deanna and the researcher anticipated one of three outcomes would occur. The most favorable response would be that the patient would say that I could call him/her to explain the study. Another response we anticipated was a flat refusal for me to call the patient. A third and as it turns out, most typical outcome, occurred whenever the appointment clerk reached an answering machine. In this case, the script that s/he used was exactly the same with an addition. It read:

“Scott and White is involved in a research study at the clinic about patient goals for their health visit. Ms. Theodori is the primary researcher. Would it be OK if Ms. Theodori calls you to explain more about the study to you?” Would you please call the clinic back at 555-5555 to confirm your appointment and to let us know if Ms. Theodori can call you back? Please ask for _____ (the appointment clerk’s name). If we do not hear from you, Ms. Theodori will be calling you some time this evening.

If a patient said that s/he could be called back, the appointment clerk noted that on his/her list and wrote down the phone number of the patient and gave that to the researcher. If a patient said not to call him/her back, the appointment clerk crossed off

the patient's name from the recruitment list. For answering machine messages that were not returned, the appointment clerk gave the researcher the names and phone numbers; later that afternoon the researcher would have to investigate if the "answering machine" recipients called back. In accordance with IRB regulations, the appointment clerk were called shortly before 6:00 (EOB) and verified which patients had called the health center to request that they not be called.

That evening patients were telephoned except those who had verbally told the appointment clerk that they were not to be called. When each patient was called by the researcher, the following script was read:

"Hello? May I please speak to M__ _____?
Thank you. M__ _____, my name is Jacqueline Barnett-Theodori. I lecture at Texas A&M University, and I have done research in the area of doctor-patient communication. I am interested in how doctors and patients talk with each other. I have been given approval by the Scott & White Clinic to conduct research at their clinic in Bryan/College Station. I would like to ask you to be part of this research. Would you consider participating so that I can better understand the communication between doctors and patients?"

If the prospective participant verbally agreed or indicated by response that s/he was at least somewhat interested (i.e., "Tell me more about it," "What do I have to do?" etc.), the reply was the following:

"There are several parts to the study. Each part will require very little of your time. First, you will receive a survey while you wait.

The second part involves video taping your health visit with your doctor. The procedures including risks and benefits to participating will be discussed more fully right before your health visit with the doctor.

The third part of the study involves taking home a brief

(2-page) survey.

You don't have to give me an answer right now. You can think about it. Would it be OK if I asked you again tomorrow when you sign in for your appointment?"

The next day at the clinic, only those patients who indicated verbal agreement over the phone were approved. In order to determine patient identity, patients signing in were watched. If a person's signature matched the name on the list, that person was asked if s/he were willing to participate in the study. Patients who said no were immediately excluded from the study. Patients who said yes to the request asking them to listen to the details of the study were informed about the goals of the study. These patients were told that the researcher studied doctor-patient communication and that this study was designed to understand more about how patient goals are accomplished in the doctor-patient interaction. They were asked to fill out two brief surveys, one while they waited for their health visit and then one which they would take home to fill out. They were told that the big part of understanding the communication process was actually in investigating everything that the doctor and patient say to each other and how this whole process can lead to patients achieving what they want in the health visit. The patients were informed that rather than have me observe in the exam room, which would seem too invasive of their privacy, the researcher had been given permission by the clinic to audio record⁹ their health visit. The researcher also explained that his/her doctor had given consent for his/her health visits to be audio recorded as long as the patient gave permission. If a patient seemed uneasy, the researcher explained that she would go over potential risks, patient rights, and the benefits of participating in this study and show

how the study was designed to protect patients from potential risks. If a patient had particular questions, they would be answered.

If a patient said that s/he would not participate, the interview was ended and his/her name crossed off the list. If a patient said that s/he would participate, the patient was given a consent form to the patient and sat with the patient while s/he read over the form. Each risk listed on the consent form was covered, and then the patient was shown under "Alternative Procedures" the safeguards that were built into the study to help protect the patients. Each patient was walked through the benefits of participating and, most importantly, informed the patient of his/her rights as a research participant. The participant was informed that s/he would receive a copy of the consent form and could call the medical doctor or researcher regarding questions about the study. Additionally, s/he could call the clinic or the state university IRB office with questions regarding his/her rights as a research participant. The patients were informed that they could withdraw at any time prior to publication. Withdrawing from the study could include asking the doctor to turn off the audio recorder during their exam, or withdrawing could include refusing to complete a survey. Additionally, withdrawing also could include contacting me any time prior to publication and requesting that the researcher destroy either or both surveys and/or the audio tape. The researcher answered any additional patient questions during this process.

After the patient signed the informed consent form, the patient was given a brief survey to complete. The survey consisted of five open-ended questions about their goals for the health visit. The patient was asked to complete the survey while waiting for the health visit. When the patient's name was called for his/her appointment, the

primary researcher collected the consent form and survey (even if unfinished). The researcher followed that patient as far as meeting the nurse/nursing assistant who had called the patient's name and informed her/him that this patient would be participating in the study. This way the clinic worker would know to put the patient into one of the exam rooms with an audio recorder. If the researcher did not follow a patient to greet the nurse/nursing assistant who had called the patient's name, the patient would be placed into one of the two rooms without audio recorders.

Patient Debriefing and Take-Home Survey

Upon completion of the exam, the patient came out to the waiting area and proceeded to "Check-out." The researcher waited until after the patient had "checked out" to approach him/her again. At this time, the patient was thanked for participating in the study.

Each patient was debriefed as the researcher explained that the purpose of the study was to learn more about doctor-patient communication by finding out more about patient goals for the interaction. Then by studying the actual communication interaction to see how goals are met, modified, exchanged for other goals, the communication process could better be understood. The patients were reminded that in writing up the results for publication, pseudonyms and not real names would be used; additionally, no other personally identifying information would be used.

The researcher offered to make the results available if s/he wanted them. If the patient indicated that s/he wanted the results of the study, the address and phone number (or other contact information) of the participant were taken down in order to ensure that the participant will receive the results upon completion of the study.

Additionally, the participant was reminded to contact the researcher at any time (patients were given a copy of the consent form in which were included all the contact numbers) should s/he have questions, comments, or a wish to withdraw from the study.

Finally, each patient was given a post-interaction survey with an attached stamped envelope bearing the researcher's name and campus address. The patient was asked to take the survey home and fill it out later that day and mail it the next day. If the researcher had not heard back from the patient within one week, the patient was telephoned as a reminder to mail the survey.

Physician Demographic Information			
Doctors	Total in Clinic	Agreeing to Participate	Total in Study
Family Doctors	14	12	10
Females	2	2	2
Males	12	10	8
Ethnicity (White)	13	11	9
Other (Asian)	1	1	1

Chapter 5: Methods and Open Coding—Analysis Level One

Introduction

This chapter begins with a summary of the significant problems with the project proposal and their resolutions. Then the chapter moves into the analysis including the initial stage of transcription followed by the first round of open coding, a summary of those findings, a brief rationale for changing the direction of the open coding, and the second round of open coding.

Study Problems

Change from video to audio recording. The researcher's initial proposal to the Scott and White Institutional Review Board was to audio record approximately 100 doctor-patient conversations. This proposal was reviewed and given approval the first month it was submitted (September, 1999). However, an ex-committee member argued that audio taping was not adequate to capture the nonverbal communication of the doctor and patient and therefore video taping was necessary. For a year the researcher sent in proposals to the three IRBs, the clinic IRB, the Texas university's IRB, and the Pennsylvania university's IRB, that included video recording. The reviews went back and forth with changes coming from one IRB that needed to be approved then by the other IRBs. After exactly one year, in August of 2000, all IRBs granted the researcher approval to conduct the doctor-patient study using video equipment.

When the medical doctor and the researcher met in August, 2000, to discuss the study, both agreed that due to all the confidentiality issues associated with the video recording, that audio recording was a better alternative. Since that audio recording proposal had been approved by all IRBs a year before, the researcher did not realize

she should have sent in an amended proposal to all the IRBs. Instead, the data collection progressed as outlined in Chapter 4; 103 doctor-patient conversations were recorded between September and November, 2000.

IRB Issues

Approximately ten audio tapes of ten doctor-patient interactions were transcribed by the time clinic IRB annual review was due. Shortly after turning in the written annual review, the researcher received the news that the study was “red-flagged.” She had promised to collect only 60 doctor-patient video-taped interactions. However, 103 were recorded because 100+ interactions were requested in the initial request for audio-taped interactions. Because of the misunderstanding, for almost nine months the researcher was not allowed to transcribe and/or analyze data while the clinic IRB met to sort out the miscommunication. One possibility the researcher faced was having the data collection completely thrown out and having to begin the project from scratch. Fortunately, this did not happen. Instead, she was invited to defend her actions at the clinic IRB full review. Following that, she had to go through IRB training, which consisted of working with a compliance research educator in reviewing a lengthy PowerPoint® presentation on human subjects’ ethics and protection. She then had to take and pass (with at least a 70%; she received a 96%) a long test on the Belmont Report and ethics pertaining to human subjects. Finally, she was permitted to resume her study but was permitted to transcribe only 60 of the 103 doctor-patient interactions.

The Analysis

Transcription

Approximately 103 doctor-patient conversations were audio recorded.

Transcription was not to be merely the words but several committee members insisted that transcription be done in conversation analysis (See Jefferson, 1979) style since that was the proposed method of analysis. This meant that each tape was to be transcribed according to intonation, inflection, pitch, loudness, emphasis, dialect, pronunciation, and annunciation.

It took a total of 4 years to transcribe the data (almost a year was lost when the researcher was not allowed to work on the data due to the IRB restrictions) at that level of diacritical markings. Three paid research assistants transcribed approximately 20 of the 60 transcripts over a period of a year and a half. The three assistants went through three sessions each of training with the researcher to ensure accuracy and consistency with the researcher's method of transcribing. Each assistant worked independently on a transcription machine that the researcher purchased with a grant she was awarded for the project. Every week the researcher met with the assistants (sometimes with more than one, sometimes on an individual basis) in order to evaluate the transcription and to review any inconsistencies compared to those done by the researcher. For example, if there did not appear to be many mispronunciations or inarticulate speech captured in one assistant's transcripts, all three would listen to a small section of the recording and compare how each transcribed it. Many inconsistencies were eliminated through this tedious but productive approach.

Introduction

A grounded theory design (Strauss; Corbin 2001; 1990; Glaser & Strauss, 1967) was applied to analyze and interpret the data¹⁰. Grounded Theory requires that the researcher become immersed in the data by reading and re-reading the transcripts of the recorded conversations until becoming “immersed” (Miles & Huberman, 1994). This allowed the researcher to acquire a general knowledge of the data (more specific knowledge is acquired as the analysis occurs), including different reasons for the health visits, varying symptoms, the range of doctors’ communicator styles, and evidences of compliant and non-compliant patient behaviors, to name a few. It is important to note that data immersion occurred not in a linear fashion but in incremental stages. That is, a handful of interaction transcripts (approximately 4-5) were read and re-read until a general knowledge of the nature of the visit and outcome was written down in memo reports and then the process was repeated until all the transcripts had been read.

At the onset of the analysis, the unit of analysis was determined to be a sentence (or several sentences in some cases if the sentences all tied into the same idea). The decision to code by sentence rather than by word or phrase seemed appropriate because one main behavior typically could be found within a spoken sentence. Since the research questions were not micro in nature, there was no need to code by word or phrase.

Open Coding Phase I

The next step involved identifying coding “units”, which could be an entire turn, sentence, or partial sentence, within a conversation, and “open coding” them (Strauss &

¹⁰ For a more complete summary of this design, see Chapter Three.

Corbin, 2001) In the absence of an a priori schema, the researcher developed all the codes. This was done by reading and re-reading the transcripts once again and assigning words or phrases to the name the code, based primarily on the actions occurring in the coding unit but allowing the research questions posited by the researcher to serve as a type of “lens” through which to see and label the behaviors.

As the initial codes began to evolve, the constant comparison method was applied to the emerging coding schema, whereby a code was assigned to a unit if the unit fit the definition for the code. The process also entailed looking at units previously assigned to the same code and making sure the new unit had the same attributes as the old units (Glaser, 1992). More significantly, units coded in other categories were examined in order to observe the contrasts along with the similarities. If no code seemed to fit the concept or action found in the unit, then a new code was devised and a description/definition written for it. Once again this definition was compared to other category definitions; and often during this course of constant comparison, older categories and their definitions were modified. Sometimes codes “almost” fit a particular unit. In those cases, definitions of codes already established were either expanded in order to include the coded units as well as the new unit or modified more narrowly and new codes created. If one category was broader, the other was defined as a subcategory, with the broader category or code considered a “parent node” or parent category, and the narrower code “child node” or “child category”. In other words, through the development of codes, a hierarchy of categories was created and modified. Thus, this process enabled the researcher to build a hierarchical schema or “tree of codes,” revealing the relationship among the categories.

Constant comparison was particularly vital to the coding during the relationship development among codes. For example, children nodes were coded under parent nodes if they related back to the broader parent category. Examples were found for each child node as it was created. To illustrate, let us say a child node was created based on one example. However, no other examples emerged after pages and pages of coding, and yet all its sibling nodes had an assortment of examples. The researcher then collapsed the child node into a sibling node or else under the broader parent node if not similar enough to a sibling node's attributes and definitions. Either way, a new or modified definition was rewritten in order for the expanded category to preserve correct assignment of codes according to their definitions.

Beginning Procedure

Introduction. In the first phase of the beginning analysis, approximately 30 transcripts were coded using the software nVivo®¹¹. Using the constant comparison method, categories or “nodes” were formed according to patient goal types, doctor goal types, and both doctor and patient sub-goal types. A hierarchical schema began to develop. Throughout the open coding phase, the researcher endeavored to relate the emerging codes to the research questions¹² However, there was uncertainty that the coded units really contained patient and doctor goals. To verify that these units in fact were patient goals, the researcher examined the open ended surveys that each patient in the study filled out before his/her health visit. The survey asked specific questions

¹¹ The software program nVivo is not described in detail because that was not what was used in the actual analysis.

¹² RQ1: What are patient goals for the health visit? RQ2: How do patients and doctors communicate about patient goals for the health visit? And RQ3: What communication strategies do patients and doctors utilize in order to uncover and try to accomplish patient goals? See end of Chapter 2 for context.

about goals for the health visit. These aided the identification of goals, while the transcripts, themselves, were used exclusively to answer the second two research questions regarding how the goals are communicated and what strategies the doctors and patients use.

Re-direction

It was at this point the researcher realized that having a schema of doctor and patient goals for the interaction did not mean it would necessarily be linked to the strategies the communicators used in trying to achieve these goals. It was thought that if the researcher identified the major segments of each interaction it would be easier to see where the various types of goals were most likely to occur in the interaction, thus perhaps shedding light onto more specific strategies. The major parts according to Smith and Hoppe (1991) are as follows:

- Opening – greeting sequences (hellos)
- Phatic Communication – exchanges of small talk or “chit chat”
- First symptom-eliciting HAY (acronym for “How are you?”) – continuation of phatic communication into medical issues or the real question that begins a patient’s account for the visit
- Intake – doctor’s questioning the patient about history and symptoms and the patient giving description
- Exam – physical examination of the patient
- Diagnosis – doctor’s conclusion of what patient’s symptoms indicate
- Prognosis – recommendation of what the next step(s) should be such as lab tests, X-rays, taking prescription medication, etc.

- Closing – agreement on prognosis and establishing a time for a follow-up if needed along with phatic communication and good-byes

Unfortunately, while identifying what part of the interaction the goals were most likely to appear, the actual strategies were not emerging as had expected. Instead, during this general labeling of predictable segments in the doctor-patient visit, predictable behaviors connected to some of the segments became noticeable. For instance, during the intake, the patient identified symptoms or problems that the patient was experiencing, indicative of normative patient behaviors. Likewise, the doctor imposed medical/health “rules” (such as “Don’t smoke” and “You need to exercise more regularly”) typically in the intake segment while asking probing questions of the patient and other directives related to remedies or solutions (like “Take your medicine twice a day”) during the prognosis section. The researcher also noticed that sometimes when the doctor mentioned (and discussed) these health rules, the patient would respond with an explanation, excuse, or justification for deviating from good health practices.

These physician injunctive norms and patient accounts highlighted more patient goals and seemed to get at the strategies used by both participants more than the original open coding. In fact, these norms were captivating enough for the researcher to read some works on normative behavior from communication scholars such as Cialdini and Kallgren (Cialdini, 2003; Cialdini & Trost, 1998; Kallgren, Reno, & Cialdini, 2000) as well as those who have written on account-giving (Dunn & Cody, 2000; Fritzsche, 2002; Tata, 2000). The researcher perused the literature for any link between normative behaviors and account strategies. Very few articles surfaced, and none were in the area of doctor-patient communication.

Normative behavior and account-giving seemed to jump right out at the researcher as an area that has been understudied, to say the least. If perhaps this research project's emphasis shifted from understanding different types of goals used by patients and doctors and do this more narrow focus, perhaps there would be a link back to goals eventually. At the very least, the researcher had renewed excitement for the project and was finding links and relationships that were not emerging from the first round of open-coding. As Barbara Sharf (1990) pointed out, sometimes a qualitative researcher will get through an entire data set performing open coding and realize that the analysis is not answering the research questions put forth at the onset of the project. Therefore, this researcher argues that there are really only two basic choices: either abandon the research questions and see if new questions can arise and be answered through any significant relationships and/or patterns occurring in the open coding, or abandon the open coding already performed and see if there could be another way to approach the data with regard to the original research questions. The link between normative behaviors of the patient, physician imposition of health rules (injunctive norms for the patient), and patient account giving when not adhering to injunctive norms seemed too noteworthy to desert. Therefore, focus shifted away from the original research questions. The new research questions became the following:

RQ1 What normative patient behaviors are discussed in the doctor-patient interaction?

RQ2 What physician injunctive norms are present in the doctor-patient interaction?

RQ3 What accounts do patients give for violation of injunctive norms?

The rest of this chapter lays out the recurring norms and accounts including examples of each.

Open Coding Phase I I: Normative Behavior and Patient Account-Giving

Patient Personal Norms

The researcher began to re-code all of the transcripts this time according to a completely new emergent schema that was guided by the work of Cialdini and colleagues (Cialdini, 2003; Cialdini, Reno, & Kallgren, 1990; Cialdini & Trost 1998; Kallgren, Reno, & Cialdini, 2000). Personal Norms depict behaviors that are routine or a regular presence in a person's life (Cialdini & Trost, 1998). In this study, personal norms of the patients were defined as actions or experiences of the patient occurring in the patient's life. These norms may include a recent incidence such as new joint pain brought on by a recent injury. Alternately, norms may be long established as patterns in the patient life such as exercise and eating habits. Because Personal Norms were so varied, they were separated into four main categories: Symptom Norms, Medicine Norms, Lifestyle and Work Norms, and Miscellaneous Norms.

Symptom Norms. Symptom norms were identified as behaviors that had not been daily norms throughout the patient's life but now were occurring at least routinely enough that the patient was convinced to make a health appointment. Of all the personal norms, Symptom Norms appeared most frequently in the patient's dialogue and include the recent onset of various types of pain, swelling, inflammation, stiffness, and nausea, to name a few. In #0001 the patient mentions the chief complaint, his knee.

21 D: (1.0) How are you doin'?

22 P: Uhh (0.5) generally okay.

23 D: Generally okay?=
 24 P: =U:m. (1.4) I've had umm (1.0) my knee's startin' ta get
 (0.5)
 25 sore []

26 D: [Ohm.]

27 P: (1.7) An' it just happened (0.5) past month or so.

28 D: Past month?

29 P: Yah.

Other examples of patient symptom norms can be found in almost every transcript.

Another example (below) is found in #0005.

33 P: It was worse about a week ago when I made the first call.
 34 Still a little redness over here in the corner?

35 D: In the corner?

36 P: It was almost I guess .hhh like a pimple look, er some kind
 37 of...

38 D: Was it on the--

39 P: It's uhh always been on the lid jus' right there where
 40 D: Which one, the lower lid er--

41 P: I guess the upper lid, right there in the corner.

42 D: Betcha have a sty.

43 P: Yeah.

44 D: It's a little swollen right there an' there.

Medicine Norms. Medicine Norms also materialized as rather common, especially when the patient's visit was a repeat or follow-up. Patients reported taking medicines prescribed by the doctor as well as taking over-the-counter drugs or home remedies.

Examples of medicine norms are found in the following passages from #0028 and #0071 respectively.

#0028

19 P: and finally went to the doctor and called in, and went to
 20 the doctor back home at S_____ in T_____. And then he
 21 gave me some antibiotics and pain killers. Pain killers
 22 workin', but antibiotics no.

#0071

144 P: An' on my sinuses, uhh the sinus >/peels/ you giv' me...
145 D: Whaddaye give you, Allegra?
146 P: Yeah.
147 D: Yeah, you ken take that if you want to..
148 P: they--they didn't find my prescription over there. Uhh
149 D: Were you on Allegra-D or: Allegra?
150 P: HHHH.
151 D: Plain Allegra?
152 P: (inaudible) Would D be bettah?
153 D: Yeah, but you got high blood pressure, [] so, it
kinda
154 P: [(Gosh.)]
155 D: ↑nixes ↑tha↓t.

Lifestyle and Work Norms. Other routine behaviors outside the medical context appeared much less often than the other norms. However, they were coded because they were found to be importantly linked to other Norms like Symptoms as well as account-giving. The following examples of the category Lifestyle and Work Norms are represented by passages from #0044, #0048, #0066 and #0078.

#0044

193 D: Are you ah (1.1) exercising?
194 P: Yes. Play basketball. Whenever I can. Usually on the
195 weekend I play xxxxxxxxxx game. So.
196 D: 'K. That will keep you very busy. With the kind of sch-
197 work load you have the schedule you have this year. And
198 how many lessons are you teaching?
199 P: Ah:: I have five kids right now. ((Laughs))

#0048

40 D: [Yeah.] When did your headaches start
41 accelerating again? Cuz they were (0.5) g-good for a while
42 weren't they?
43 P: Yeah. I would say the last month.
44 D: What's changed in the last month?
45 P: Oh:it's ah life style has just been absolutely nuts.
46 D: In what way?
47 P: Ahm couple trips. Road trips all in one day to Houston to
48 pick up relatives from out of town ahm birthday parties.
49 Ah:: just we've got cheerleading this year ahm our eldest
50 is a varsity cheerleader
51 so she's got a lot more games involved [and an]

52 M: [Maybe] it's cuz I
53 moved in with you.

#0066

60 P: Well, you know, I-I ↑feel pretty stressed out a lot of
61 times, I have three kids at home ((Slight laugh)) an'- with
62 a lot of problems. An' so I ↑guess when I get stressed
63 out, I get [yeast infec] tions.
64 D: [It gets worse.]

#0078

98 D: How's your slee:p?
99 (1.0)
100 D: How's your sleep? Are you able to sleep: well?
101 P: (0.5) Well r/ee/lly I get about (.) ((short laugh)) ma::
102 °°be°° about four or five hours a n↑ight.
103 D: Why: ↓so little?
104 P: Well I go in at-at ↑four in the morning, y'know, that°'s °
105 the time I go to bed, I go to ↑bed late.=
106 D: =Wh↑y?
107 P: There's work at the ↑house.

Miscellaneous Norms. Norms that did not seem to belong to any other category and were not found in the transcripts more than once or twice were labeled as Miscellaneous Norms. There is no readily apparent connection to the other norms or account-giving, so no examples follow.

In addition to the broad or "parent" category of Patient Personal Norms, the researcher theorized that Patient Descriptive Norms would prove to be another category of norms. According to Norm Focus Theory (Bator & Cialdini, 2000; Cialdini 2003; Cialdini & Trost, 1998), Descriptive Norms are the behaviors a person thinks are typically happening in society. For example, drug research has been concerned with adolescents' perception of problem drinking and other drug use among their peers (Allen and Page, 1994; Centers for Disease Control and Prevention, 1995; Miller-Day &

Barnett, 2004; Wallace, Bachman, O'Malley, & Johnston, 1995). Some findings have suggested research should focus on both general peers (e.g., in the school setting, what is common at the grade level) as well as closer peers who are friends and other members of the social network. Thus behaviors that are common among peers comprise the Descriptive Norms category.

Physician Injunctive Norms

Injunctive Norms (Cialdini, 2003) are those behaviors that people believe others' notions of "right and wrong" or "good and bad". Usually some type of authority—society, the media, church, parents, etc.—is the foundation of injunctive norms. For example, we "know" that people around us think that we are supposed to obey the speed limit, as established by our laws just like we "know" that they think we should get enough sleep, eat properly, etc. In the doctor-patient visits in this study, almost all injunctive norms were voiced by the doctor although a few times patients echoed the doctors' norms. Additionally, there were fewer injunctive norms than personal norms, as might be expected, considering patient symptoms and medicine norms comprised a good deal of the patient's dialogue the doctor's dialog mainly focused on questions and probes into patient symptoms. One way of categorizing the injunctive norms would be by type (i.e., "Take your medicine," "Get enough sleep," and "Lose more weight"). The researcher began to categorize the injunctive norms this way. Chapter 6 rather than this chapter provides the specifics of these classes and the patterns found because those injunctive norms are crucial to the second level of coding, axial coding, which is detailed in Chapter 6.

Throughout the coding of these norms, the researcher noticed that some norms were very directly stated by the doctor. In other contexts, some norms were more implicit but still seemed to fit the definition of “injunctive norm,” according to Norm Focus Theory (Cialdini, 2003; Kallgren et al., 2000). That is, in the doctor-patient world, norms pertain to unspoken rules that the patient *should* or *ought* to follow (Cialdini, Reno, & Kallgren, 1990). The researcher began to take notice that this indirect type of injunctive norm seemed to elicit more patient account-giving than the explicit injunctive norms. Therefore, the researcher reworked the subcategories into two main types: Explicit and Implicit. In fact, in this data set, the doctors do not put forth many explicit injunctive norms but rather implicit. Four examples of each of these two main injunctive norm categories, Explicit and Implicit, are provided to show how the implicit norms unfold differently from the directly stated injunctive norms.

Explicit Injunctive Norms. In the first example, the doctor proposes a situation, a heart attack, asking the patient what he would do if he were to find himself in that situation. After the patient answers, the doctor tells the patient exactly what he should do and then provides a clear explanation.

#0001

227 D: Any ↑idea what a heart attack would feel li:ke if you know
 228 you were ever to experience that? What do you t↑hink in
 229 your mind-what do you think that would ↑feel like?
 230 P: U:hm (0.8) /Proibly/ (.) a hurting, a weight on yer ↓chest.
 231 D: Yah. Or an equal pressure, squeezing, vice-like, people
 232 de↑scribe it as different thi:ngs like ↑that Typically
 233 right here. So people sorta do like (0.7) uhn squeezing
 234 feeling right ↑here. [] It makes ya pale and sw↑eaty?
 235 P: [Umm.]
 236 D: Sometimes it a:ches in yer ↑jaw an yer ↑neck. Sometimes it
 237 goes down yer ↑arm. Sometimes it makes you queasy to yer
 238 stom-stomach an' sometimes it makes you uhh short of
 239 breath. [] Now the only reason

240 P: [Umm.]
 241 D: I ↑tell ya that is, .hh is that if-if it ever happened to
 242 you what should you ↓do if you felt that.
 243 [] What should you do?
 244 [((knock on the door))]
 245 P: Help.
 246 D: ((nurse comes in and speaks with doctor very quietly)) Yah.
 247 Thanks. What-what should ya do?
 248 P: You sh' take some aspirin an' go to the emergency [room.]
 249 D: [That's]
 250 exactly right. Chew an aspirin.
 251 P: Chew an aspirin?
 261 D: Uh-huh an' go to the nearest emergency room because .hh if
 252 it turns out that it is a heart attack (0.9) if you get
 253 within four hours there's a good chance you can take
 254 (clichesol) an' reverse it an' not have permanent ↓damage.
 255 (0.7) Okay?

Many of the injunctive norms pertain to taking medicine. In #0012, the doctor is interviewing a patient with a sore throat. He directs the patient to continue taking her antibiotic.

#0012

43 D: That's fine. Tha-uhh than you started it <and because your
 44 throat is a little bit ↑red>, you probably had time to
 45 ↑wait a couple of days before you ↑started it? But since
 46 you di[↑]d, since you di[↑]d tho-tha-that's fine ju-just to
 47 make sure that it that we got you covered for ↑strep, let's
 48 go ahead an' an' continue to do °Amoxicilin° (go ahead an')
 49 finish that off. Are you doin' any decongestant kind of
 50 stuff?

In the following interaction the doctor alludes to the patient's weight and that the extra weight is making her pain and condition worse.

#0035

111 D: Ok, go ahead and sit back up. You can put your shoe back
 112 on. I'm gonna do an x-ray on your knee. Have you tried
 113 any weight loss programs?
 114 P: Yeah.
 115 D: How successful were you?
 116 P: Not too well.
 117 D: Because I bet a lot of it, you know, the knee pain has to
 118 do with the weight. When you walk, you basically support
 119 all the weight and that can aggravate it and inflame it.

120 I'm just gonna do an x-ray and make sure there's nothin'
 121 bad in there.
 122 P: Ok.
 123 D: And do you have some medicine you take for the pain?
 124 P: Na uh. Usually I just if it hurts that bad, I just take
 125 some Tylenol.
 126 D: Ok, and you can take Advil or Aleve, the Aleve you can take
 127 two pills three times a day and then when we get these
 128 results of the x-ray back and uh, go from there. But, I
 129 think a lot of it is gonna have to come from the weight
 130 loss.
 131 P: Probably.
 132 D: So we need to do that. ((Tearing off paper))

Finally in the last example here the patient directly asks the doctor for some medication for her nerves. The doctor answers her with a clear injunctive norm, to stop using caffeine and to exercise.

#0068

63 P: ↑All, aye ↓think so. Some pills I think I'm gonna ask you
 64 if you cou' give me somethin' for ↑nerves, so aye ↑won't
 65 ↓be so nervous.
 66 D: Yeah? ((Sounds like moving in chair b/c sounds like wheels
 67 are squeaking)) (...) I'll tell ya the ↑best ↓way to
 68 manage ↑nerves (.) /are/ anxiety (.) ->ya havin' trouble
 69 sleeping< or...
 70 P: (...) °No.°
 71 D: °No.° ((Sounds like the Dr. drops something—it's very
 72 loud!!)) It's non-pharmacologically. >An' the ↑best way<
 73 thing to do, ya know, is eliminate caffeine an' ↑exer↓cise.

Implicit Injunctive Norms. This category emerged primarily from coding patient account giving. That is, as patient accounts were identified, it was discovered that justifications and excuses, among other types of accounts, related to some type of "accusation," or in this study, a physician injunctive norm. However, often the injunctive norms were not as direct as in the above examples. Sometimes they were embedded within the context. The following excerpts show these implicit injunctive norms. In the first example, the implicit injunctive norm is that the patient should get more sleep.

While the doctor does not explicitly state, “You need more sleep,” it is understood because she explains to the patient the negatives of not getting enough sleep. Thus, the injunctive norm is understood.

#0078

315 P: Cuz that’s somethin’, you know, I was work/ee/n’ at work,
316 cleaning up, cuz I work at C____↑____, an’ uhh, a ↑lot of
317 times I feel like I’m gonna faint!
318 D: Right, right. It’s too MUCH!=
319 P: =Like, I feel like kinda [(XXXXXX)]
320 D: [Right, right.] An’ that’s—that’s
321 gonna be—↑lack of sleep is—makes you sick! >You get sick!<
322 (0.5)It’s dangerous! HH

In Interaction #0074, a patient recounts the time she was late to work and her boss became upset with her. The doctor’s implicit injunctive norm, “You shouldn’t be late” are present without actually having to saying those words. Instead, she gives an example of someone else with a similar behavior and explains what happened to her.

#0074

48 P: Yeah. An’ I went to Austin yesterday an’ came ↑back (.)
49 like two hours late to work but I ↑called like around
50 ↑three an’ I wasn’t supposed to be in at five?
51 D: °Yeah°
52 P: An’ he ↑said, If you’re not responsible about >comin’ in on
53 ti:me when we ↑need you<, how do I know you’re responsible
54 about ↑this?
55 D: °Yeah. Yeah.°. °°Yeah.°°
56 (1.0)
57 D: {People} ↑work people. I-I’ve had—I had a gal who worked
58 out at ↑their corp, an’ she loved °the job, and she lost it°
59 because she came in late. An’ like even one ti:me is a big
60 deal to people, ya know. =
61 P: =Mmm.
62 D: But that’s rough, it’s bad timing.

Another example of an implicit injunctive norm is shown here in #0002. The entire health visit is approximately 40 minutes long. However, never once does the doctor admonish the patient directly to “abstain from sexual intercourse.” However, it is very

clear through reading the doctor's comments about making good decisions and reaping the benefits that the message, or injunctive norm, is abstinence.

#0002

288 D: [] But if you truly honestly have never ever
289 had-had sexual
290 P: [Uh-huh?]
291 D: ↑intercourse? [] an' never had penis in vagina you
292 can't get an
293 P: [Yah?]
294 D: abnormal pap test. An so .hhh that's one of the unknown (.)
295 advantages of makin' a-a choice ta-ta-ta not be sexually
296 ↑active. An'-an' ya need ta take adv↑antage of that an' not
297 put yerself through (.) te↑sts that ya don't ne↑ed
298 because you made a good ↑lifestyle choice. It's like []
299 P: [Okay.]
300 D: me .hhh if like you don't ↑smoke. I don't need to worry
301 about you getting ↑lung cancer. [] It's one of the
302 P: ['Kay.]
303 D: good things that comes with a good
303 ↑lifestyle choice. So-so to go through the same annual
304 ↑screens that somebody that's made a different choice an'
305 put themselves at ri↑sk (1.3) you can ↑do it but it's not
306 necessary.

In the final example the doctor uses the "If it were I" technique to tell the patient what he wants her to do. Even though he can't relate to what she, a female patient, is undergoing (menopause), the doctor makes use of the subjunctive mood tense as a vehicle for the injunctive norm to get on hormone replacement therapy.

#0045

263 D: But where we are right now. Knowin' what we know. If I
264 were (1.0) a female. And had the mess with all this.
265 P: Uh[,huh.]
266 D: [And]I thank God that I don't.
267 P: Uh,huh.
268 D: I would:a I would actually be on low dose birth control
269 pills until about the time I went through menopause and
270 then I would just switch over to a once a day (1.2)
271 estrogen or progesterone pill. No bleeding. No periods.
272 P: Uh, huh.
273 D: Ah (0.8) with few minor exceptions? But ahm for the most
274 part no bleeding. No periods. And you have the hormone

275 protection for your bones. For your heart. Your blood
276 vessels. Ok? . Ok?
277 P: A-ah:how. U::hm. How long do you take that? Till you get
278 dead?
279 D: Well nobody knows yeah until you get dead.

Physician injunctive norms may new information that the patient needs to follow for better health. On the other hand, they could be accusatory in nature (a reproach) and indicate that the patient either has done something wrong (norm violation); the patient in this case typically responds with an account (Schönbach, 1990). The following section shows the open coding of patient accounts found in the data.

Patient Accounts

Account giving is a feature of human communication behavior in the context of accusation of something. That is, people tend to supply the other person with information that will try to “save face” (Goffman, 1959) when accusing of doing something that is perceived as inappropriate or bad. Specifically concerning doctor-patient communication, it is “face threatening” to the patient when the doctor tells the patient to “Lose ten pounds” or “Quit smoking or lose ten years off your life.” In order to try to “save face,” the patient may be inclined to say something like “I have tried to lose weight but it’s difficult raising three children on my own and working two jobs. I don’t have time for exercise.” This excuse helps the patient “look better” because it supplies a reason why the patient has not adhered to an injunctive norm.

The two most frequently occurring patient accounts were “justification” and “excuse.” Patients occasionally gave these accounts during the “Intake” part of the

visits¹³. The intake segment of the interaction includes the highest frequency of injunctive norms. Since the intake or history-taking part of the interaction contained the most injunctive norms, it would stand to reason that this segment would also contain the largest number of accounts. This hypothesis is tested in Chapter 6.

Justifications

People use justifications when they admit to a certain behavior(s) but claim their actions were harmless or involved positive outcomes (Dunn & Cody, 2000). In the following examples, patients used justifications when talking about some activity or behavior of which the doctor would disapprove. In the first example, while the doctor never says that too much caffeine is bad, the patient seems to already know this. We can tell that the patient knows this since a comparison is made to an old behavior pattern (drinking eight to ten Cokes a day) and the current level of once-a-day. The justification is that the one soda helps to keep away the headache presumably caused by caffeine withdrawal.

#0027

57 P: An'-an'-but you know gettin' back into sh[↑]ape. And (.)
58 stuff like that and (.) but all my life (...)I've had pain.
59 Right here?
60 D: Mmm hmm.
61 P: Well it's (.) kind of subsided an' I think it's-I used to
62 drink eight or ten Cokes a day.
63 D: 'N 'kay.
64 P: Diet Coke. An' now (.) I drink one to get keep a caffeine
65 headache away.
66 D: Okay.
67 P: I drink a lot of water but I still had a [↑]pain now and
68 then.

¹³ Patients used far fewer accounts than the researcher had expected. Chapter 6 further explains the findings regarding patient account-giving and the Chapter 7 (the Conclusion) offers reasons for this phenomenon.

In the next example, the justification type is the most common one used in this study. Patients know that when they feel sick, they should go to see their health care provider. However, many either do not take the time or else they believe that it will resolve itself. The patient in #0028 as is typical of many patients believes that “things will just get better.”

#0028

96 D: Now you got seen up at Temple, is that right, at the
97 hospital or at the clinic or...?
98 P: Yes, that's right. Yes. Hospital.
99 D: Okay, the emergency room?
100 P: One of those weekend deals.
101 D: Weekend fast.
102 P: Well, I should have gone last week, should've came over
103 here, but I didn't. I thought aw, it'd get better.

A final example of justifications involves medicine taking. Already established in Chapter 2, patients are non-compliant one third to one half of the time or even more, depending on the researchers' definition of non-compliance. Not surprisingly, patients frequently use justifications for not taking their medications or in this case, for avoiding doctors as much as possible.

#0021

297 P: She knew I was hurtin'.
298 D: ((laughter))
299 P: An' I died in the car as well. ((laughter)) I's so nervous
300 I couldn't even hold my hands still. ((laughter))
301 (8.7)
302 P: I haven't seen a doctor in twe:nty years an' even if I'd
303 ever seen one ↑before the:n. We didn't go to doctors when
304 we was children. (1.1) An' I'm pretty good about doctorin'
305 myself. ((laughter))

Excuses

Excuses, just like justifications, attempt to recount why the patient is not taking prescribed medications. Unlike justifications, excuses do not include rationalization; people use excuses in attempt to minimize personal responsibility, claiming that the event was attributable to external, uncontrollable, and/or unintentional causes (Dunn & Cody, 2000; Schlenker & Weigold, 1992). The patient in the following first example makes an excuse for not taking her migraine medicine; since her appeal is to ignorance, she escapes responsibility for not taking the prescribed drug. If she cannot find it, she cannot be held responsible to take it.

#0078

91 P: An' then the doctor gav-he had /gaven/ me (...) some ↑other
92 pills but I-I-I couldn't find the bottle an' so I didn't
93 take /↑enee/ [for the mi] graine.
94 D: [(Metrin.)]
95 D: Uh-huh. The-the Metrin.
96 P: °°Yah.°°
97 D: An' was ↑that helping?
98 P: Yea it helped, yea, mmm-hmm.

The next patient also denies taking her medicine as prescribed; according to Schönbach (1980), the appeals seem to be to biological factors. That is, the medicine kept her awake at night, so she stopped taking it at night and said she was only taking it during the day.

#0046

31 D: And now the [Well]butrin.
32 P: [Thi]s. Uhm, hmm.
33 D: Ah takin' it once? Or twice a day now? Twice.
34 P: I tried twice but I'm takin' it once.
35 D: Ok.
36 P: Because I go-ah-didn't get it-I when I take it at night I
37 feel like it keeps me awake.

Conclusion

This chapter begins with a description of the original focus on patient goals and the effects of the communication process between doctor and patient in modifying or enhancing goal realization. The author then depicts the shift to norms and account-giving. Patient Personal Norms were identified and coded into four categories: Symptom Norms, Medicine Norms, Lifestyle and Work Norms, and Miscellaneous Norms. Throughout the analysis, injunctive norms were broken into two main types—explicit and implicit. Injunctive norms that were directly stated by the doctor were labeled as “Explicit Norms.” “Implicit Norms” referred to statements or questions by the doctor which “implied” but did not directly state what behaviors the patient knew s/he should do. Patient accounts were also discovered as some patients seemed to be concerned with facework. Excuses and justifications were the most commonly found patient accounts. In Chapter 6, the researcher details the relationships found among some of the norms as well as new findings about norm

Chapter 6—Axial Coding—Analysis Level Two

This chapter delineates the move from categories of coded doctor and patient actions during the health visit to connections among the categories. The chapter begins with a sketch of the process of axial coding and then moves on to a description of each of the main relationships (following the order of codes found in Chapter 5), and significant patterns that emerged from this level of analysis. The chapter thus is divided into three main sections: Process of Axial Coding, Category Relationships, and Resulting Themes and Theory. Dialogue models which capture the resulting prototypes along with brief references to literature as they pertain to specific outcomes of the analysis are included within these sections.

Axial Coding: The Process

The second level of coding according to grounded theory is known as axial coding (Creswell, 1996; Strauss & Corbin, 2001). This stage of analysis comes after the process of open coding, the naming and categorizing of actions and behaviors which seem relevant to the research questions guiding the study (See Chapter 5 for more details on the process of open coding). When no new categories are emerging and no more are thought to be unearthed even if the researcher were to continue coding indefinitely, the researcher is said to reach “saturation” (Guba & Lincoln, 1982). At this point, axial coding can begin.

Axial coding is the procedure whereby all of the open codes are examined carefully according to their properties and attributes, comparing and contrasting them with other codes for the purpose of reducing the data into a more manageable and interpretable state. Data reduction is crucial in axial coding. It rarely is feasible to work

with over a thousand typed pages of data and the attendant x (fill in your number) of code and still produce significant or meaningful results. Therefore, open coding¹⁴ allows concentration on a more limited number of salient themes. The process of data reduction involves constant comparison to derive rules or patterns, grouping of these rules or patterns into a “tree” format, and then deriving themes as a final step

The first step in data reduction is to examine particular codes or group of codes (i.e., a parent node and its children nodes) can be the focus for the next level of analysis, axial coding. That is, in the mode of constant comparison (Miles & Huberman, 1984), whereby each coded unit in its context is compared with other units bearing the same code. Qualifying or conditional questions such as “How much?” or “How often?” or “When does this occur?” are asked of each code. For example, if two units both are coded with “Injunctive Norm: Medicine,” then the researcher looks to the contexts of that code. The researcher asks about conditions such as when the doctor invokes these, if an explanation typically follows the injunctive norm, if the patient frequently or rarely asks questions about the injunctive norm, etc. This way rules or patterns begin to become established for the use of the codes. As the usage patterns become recognizable, codes can be grouped with other codes bearing similar property or attribute values. For instance, if the patient seems to use several different excuses for not taking medicines such as “forgetting,” “not enough time in the morning,” “not thinking they were necessary,” and “too hard to swallow,” then the researcher is left with the challenge of seeing if and how those excuses fit together. Perhaps with the four codes listed in the previous sentence, the researcher might group the first two excuses together under “Unintentional Excuses” and the second two excuses under “Intentional

¹⁴ See Chapter 5 for a more in-depth explanation of open coding.

Excuses.” The context would be used to provide supportive examples of the connection of each of the subcategories. As subcategories of broader categories become evident, a type of “tree” with branches and smaller branches stemming from larger branches and the trunk can be constructed to display the relationships among all the categories.

During the process whereby codes are organized into groups with similar patterns and put into the hierarchical tree, main themes connecting the categories are beginning to materialize. These themes lead the researcher to make the connections or relationships and thus the founding of new theory or new spin on an already established theory.

From Opening Coding to Axial Coding: Category Relationships

Patient Personal Norms

As the process of categorization grew from labeling to identifying relationships among the codes, researcher noted that patient accounts sometimes followed physician injunctive norms. This awareness was augmented by a closer look at the idea of explicit versus implicit injunctive norms (discussed in more detail in Chapter 5). Therefore, even though all 60 doctor-patient transcripts were coded for patient personal norms, nothing further was analyzed in that area for several reasons. First, most of the personal norms concerned either patient routines or symptoms and did not directly relate to the emergence of physician injunctive norms, which was becoming one of the spotlights of the analysis. Second, there was a growing relationship between physician injunctive norms and patient accounts. This researcher did not want to shift attention away from this key link.

Physician Injunctive Norms

Physician injunctive norms¹⁵ emerged as the more salient set of codes. At first, the researcher tried to look at explicit and implicit injunctive norms (See Chapter 5) to see if main differences were related to theme of the norm such as medicine, exercise, stopping bad behaviors like smoking, etc. Breakdown according to theme did not produce any noteworthy distinctions. Another path of analysis led to studying explicit and implicit injunctive norms to see if there were differences in whether the norms were said as preventive measures (e.g., “Exercise will keep you healthy” and “Asprin can help prevent a heart attack”) or as intervention measures (e.g., “Take this antibiotic for 10 days to get rid of the infection” and “Try to cut back on your smoking”). This approach also did not generate anything new. However, because this method of analysis entails constant comparison (See Chapter 3), the researcher continued to read and re-read the transcripts for anything notable in the area of injunctive norms. Finally, some real variation and relationships emerged.

One finding caused the researcher to go back through all the injunctive norm codes (both the ones labeled “explicit injunctive norm” and also “implicit injunctive norm”) and re-categorize. As a reminder to the reader, in an earlier analysis stage (Refer to Chapter 5), the main difference between the two main categories of injunctive norms entailed whether or not the “You should do X” was directly or indirectly stated.

Brief examples from the data follow.

#0068

68	D:	->ya havin' trouble
69		sleeping< or...
70	P:	(..) °No.°

¹⁵ Since the vast majority of injunctive norms came from the doctor's speech, from this point on they will be referred to as simply “injunctive norms.”

71 D: °No.° ((Sounds like the Dr. drops something—it's very
 72 loud!!)) It's non-pharmacologically. >An' the ↑best way<
 73 thing to do, ya know, is eliminate caffeine an' ↑exer↓cise.

In the above example, the doctor's injunctive norm is clear, "Eliminate caffeine and exercise." In the next example, the doctor is more subtle in using the same theme of exercise. He asks poses the norm as a question.

#0044

193 D: Are you ah (1.1) exercising?
 194 P: Yes. Play basketball. Whenever I can. Usually on the
 195 weekend I play xxxxxxxxx game. So.
 196 D: 'K. That will keep you very busy. With the kind of sch-
 197 work load you have the schedule you have this year.

This time around in the analysis, a third main category of injunctive norms emerged, Understood Injunctive Norms. This label was applied to norms that surfaced from the *patient's speech* and not from the doctor's. In other words, the doctor did not tell patients what to do for improved health but it was patients who volunteered what they should be doing. These norms were not labeled personal norms because the patients in these cases acknowledged what they *should* do but either directly or indirectly indicated that they are *not* engaging in what they know would be good for better health (Kallgren, Reno, & Cialdini, 2000). These behaviors could not be considered "personal norms" until they became a part of the patients' lives. Three basic patterns of patient speech occurred (specific examples from the data are given later in this section under the appropriate headings). The patterns are, "I should have done X but didn't," "I need to do X," and "I used to do X but don't anymore."

. With the advent of this additional category, the axial coding took a slightly different twist than in the earlier stages. The researcher looked for ways to group

examples together under each of the three categories in order to compare and find similar patterns of dialogue, thus creating new subcategories. The rest of this chapter pursues this path presenting subcategories of injunctive norms in doctor-patient conversation and the common ways in which the norms unfold. Significant findings which have the potential to increase understanding of doctor-patient communication are therefore highlighted.

Explicit Injunctive Norms

Explicit injunctive norms were found to be the most frequently observed of the three main categories of injunctive norms. The vast majority of explicit norms spotlighted remedies or directions on how to take medicine. Additionally, with the explicit injunctive norms often came detailed explanations not found with the implicit norms or, understandably, with the understood norms coming from the patient's point of view. The following examples show doctors "giving orders" to their patients along with detailed instructions and/or explanations.

Very typically when doctors used explicit injunctive norms, patients tended to agree or promise to adhere to the doctor's directive. Doctors often included explanations with their directives. Model 1 Illustrates this. If physicians did not restate the norm and/or provide a rationale or explanation, then they moved onto the next topic, usually a question about symptoms (See Model 2 below).

Model 1

∴ Dr.: You need to do (not do) X. (Explicit injunctive norm)
Pat: Yes, will (do X). or OK. (Patient agrees or backchannel)
Dr.: It is good to do X because of Y. (Re-statement of norm plus explanation/rationale)
Pat: OK. (Patient agrees or backchannel)

OR

Model 2

Dr.: You need to do (not do) X. (Explicit injunctive norm)
Pat: Yes, will (do X). or OK. (Patient agrees or backchannel)
Dr.: Now, how is Y doing? (Moves onto next topic)

#0072

69 D: I mean you nee' to be on fluid pill an' you need to be /aun/ (.)
70 .hh Beta blocker to: (.) {/i/nhance - your: - (.) lifespan. You
71 know, ta (.) protect your heart. Ya know, so:...

72 P: Okay.

73 D: °You know°, {an' I hate-} an' I hate t-ya know the fact ya know
74 that we have to add (.) seemingly >↑one pill after another after
75 another<, but you know, [an' ↑sometimes you git up], you know,
76 you wake ↑up an' you're on
77 P: [(LOUD but can't decipher)]
78 D: ten ↑pill↓s, you know, HH >an' you say, (.) you know, well ↑how
79 did I ↑do this?< >Well you kinda< (.) peacemeal we've been
80 attacking °dif'rent ↑things, but°...
81 P: '↓Nother ↑thing >that makes life a little bit more ↑complicated.

#0069

120 D: Okay. So (.) Ibuprofen-I wantchu on Ibuprofen, .hh uhm, around
121 the clock, then, for the ↑nex' (.) week. Uhm, (.) how much are
122 you takin' right now?

123 P: Uhh, jus' whenever-I took one (.) /aun/ or I took two on
124 Saturday. They're eight hundred miligrams, not five. I thought
125 they were five, °but (XXXX).° I didn't take ↑an/ee/ yesterday
126 b'cause I (.) >hadta go to school< an' I didn't wanna (.) get
127 drugged up.

128 D: Well, Ibuprofen's not goin' make you (.) drowsy, okay? .hh An'
129 you need somethin' jus' ta (.) you know, fight the inflammation,
130 'n' uhm, you know. You don't ↑have to do an/ee/thing for ↑back
131 pain. Usually (.) particularly whiplash pain, is a self-limited
132 type of pain. (.) I know .hh when we've got (.) a complicating

133 factor wit the fact that you've got some chronic—you've got acute
134 and chronic pain. An' so, 9.) you know, one thing uh-hh—one
135 thing, the—the ↑right ↓low back pain, an' some of the off an'
136 /aun/, you know, numbness an' tingling, this may be somethin'
137 that's gonna continue↑. Th/ee/ (.) ↑neck should get be/dd/er an'
138 I suspect the med—mid-back will get be/dd/er. SHOULD, (.) all
139 right? An' you oughtta take somethin' pretty regular >as far as<
140 an anti-inflammatory. An' six hundred milligrams three times a
141 day at least (.) of Ibuprofen. If you've got the prescription,
142 fine. If you don't, you can use Advil®. You've got the
143 Cycloedenziprine, you oughtta take ↑that at least for the next
144 four or five days, an' generally back pain, an' ↑neck pain,
145 ↑whiplash pain gets be/dd/er. An' shoot, if it gets worse three
146 ta five days ↑after the (.) car accident. All the adrenalin
147 rush, an' everything, us'llly doe'n't bother you too much right
148 a↑way. An' it kinda sets ↑in over a °few days.° I dunno, that's
149 somethin' you know, will putchu to ↑sleep, if you're in, you
150 know, jus' bad pain. It's like Vicadin® or Tylenol number
151 ↑three.

#0016

26 D: So yur kind a stuck unless it turns bacterial an' kinda (.) .hhh
27 ya know it—is it [clea:r or is] it—as long] as it's kinda
28 clear stuff it's jus' ↑baby
29 P: [xxxxxxxxxxxxxx]
30 D: mucus an' .hhh an' uhh (.) ((swallow)) yeah the bulb suction.
31 Are you doin' ↑Saline (.) first? Are you puttin' some drops a
32 [] Saline
33 P: [Mmm hmm.]
34 D: down there? Yeah you should just get ah you know just the the
35 regular like Saline spray for adults? [] At-at
36 Albertson's or whatever just in
37 P: [Uhh hmm.]
38 D: their cold section—nothin' with medicine but jus' like saltwater
39 spray? An' put like ↑two drops down each side, one at a time put
40 like one or two drops down there .hhh an' suck that back <an'
41 then one or two drops down the other side>? <So it'll be two
42 things> that one you're gonna get more back↑ cuz it's gonna (.)
43 moisterize it a-an' then some of that is gonna actually
44 [go through and make it g]o down the other way. A-an'
45 P: [Make it (.) go down]
46 D: kind of lubricate that up. So just a couple a drops down uhm you
47 know each each nose an'—an' that's—°each nose each° nostril an'
48 that's abou:t a::ll you can do. .hhh We::ll? Doin' good
49 otherwise? Any problems?

#0068

129 D: I con↑gratulate you on (.) the smoking cessation, okay? You're
130 doing [really good.]
131 P: [(Oh, yeah.)] It's for my own ↑health. I've jus' got to ↑do

132 that.
133 D: Yo-you're-that's right. An' you're fifty-eight now. An' there's
134 not a, (.) you know, (.) i-if you're gonna ↑do it, now is the
135 ti:me. Because you know, you're gonna start runninn' to problems
136 with emphysema, .hh an' uhh problems with uhh you know, you've
137 dodged the ↑bullet as far as lung cancer so ↑far, and, you know,
138 [] no more of ↑that. An' then
139 P: [°Yeah.°]
140 D: ↑plus, you know, you're not at a point where you're ↑really are
141 (.) .hh your ↑lungs ↓have deteriorated where you have to use
142 ↑medicines, or oxygen, or an/ee/thing like that. You don't want
143 to ↑get there.
144 P: °Ahhh.°
145 D: You know.
146 P: An' you've ↑helped ↓me by talkin' to me about this ↑befor↓e. (.)
147 I don't wanna be walking around with an ↑oxygen bottle be↑hi:nd
148 me, draggin' it everywhere. (..) Yeah, I-I appreciate your
149 ↑help on this.

One interesting side note from the above transcript (#0068) is that is this only documentation in the entire data set where a patient refers back to an injunctive norm from an earlier visit and displays evidence of compliance with the physician norm.

Implicit and Explicit Injunctive Norms Together

As the constant comparison of codes evolved, there were dialogues where both explicit injunctive norms and implicit injunctive norms occurred within a few lines of one another. The common thread in all of these passages is that the implicit injunctive norm always appeared first and the explicit norm(s) came afterward. Very commonly the pattern was in Question and Answer (Q&A) form. That is, the doctor poses a question, which was really only “question” grammatically but actually was an implied or implicit norm. The patient responds affirmatively or negatively (and sometimes with an account if negatively), and the doctor reiterates the norm explicitly. The three examples that follow make use of these two patterns:

Model 1

Dr.: Are you doing *X*? Or assumption
patient is doing *X* (Implicit norm)
Pat: Yes, I'm doing *X*. (Patient admission/account)
Dr.: Good, keep doing *X*. (Explicit norm)

OR

Model 2

Dr.: Are you doing *X*? Or assumption
patient is doing *X* (Implicit norm)
Pat: No, but I need to do *X*. (Patient admission/account)
Dr.: Yes and here's why. (Explicit norm plus explanation.)

The following three examples have the implicit norm highlighted in green and the explicit norm highlighted in yellow.

#0001

272 P: An' when I walk (0.5) I ken still feel it °sometimes°.
273 (1.5)
274 D: The only other thing that ↑moves here is yer lateral cartilage?
275 an' sometimes when doin' a lot of ↓squatting you can get a
276 partial tear of the cartilage °right here°.
277 (0.7)
278 P: Well I don't squat. I sit on a...
279 D: Sit on a ↑bucket thing?
280 P: Yah.
281 D: Then that's good. That's a better way to do it.
282 P: Yah. You know sometimes I do that.

#0002 (Some of the dialog is truncated due to length)

100 D: How's your sleep? Are you able to sleep: well?
101 P: (0.5) Well r/ee/lly I get about (.) ((short laugh)) ma:: °°be°°
102 about four or five hours a n↑ight.
103 D: Why: ↓so little?
104 P: Well I go in at-at ↑four in the morning, y'know, that°'s ° the
105 time I go to bed, I go to ↑bed late.=
106 D: =wh↑y?
107 P: There's work at the ↑house.

119 D: Okay. An' uhm, ((swallows)) are you ↑not sleeping cuz you can't
 120 get to sleep or cuz you're wakin' up early an' you can't get back
 121 to sleep?
 122 (0.8)
 123 D: Is it hard for you to sleep?
 124 P: No it's ↓not ↑hard.=
 125 D: It's because you're (.) purposely forcing yourself to wake ↑up?
 126 and work?
 127 P: Ahh th/e/nk so. ((soft laugh))
 128 D: So at ↑four o'clock in the morning when you get ↑up, you set your
 129 alarm?
 130 P: Yes, Ahh set my alarm an' [XXXXXX] at r/ee/ly three-fifteen cuz I
 131 go /e/n
 132 D: [XXXXXX]
 133 P: at twelve.
 134 D: You go to ↑work at four?
 135 P: Mmm-hmm.

298 D: Uhh, would you like to try uhh a medicine (.) to uhh (.) decrease
 299 your headaches? that you take every day. You take it at bed
 300 time? every day? One thing, ↑though, th-five hours isn't enough
 301 sleep. Can you >go to bed< earlier?
 302 P: Mmm. I'll try. ((short laugh))
 303 D: Cuz, (.) I mean most people↑, a minimum of seven hours.
 304 P: Yeah.
 305 D: Do you know what I mean? An' u-uhh, the ↑headaches could be
 306 coming from that a↑lone.

#0035

111 D: Ok, go ahead and sit back up. You can put your shoe back on.
 112 I'm gonna do an x-ray on your knee. Have you tried any weight
 113 loss programs?
 114 P: Yeah.
 115 D: How successful were you?
 116 P: Not too well.
 117 D: Because I bet a lot of it, you know, the knee pain has to do with
 118 the weight. When you walk, you basically support all the weight
 119 and that can aggravate it and inflame it. I'm just gonna do an
 120 x-ray and make sure there's nothin' bad in there.
 120 P: Ok.
 121 D: And do you have some medicine you take for the pain?
 122 P: Na uh. Usually I just if it hurts that bad, I just take some
 123 Tylenol.
 124 D: Ok, and you can take Advil or Alleve, the Alleve you can take two
 125 pills three times a day and then when we get these results of the
 126 x-ray back and uh, go from there. But, I think a lot of it is
 127 gonna have to come from the weight loss.
 128 P: Probably.
 129 D: So we need to do that.

29 D: Are you doin' ↑Saline (.) first? Are you puttin' some drops a
 30 [] Saline
 31 P: [Mmm hmm.]
 32 D: down there? Yeah you should just get ah you know just the--the
 33 regular like Saline spray for adults? [] At-at
 34 Albertson's or whatever just in
 35 P: [Uhh hmm.]
 36 D: their cold section--nothin' with medicine but jus' like saltwater
 37 spray? An' put like ↑two drops down each side, one at a time put
 38 like one or two drops down there .hhh an' suck that back <an'
 39 then one or two drops down the other side>?

Implicit Injunctive Norms as Suggestions

Injunctive norms were found in two grammatical forms: Statements and Questions. Almost all of the statements (not questions) were imperative in nature; therefore, those falling into that category were labeled as “Suggestions.” One commonality among all of the Suggestions involved the category’s attributes. To briefly explain, all the norms were coded for their attributes and properties (Strauss & Corbin, 1990; 1998). If the injunctive norm was coded as “Intervention,” the norm was related to remedy or something the patient should do to help a current health situation or problem. If the norm was coded as “Prevention,” the norm was connected to something the patient should do to try to avoid a health situation or problem. Remarkably, of all the subcategories spawned during axial coding, Suggestions was the only one with all the injunctive norms containing the attribute of “intervention” solely and holding no “prevention” attributes.

Another distinction among the Suggestions, as might be expected, involves the use of the first person pronoun, “I.” Many of the Suggestions entailed the doctor saying, “What I would do is...,” “If I were you, I would...,” or “What I think we do right now is...” Other patterns included, “Maybe you can do X,” “If X happens, then you can do Y,” and

“Why don’t you do X?” Key words and phrases that signified the Suggestion subcategory consisted of “Would,” “Recommend,” “Why don’t you,” “What I think,” “Maybe,” “Might,” “Can,” and “Could.”

There were no patient refusals or any other form of account-giving found for this set of norms, plausibly because the behaviors were “suggested” by the doctors and therefore were to be enacted by the patients *in the future*. On the other hand, patients could have said that they would not be following the doctor’s orders; however, this response was not found in any of the coded transcripts. A few examples of suggested implicit norms follow.

#0078

271 P: he’s b/i/n doin’ so ↑good, you know, A’s and B’s.
272 D: I–I would uhh–I would ↓try to go get the school to try ta help.
273 {We could have} him uhh tested an’ we ↑counsel here for him?
274 P: Mmm.

The above example is a suggestion from the doctor (this is the third time the doctor has made this suggestion in this particular interaction) regarding getting some counseling for the patient’s son. The others that follow are suggestions for remedies and plans of action, the most common kinds of injunctive norms as suggestions.

#0050

153 D: Good hurt or a bad hurt.
154 P: Just (1.2) Ah(1.7) Hurts like a twisting er OW.
155 D: Bad hurt?
156 P: Yeah.
157 D: Okay. Instead of heat. I would not use heat there I would ju-I
158 recommend usin’ ice. Okay.

179 D: A::s:I was sayin’ a little bit ago. For further u-use. Ice.
180 Not heat. And just layin’ down either on your stomach or your
181 back with like a little cold pack. You know put it (0.8) in a

182 wash rag or a dish towel somethin' (0.7) between you and the ice.
183 Put an ice pack or a bag of frozen peas or whatever. Laying on
184 that because it's gonna push up on the tail bone that's gonna be
185 very very uncomfortable. If you can lay on that for thirty forty
186 minutes that would be ideal. That cold's gonna penetrate in
187 there really help reduce that spasm.

#0082

185 D: You know. An' uhh, I would stay away from (.) milk things. If
186 possible.
187 P: Dairy stuff?
188 D: Yeah, I would stay away from milk, but cheese is fi:ne, an' uhh,
189 it's jus' that milk is a little harder to break down when
190 [you have] one of those
191 P: [Right.]
192 D: viruses. But uhh, whatever appeals to you, you ken go ahead an'
193 eat, an' uhh (.) whether you throw [↑]up has more to do with the
194 illness usually, you know, with the virus, how strong it is in
195 your system, an' whether you're getting better or not, so.

#0021

221 D: Well, there's a couple things that I would recommend doin' the::n
222 is one I'll set ya [↑]up ta see the anesthesiologist. They're the
223 ones that do these injections. Okay. Uhm. I'll set that up, an'
224 I'm gonna set ya up ta see Doctor M____ back next week 'cuz yer
225 blood pressure's been up
226 [an] somethin' he needs ta—he needs ta evaluate. Uhm. And may
227 need ta—you know. I-I wouldn't jump on it real quick
228 P: [Yes.]
229 D: 'cuz you've said your blood pressures have been in the one
230 fifties and that's fine. The last time you saw him it was one
231 sixty. [] But it's-but it's hi[↑]gher than it should be.
232 P: [Yes.]

299 D: [It's very possible,] very possible. I would maybe seriously
300 consider about not usin' an/ee/:thing, an' if you git a rip
301 roarin' (.) itching with a lot of discharge, you know, come in
302 ↑then an' let me swab it or let whoever swab it an' then, uhh,
303 an' then maybe jus' use some ↓Di:flucan or (.) or a diff'rent
304 product, something like Terozol, or Femstat, or Loti
305 Gynelotrimen, it may ↑ha↓ve jus' a slightly diff'rent ↑ba↓se.
306 So.
307 P: °Mmm-hmm.°
308 D: Uhh, y'know, usually they use a—a fairly hypoallergenic (.) uhh,
309 base to mix the—to make the cream with. [] Uhm,
310 but it's possible,
311 P: [Mmm-hmm.]
312 D: you know, it ↑is possible tha t it ↑irritated °it, so.° .hh
313 P: Yeah, I remember now, I used the ↑Femstat before, I ↑think
314 {that's a ↑three-day (.) treatment?} (.) But uhh, uhh, it—it
315 doesn't ↑burn so much, but I had the feeling also it doesn't
316 ↑help that much. [] You know.
317 D: [Right.]
318 P: ((Slight short laugh))
319 D: I would (.) maybe refrain from doin' anything ri:ght now unless
320 you jus' get an obvious, ↑obvious yeast infection. []
321 Uhh, an' ri:ght ↑no↓w, you
322 P: [Yeah.]

Implicit Injunctive Norms as Questions (and Patient Accounts)

The most common implicit injunctive norm came in the form of the doctor's questions. The two types appearing most often in the data set questions about medicines (i.e., "So what are you taking for X?") as well as diet, exercise, and bad habits such as smoking (i.e., "Are you doing X regularly?" or "You don't do X, do you?") There were found to be no real differences among intervention and prevention types of norms; both were found.

None of the doctors appeared to make direct personal accusations in verbalizing injunctive norms, whether by direct statement, suggestion, question, or by any other grammatical device. Additionally, the researcher did not find that doctors expressed

issues in very direct ways indicating the doctor's knowledge of the patient's behaviors. An example would be "I know you still smoke two packs a day and you need to give that up" rather than what was found in the transcripts, "You need to give up smoking." Yet the researcher found that implicit norms as questions often elicited patient accounts; contrariwise, other forms of physician injunctive norms drew forth few, if any, patient reasons and accounts.

Because patient accounts are regularly given after Questions that are injunctive norms, there are more examples given in this section, showing various ways the dialogue progresses from injunctive norm to patient account. More commentary is included as well between quotations from the data. In the rest of this section, Injunctive norms and doctor explanations and questions are highlighted in yellow; patient accounts and other responses are highlighted in blue.

#0050

78 D: Have you been doin' this [(0.8)] regularly at home.
79 P: [Uhm mm.] °No I haven't.°...

89 D: Can you ah (0.5) tilt back er ah (0.5) stretch and make it do
90 that?
91 P: I don't know.
92 D: We'll try that in a little bit cuz that may be (0.7) related.
93 But a totally separate process. (Gonna) hurt you on this side
94 now. (See ya) hurtin'...

110 D: Ah if you let me give you a shot I could give you a shot right
111 now and help the pain today. When it wears off the pain comes
112 back so if that would be tonight give you a mu-couple a muscle
113 relaxants for that. A:nd. (1.5) Get you stretchin' again. (1.8)
114 (I mean) stretchin' this out and just makin' you (0.7) get takin'
115 (a dive.) (Real ginger there). Don't fall. (Oh.) If
116 it hurts just stop me. Ok so far?...

157 D: Okay. Instead of heat. I would not use heat there I would ju-I
158 recommend usin' ice. Okay. Go ahead and roll over and sit up.
159 Take yer time. Now (stops) take it easy...

162 D: Let me run and ah see if I have any samples of that for you. And
163 then I'm gonna go ahead and give you some Vicodin just for like
164 two or three days. To get you through the worst part of it. You
165 can take both and if you do it'll make you sleep good. Couple
166 times a day. Hot shower. Bendin' over. (Stout. You need to
167 stand up more I'm:onna test that.) Grab hold of the counter top
168 here with your left hand. Then. (1.0) turn around facin' me.
169 Grab your right ankle. Pull your knee straight down. Does that
170 (0.7) cause that tingling?
171 P: No not in that leg..

179 D: A::s:I was sayin' a little bit ago. For further u-use. Ice.
180 Not heat. And just layin' down either on your stomach or your
181 back with like a little cold pack. You know put it (0.8) in a
182 wash rag or a dish towel somethin' (0.7) between you and the ice.
183 Put an ice pack or a bag of frozen peas or whatever. Laying on
184 that because it's gonna push up on the tail bone that's gonna be
185 very very uncomfortable. If you can lay on that for thirty forty
186 minutes that would be ideal. That cold's gonna penetrate in
187 there really help reduce that spasm. Before you do that you may
188 get in the hot shower. Really stretch out. Take the medication.
189 Keep takin' the Naprocin even though it doesn't do anything cuz
190 it's helpin' reduce the inflammation. And I would urge you to
191 stay off ladders for a little while.
192 P: Twice a day?
193 D: Yes.

Physician Injunctive Norms with Accounts Model #1. In the above excerpt, the doctor and patient follow the basic model the researcher found in other conversations with injunctive norms as Questions. First, the doctor asks the Question; next, the patient gives an account; third, the doctor gives an explanation/rationale for engaging in the injunctive norm; fourth, the patient provides some type of positive feedback like agreeing with the doctor or perhaps backchannels during the doctor's explanation; and fifth, the injunctive norm is reinforced as it is repeated as an explicit injunctive norm.

The two models are similar to the patterns seen above when both explicit and implicit injunctive norms are evidenced in the same conversation. Here is Model #1:

Dr.:	Are you doing (not doing) X?	(Implicit injunctive norm)
Pat:	Yes, I'm doing X.	(Patient admission/account)
Dr.:	It is good to do X because of Y.	(Explanation/rationale)
Pat:	OK. I will.	(Positive feedback and/or backchannel)

Physician Injunctive Norms with Accounts Model #2. The next example typifies a slightly different model. When patients give excuses or justifications, they seem to follow these steps. First, the doctor asks the Question; next, the patient admits or gives an account of the behavior, including an excuse or justification; finally, rather than address the patient's account, the doctor either continues with more implicit injunctive norms as history or intake questions or else falls back to focusing on the chief complaint or concern of the visit. Interestingly, in no health visit does any doctor question, downplay, or directly refuse to accept the patient's account.

Model #2 appears below:

Dr.:	Are you doing (not doing) X?	(Implicit injunctive norm)
Pat:	No because of Y.	(Patient account— excuse/justification)
Dr.:	Are you doing Z?	(Additional implicit norms or chief complaint)

214 D: You don't smoke or drink or any of those kinds of things?
215 P: I drink, and I did smoke up until three years ago. I quit
216 smokin' three years ago and your nurse asked me, obviously you
217 don't use any tobacco products, and I said yes I do. I dip
218 snuff. I can't get away from the nicotine it seems like, you
219 know. But, I've been able to get rid of the cigarettes but...
220 D: How long did you smoke for?
221 P: Well, I quit one other time for three years, so that would be
222 about twenty - some odd years. Twenty-seven, twenty-five,
223 somethin' in there.
224 D: Ok. Alcohol is more or less a social alcohol use. No heavy
225 drinking.

226 P: [Um hum.]
227 D: Well, what I think we do right now, I mean we know what your
228 total cholesterol is and we know presumably what your LDL has
229 been in the past, which is been slightly elevated at least. We
230 do diet and exercise and repeat it in three months, but what
231 I'd like to do is get another fasting blood sugar here.

Following the second model introduced, in the next example the doctor brings in an injunctive norm. The patient admits she has not followed it and apologizes. She also gives the excuse that the reminder instruction card is not in plain view but in her dresser drawer. The doctor follows up with an explicit injunctive norm.

#0049

305 D: ((Laughs)) Yeah there's been a lot of that goin' around. Ah
306 soon as she gets here we're gonna check yer breasts. Are you
307 checking yer breasts-
308 -((Knock on door))
309 are you checking yer breasts regularly?
310 P: Ahh:: well no. Sorry 'bout that. No:?
311 D: XXXXXXXXXXXXXXXX.
312 P: I have the thing to tell ya but I haven't been doin' it.
313 D: ((Hang it in the shower.))
314 P: No it's in my dresser drawer right now. ((Laughs)) AHH.
315 D: XXXX[XXXXXXXXXXXX]
316 P: [I KNOW W]HERE IT'S AT AT LEAST!
317 C: Oh I XXXXXXXXXXXX sorry about that.
318 D: That's all right. (1.3) Yeah. At least once a month you oughta
319 check your breast. Just do it in the shower.

Another example of the Physician Injunctive Norms with Accounts (PINA) model follows. It is likely the patient says something about forgetting to take the vitamins (excuse) even though the recording could not capture the patient's words. Based on the doctor's response, it seems like the patient is making an excuse for not engaging in the behavior (vitamin-taking) that she knows she should.

#0039

70 D: Ok, well good, when you drink that stuff you'll probably have to
71 go. Ok, scoot on down to the end of the table.

72 D: What questions do you have?
 73 P: Don't know.
 74 D: Are you taking vitamins?
 75 P: As much as possible.
 76 D: Uh oh. Are you forgetting some?
 77 P: ((mumbling))
 78 D: Yeah. That baby needs those vitamins. Did you try putting it by
 79 your toothbrush?
 80 P: No.
 81 D: Sometimes that helps. You know, you brush your teeth twice a
 82 day, and one of those times you gotta remember it.

The next excerpt includes a patient's justification for not following a norm. That is, the patient knows she is not following an injunctive norm but what she is doing by not following the norm (sleeping more hours) is more important (work) and therefore she must be choosing the correct behavior. As an important side note, throughout the rest of the interaction the doctor continues to question the patient about the lack of sleep and remind the patient how important it is to get enough rest.

#0078

98 D: How's your slee:p?
 99 (1.0)
 100 D: How's your sleep? Are you able to sleep: well?
 101 P: (0.5) Well r/ee/lly I get about (.) ((short laugh)) ma:: °°be°°
 102 about four or five hours a n↑ight.
 103 D: Why: ↓so little?
 104 P: Well I go in at-at ↑four in the morning, y'know, that°'s ° the
 105 time I go to bed, I go to ↑bed late.=
 106 D: =Wh↑y?
 107 P: There's work at the ↑house.

The following is an example of a patient who does not take her medicine but uses the weather as an excuse.

172 D: You were takin' (Arturtec) at one time. Yur not takin' that
 173 anymore.
 174 P: °No.°
 175 D: That was a (0.5) anti-inflammatory (.) like the (1.4) ibeeprofin.
 176 (0.6) Yur not takin' that anymore?
 177 P: No. Just two's all [I-]

178 D: [Jus'] those two. Okay. Did ya (.)—do you
179 r'member why you stopped that one you were takin' at bed↑time?
180 P: (0.7) Yeah I'm—I was gonna take (.) all through the summer it was
181 so hot I don't know if the heat was what was kept me. I-↑I've
182 done good through the summer. [] But when the first
183 real cold spell started (1.2) if
184 D: [Uh huh.]
185 P: that's got anything to ↑do <with it or not>.
198 D: Well .hhh what I would do:: is (0.6) uhm (0.5) but you didn't—as
199 far as you know you really didn't have a whole lot of trouble
200 takin' that pill at bedtime.
201 P: Oh no! I liked that pill. It (.) relaxed me. ((laughter))
202 D: You were takin' a 50 milligram pill? Or you don't remember.
203 P: Fif-I think it's a fifty-
204 D: Fifty milligrams? (0.5) Did it make you too sleepy?
205 P: No? [(I didn't think)] take it before I go to sleep. ((laughter))
206 D: [((laughter))]
207 All right. (0.6) Uhh:. Let me uhh—we'll I wanta start ya back on
208 that pill.

In the final example here a pregnant woman has not signed up for child birth classes. Her excuse, not having a car, may be valid. While the doctor does not press her to sign up, she does ask if the patient is going to get a car soon. This is the only case in the data set where the doctor actively pushes the patient by pursuing the injunctive norm even when the patient offers an excuse. In fact, the doctor offers an alternative suggestion, an all-day child birth class, when the patient indicates she is unable to attend weekly classes.

#0034

23 D: 'N 'kay. Come on up here an' have a seat:. Did you sign ↑up for
24 the child birth class at all?
25 P: No.
26 D: No? Are you going to?
27 P: Trying to.
28 D: Trying to? Where are you gonna sign ↑up?
29 P: ((no audible response;))
30 D: Where did you ↑try?
31 P: I'm gonna try—since I don't have a car.
32 D: Oh, you don't have a car, that's right. Do you think you could
33 do the ↑one-day class at S_____ J_____ 's?

34 P: ((no audible response))
 35 D: Have you checked anywhere else?
 36 P: Nnn.
 37 D: No? Okay.
 63 D: Okay. How do you git here if you don't have a car?
 64 P: My sister.
 65 D: Okay. So she's here?
 66 P: Yeah.
 67 D: °'Kay.°
 68 (2.5)
 69 D: Are you gonna git a car any time soon?
 70 P: Hopefully?
 71 D: What are you gonna do if you go into labour?
 72 ((both are laughing))

Descriptive Norms Used as Implicit Injunctive Norms

Descriptive norms are labeled as such because they describe people's "normal" or typical behaviors. Cialdini and colleagues asserted that descriptive norms are motivating because they describe what the majority is doing and thus by sheer numbers suggests that the behavior is an "effective and adaptive action" (1990). There are only a few occurrences of descriptive norms found in the transcripts, and they all have two common factors. First, the doctors only and not the patients used descriptive norms; and second, descriptive norms were used always as implicit injunctive norms.

The first example is not necessarily health-related but is used nonetheless by the doctor to educate a young patient on work ethics. She tells the patient that employers do not like it when people come in late to work, thus implying that the patient needs to be on time for work.

#0074

48 P: Yeah. An' I went to Austin yesterday an' came [↑]back (.) like two
 49 hours late to work but I [↑]called like around [↑]three an' I wasn't
 50 supposed to be in at five?
 51 D: °Yeah°

52 P: An' he ↑said, If you're not responsible about >comin' in on ti:me
53 when we ↑need you<, how do I know you're responsible about ↑this?
54 D: °Yeah. Yeah.°. °°Yeah.°°
55 (1.0)
56 D: {People} ↑work people. I-I've had-I had a gal who worked out at
57 ↑their corp, an' she loved °the job, and she lost it° because she
58 came in late. An' like even one ti:me is a big deal to people,
59 ya know. =
60 P: =Mmm.
61 D: But that's rough, it's bad timing.
62 P: It's rough when ↑all this stuff happens.

In another example of a descriptive norm used as an implicit injunctive norm, the doctor is shrewd in addressing a potential factor for the patient's fatigue (i.e., not eating properly). Instead of asking what the patient eats or even if the patient considers her diet to be healthy, the doctor uses a descriptive norm to admonish Americans in general about their poor eating habits, thus eliciting the start of a conversation about the patient's diet without being face-threatening.

#0085

72 D: Uhm, but your serum-iron is ↑low. I mean, you DEFINITELY have an
73 iron deficiency anemia. .hhh Uhm, normal serum-iron levels
74 thirty-nine to hundred an' fifty an' yours is twenty-seven.
75 P: 'N' kay.
76 D: So {reall:y} (.) you know in terms of the things that would
77 ↑cause this? .hh First and foremost is in the American diet, is
78 is-it's diet-related. So if you're doin' any funky diets, err-
79 P: I'm not, I don't believe in the Zone, I don't believe in uhm
80 Atkins, or anything like that. I eat (.) regular foods. I
81 really do, an' maybe that's my downfall ((slight laugh during
82 last phrase)) because I don't-number one thing I ↑don't do is eat
83 enough (...) healthy↑...

Doctors in this data set used descriptive norms for the most part as a way of instruction about medication or other treatment.

Excerpts from #0044 and #0040 illustrate this concept.

117 P: Uhm. It said like apply like a really thin layer
118 D: For. (0.3) Several times a day? Two three times a day?
119 P: Uh:m. It was (1.6) let's see. I think most of the time it was
119 just once. I-I really (don't [know.])
120 D: [Yeah.] Most of the time people
121 will use it either morning or at night time. They use it once a
122 day instead of three times a day.
123 P: Ok.
124 D: And ah use it for three or four da:ys and it'll get better than
125 they'll stop. It'll come back. It's really better to try to hit
126 it hard.
127 P: [Uh, huh.](Chuckles))
128 D: You know.
129 P: Uhm,hmm.
130 D: Three-two or three times a da:y. For seven to ten days. Unless
131 it clears sooner than that. (1.6) And then be done with it for
132 (0.5) hopefully a month or two.
133 P: Oh. Ok.

#0040

115 P: But I guess your allowed to have a down day once in a while.
116 D: You know what guys I'll te[ll ya.] Yah-no
117 that's good
118 P: [Got r]eal nervous.
119 and ah and ah concerned.
120 P: Yeah.
121 D: Now well say concerned.
122 P: Yeah.
123 D: Y-you know here's the deal. ((Clears throat)) When people go
124 into surgery it's funny but when you go into major surgery. Ah::
125 hysterctomy, colon you know any type of major surgery
126 [] ah outside ah just
127 P: [Uhm hmm.]
128 D: local n[umbin]g. But when they put you to sleep and you have
129 P: [Yeah.]
130 D: major [] internal surgery. People kinda you know how they
131 their
132 P: [Yeah.]
133 D: feel good goin' into it even when your talkin' about forty year
134 old people. They feel good goin' in they have it done and they
135 they whoah once it stops hurting and two or three days and I'm
136 gonna feel like my normal self.
137 P: Xxxxxxxx.
138 D: And you have to put it in people's minds that even when you're
139 forty years old it's gonna be four or five weeks before you feel
140 back to the way you felt you know leading int[o that.]
141 Ah and if you're
142 P: [Yeah.] Uhm hmm.

143 D: eighty years old you're probably gonna have to double that. And
144 so people get a little bit ah ah (1.0) ahmm ah:what's the right
145 word impatient.

As stated previously, another example of a doctor using descriptive norms comes directly above. Perhaps significant in reassuring the patient, this doctor uses a series of descriptive norms to emphasize to the patient that she is “normal” and doing fine post-surgery.

Understood Injunctive Norms

This was a main category of physician injunctive norms labeled by the researcher; unlike explicit and implicit injunctive norms, understood norms are those that are spoken or referred to by the patient, not the doctor. Therefore, the statements “I should have done X but I didn’t,” “I need to do X,” and “I used to do X and now I don’t” are models for the understood injunctive norms echoed by the patients.

Some of the patients admitted that they should have come in sooner but kept putting off a health visit. The mindset of some patients was to avoid the doctor as much as possible.

#0028

96 D: Now you got seen up at Temple, is that right, at the hospital or
97 at the clinic or...?
98 P: [Yes, that's right] [Yes] [Hospital]
99 D: Okay, the emergency room?
100 P: One of those weekend deals.
101 D: Weekend fast
102 P: Well, I should have gone last week, should've came over here, but
103 I didn't. I thought aw, it'd get better.
104 D: Okay.

Other patients used the understood injunctive form to describe former “bad behaviors” they now avoided. In #0027 the patient justifies drinking one soda because

his behavior used to be much worse and at least now he has cut back considerably.

#0027

57 P: An'-an'-but you know gettin' back into sh[↑]ape. And (.) stuff
58 like that and (.) but all my life (...)I've had pain. Right here?
59 D: Mmm hmm.
60 P: Well it's (.) kind of subsided an' I think it's-I used to drink
61 eight or ten Cokes a day.
62 D: 'N 'kay.
63 P: Diet Coke. An' now (.) I drink one to get keep a caffeine
64 headache away.
65 D: Okay.
66 P: I drink a lot of water but I still had a [↑]pain now and then.

In the last example, the patient justifies stopping medication due to the side effects even though the medicine was prescribed to treat an ailment.

#0004

22 D: Well how've you been doin'?
23 P: I-I'm o-I'm o[↑]kay. Ya know you got the crud but that's okay. I
24 uhh (.) took the Zoloft for about a week an' it made me sick as a
25 dog.
26 D: Did it real[ly?]
27 P: [An'] I mean sick sick as a dog. An' (.) then we
28 got ca-we got like telephoned like Friday that we were gonna have
29 to be in Odessa on Mon/dy/ (.) so I had to drive straight out
30 there an' drive straight back (.) got back, (.) my (.) seventeen
31 (.) an' two week year old, an' uhh <pulled a lot of stuff> an'
32 promptly moved out of the house. She's now [↑]married. Uhm.
33 D: Humph.
34 P: Yeah I just didn't feel like rushin' to the bathroom. (0.8)
35 ((laughing)) So I quit takin' it.
36 D: Okay.

Resulting Themes and Theory

The main focus of this chapter has been to describe the means whereby the researcher arrived at the differing types of injunctive norms and their relationships (if any) to patient accounts. This next section summarizes the findings and poses

suggestions for future work in doctor-patient communication¹⁶.

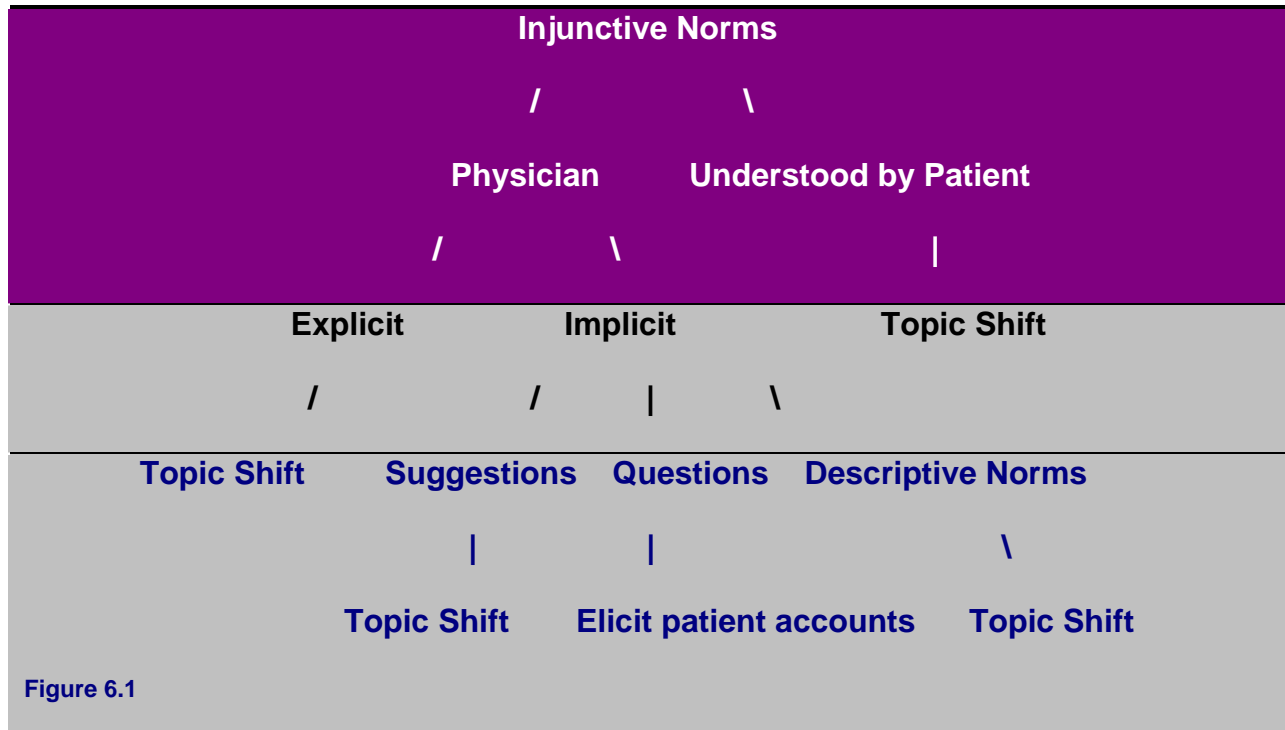


Figure 6.1

Explicit Injunctive Norms

Explicit injunctive norms were defined by the researcher as those directives by the physician that were phrased directly. The majority of explicit norms consisted of remedies or directions on how to take medicine. Interestingly, sometimes a long explanation or rationale would accompany the directives, especially with taking medicines. The only exception took place when the physician prescribed refills. Shorter explanations were found when ordering the patient to undergo some type of tests or other lab work. Detailed explanations did not come with exercise and diet injunctive norms.

There were no patient accounts given with explicit injunctive norms. In fact,

¹⁶ See Figure 6.1 for a depiction of the Relationship Tree of Categories

patients either did not respond verbally or else they had one of two other responses: they gave backchannels such as, “Mm-hmm” or “Yeah” or else they indicated verbally that they agreed with the doctor. A likely explanation is that normative behavior dictates agreeing with the authority figure (doctor) in the health visit. The researcher does not hypothesize the patient complied or even intended to comply in every instance there is an explicit injunctive norm; however, normative patient actions would not consist of disagreeing or arguing with the doctor.

Implicit Injunctive Norms as Suggestions

The idea of implicit injunctive norms emerged from the data. Distinguishing between implicit and explicit injunctive norms has not been an issue in doctor-patient dialogue to date. Perhaps one explanation as to why this distinction has never been made is because the patient goes to the doctor to obtain an evaluation on his/her health. Unlike in most other interpersonal situations, the patient is in a sense seeking good medical advice. Doctors know the situation is not one of equal power distribution. So perhaps doctors do not want to offend patients by touting too many injunctive norms. Explicit injunctive norms according to this researcher are more direct and therefore are potentially more face-threatening. Implicit injunctive norms are indirect, especially when phrased as suggestions. Linguistically, suggestions are not as face-threatening. Accordingly, doctors in this data set often followed the model of “If it were me, I would do X.” Even the doctor articulating, “I recommend doing X” is softer than “You need to do X” (Tedeschi & Reiss, 1981; Ting-Toomey, 1994)

Implicit Injunctive Norms as Questions

While the contention of this researcher is that implicit injunctive norms (as statements or suggestions) are not as direct or face-threatening as explicit injunctive norms, implicit norms as questions can be very face-threatening. Linguistically, questions innately are more face-threatening than declarative statements (Tracy, 2002). Questions require the other person to respond; in an uneven playing field where the doctor asks the patient about fitness and proper diet, the questions themselves can be extremely face-threatening if the patient isn't following good health practices. Doctor questions therefore can be more discomforting than explicit injunctive norms because there the latter do not require a patient response and/or admission. Additionally, injunctive norms as questions elicit patient accounts more than any other injunctive norm type but do not have the tendency to be perceived as pejorative like explicit injunctive norms, "You need to X" or "You should be doing X."

Two models came from the transcripts. The first is occurs when the doctor asks a question that is not followed by a patient account of defense. The model looks like the following:

Model 1

- D: Implicit injunctive norm as a question
- P: Answers question; no defense of bad behavior
- D: Rationale or explanation for asking the question
- P: Positive feedback or backchannels
- D: Usually injunctive norm repeated as explicit here

Model 2

- D: Implicit injunctive norm as a question
- P: Answers question and gives account for behavior (excuse or justification usually)

D: Does not address patient account; continues with questions or chief complaint

Descriptive Norms Used as Implicit Injunctive Norms

Descriptive norms are used in the literature of social norms to talk about what people generally are doing. Based on the idea of social comparison, descriptive norms could function as injunctive norms. A few doctors did utilize this concept; letting a patient know that s/he is normal for feeling a certain way is a good empathy or coping strategy. A few doctors employed the strategy of explaining that people who are taking X medicine have a better quality of life. Perhaps doctors can use more descriptive norms in their dialogue with patients since people in general are influenced by what they conceptualize as the popular norm of behavior.

Understood Injunctive Norms

Some of the patients acknowledged that they needed to be doing something or did something that they knew they should not have done. The researcher created a third main category of injunctive norms for these: Understood Injunctive Norms. Doctors generally did not comment on those types of admissions by patients. Accordingly, since doctors did not address patient excuses or justifications, it follows that they would move to another topic of question after patients had admitted they knew what they *ought* to do. Nevertheless, perhaps doctors might be able to make use of patient admissions by incorporating a plan of action, if need be, for the patient to be more compliant. In other words, in Prochaska and DiClemente's Model of Behavior Change, the first step is to acknowledge there is a problem and to want to change (1983). Perhaps doctors could use this model in terms of strengthening a patient's desire to do what s/he should do. Then, according to the Behavior Change model,

continue to gauge a patient's success in terms of psychologically changing behavior and moving in increments toward total behavior modification.

Conclusion

This chapter captured the process of axial coding by detailing the development of the main categories. The second part of the chapter discussed the relationship among the categories and pointed out their significance. Finally, the last section summarized the key findings including the reduction of the data into a few basic models of how doctors used norms in the data set and how patients responded.

Although much work has been done on account-giving, there is minimal research on the link between accounts and normative behavior (See Fritsche, 2002). Additionally, exhaustive searches have unearthed nothing on the categorization or development of injunctive norms or on a link between physician injunctive norms and patient accounts. This study, however, shows a strong association between doctor implicit injunctive norms (phrased as questions) and patient account-giving. Doctors frequently used implicit injunctive norms (questions), which were followed by patient responses/accounts. If a response was a refusal or admission, the doctor explicitly re-stated what the patient ought to be doing, or praised and emphasized the patient to continue with the (favorable) behavior. On the other hand, if the patient responded with a justification or excuse, the doctor seemingly accepted the account and moved onto another topic without further addressing reasons for not adhering to the injunctive norm. These findings reveal that there is much work left in trying to understand the process of communication between doctors and patients.

Chapter 7: Conclusion— Summary of Findings and Discussion

The purpose of the concluding chapter is to provide a summary of the major findings and to discuss how they add to current understanding of doctor-patient communication. The first section reviews the main categories of injunctive norms that emerged and the basic interaction models associated with them. The next section recommends suggestions for expansion of the findings in future studies. Limitations are offered in the final section.

Summary and Discussion

This section goes through the main tenets of explicit injunctive norms and the major categories of injunctive norms labeled during open coding. Patient accounts and their relationship to physician injunctive norms are explained. Additionally, models constructed during the last phases of axial coding are presented.

Types of Injunctive Norms

The first major contribution of the study entails the breakdown of injunctive doctor-patient communication norms into subcategories of explicit, implicit, and understood. Nowhere in the social sciences literature can these distinctions be found.

Explicit Injunctive Norms

Explicit injunctive norms (EINs) used by the physician are defined as more directly stated injunctive norms. Grammatically, EINs are in imperative form. Often they concerned medicine or prescriptions, diet, and exercise. Longer physician explanations accompanied prescription or treatment EINS but no explanations were found with diet and exercise EINs. A doctor's explanation to a diabetes patient of diet and exercise

following the EIN was the only exception found. Perhaps because the patient seemed to be diagnosed rather recently with diabetes (according to contextual details), the doctor included more explanation regarding proper nutrition and fitness habits.

Two models of typical explicit norms are found below. Model 1 depicts the physician including an explanation with the EIN; Model 2 occurs when the physician mentions the norm and then moves onto another topic after the patient has agreed or given a backchannel.

Model 1 of Explicit Norms

∴	Dr.:	You need to do (not do) X.	(Explicit injunctive norm)
	Pat:	Yes, will (do X). or OK.	(Patient agrees or backchannel)
	Dr.:	It is good to do X because of Y.	(Re-statement of norm plus explanation/rationale)
	Pat:	OK.	(Patient agrees or backchannel)

Model 2 of Explicit Norms

	Dr.:	You need to do (not do) X.	(Explicit injunctive norm)
	Pat:	Yes, will (do X). or OK.	(Patient agrees or backchannel)
	Dr.:	Now, how is Y doing?	(Moves onto next topic)

Implicit Injunctive Norms

Implicit injunctive norms (IINs) comprised the second category of norms created by this author. The author named these injunctive norms “implicit” because the actual language used by the doctor was not direct, like explicit norms. Instead, the norms were phrased *indirectly* as questions, hints, or suggestions rather than phrased directly. These norms

potentially were more face-threatening, particularly if presented in the form of a question¹⁷, when they typically were followed by the patient's account.

Two models were derived for injunctive norms. In each, explicit norms are included in the conversation thread. In the first model the physician asks the patient a question or assumes the patient is doing something (IIN). After providing an admission or refusal type of account, the doctor restates the norm explicitly. Models 1-2 show this type of conversation, the difference being that in the second model, the doctor provides an explanation along with the EIN.

Model 1

Dr.: Are you doing *X*? Or assumption patient is doing *X*. (Implicit norm)
Pat: Yes, I'm doing *X*. (Patient admission/account)
Dr.: Good, keep doing *X*. (Explicit norm)

Model 2

Dr.: Are you doing (not doing) *X*? (Implicit injunctive norm)
Pat: Yes, I'm doing *X*. (Patient admission/account)
Dr.: It is good to do *X* because of *Y*. (Explicit injunctive norm + rationale)
Pat: OK. I will. (Positive feedback / backchannel)

The third model is the one the researcher found extremely interesting. If after the IIN, the patient supplied an excuse or justification, the doctor did not pursue the account but continued on with another thread of conversation. Perhaps if even occasionally if not routinely a physician had commented or questioned the patient's excuse or justification,

¹⁷ See Chapter 6, Subsection entitled "Implicit Injunctive Norms as Questions" for more on questions as face-threatening.

the researcher would not have been so intrigued. As it was, doctors did *not* follow-up on these patient accounts.

Model 3

Dr.:	Are you doing (not doing) X?	(Implicit injunctive norm)
Pat:	No because of Y.	(Patient account— excuse/justification)
Dr.:	Are you doing Z?	(More implicit norms chief complaint)

Understood Injunctive Norms

A third category includes Understood Injunctive Norms (UINs). These were labeled UINs because they were not brought into the dialogue by the doctor but by the patient. The patient voluntarily said what s/he should be doing. For example, “I know I should cut back on caffeine” or “I should be wearing shin guards when I catch for my daughter” show that the patient is aware of good health and fitness practices. These were not considered “Personal Norms” because according to the patient’s wording, these were not adopted by the patients yet. Instead, they were behaviors the patients acknowledged they *should* be doing. Because these were less frequently found in the data, no models were developed.

Descriptive Norms Used as Injunctive Norms¹⁸

Just like with UINs, no models were developed for the subcategory of implicit injunctive norms even though this was a discovery by the researcher. Only a few examples could be found for Descriptive Norms Used as Injunctive Norms. In these dialogues, the doctor appeared to gently scold or convince the patient to use a

¹⁸ See Table 6.1 of Chapter 6 on Page 160 for the Relationship Tree of Categories followed by a discussion of descriptive norms used as injunctive norms.

medicine, utilizing descriptive norms as injunctive norms. For example, “People do not like it when their workers are late” and “Most people tend to do well on this medication.”

Implicit Norms and Patient Accounts

IINs, particularly those phrased as questions (i.e., “Do you exercise several times a week?” and “Are you eating three healthy meals a day?”) were the only type of injunctive norm that elicited patient accounts. Previously published models of normative behaviors and account-giving (Schönbach, 1990) these stages of the account episode:

- Failure event (actor commits norm violation)
- Opponent’s approach (opponent verbalizes negative reaction to norm violation)
- Account (accused gives admission or refusal and/or reason—justification or excuse or concession)
- Evaluation (opponent judges validity of accused’s account-giving)

According to Schönbach and other scholars writing about injunctive accounts and norms (Fritsche, 2002), there needs to be a failure event followed by the opponent’s reproach. The literature did not unearth any studies in which the researcher found the opponent (or actually, tentative opponent) beginning the account episode by presupposing, hinting, or questioning that the (soon-to-be) accused has done something to violate a norm. In the review, the violations were of social norms (Cialdini, 2003; Fritsche, 2002; Schönbach, 1990). It is questionable whether or not patient “bad behaviors” constitute social norm violations; this study may prove useful in breaking ground in a subsection of society: doctor-patient relationships. In fact, to date, there are no known models of doctor-patient communication which include any type of norms and accounts. The idea of norms and accounts and the models created through this

study may help other researchers to look more closely at patient behaviors, particularly in the area of compliance, and investigate more thoroughly the reasons for non-compliance.

Suggestions

The model of IIN, patient response, and EIN incorporates the device of repetition in attempt to secure patient compliance. Some doctors routinely made use of this sequence model while others did not. Since there was no follow-up with patients after the interaction and since the sample was so small, validity of the model could not be tested. However, future studies may consider testing this model for effectiveness in gaining patient compliance. If compliance is stronger following implicit injunctive norms than it is with other normative forms, then perhaps the two variations of this model should be taught in medical school.

UINs are also important conversational moves because they can alert the doctor that patients already know they need to be doing something. These patients are not denying that they have a problem; therefore, doctors have a good opportunity to explain good health practices or the benefit in continuing certain behaviors.

Hypotheses and Research Questions

The purpose of a grounded theory study is to investigate some phenomenon and to provide more insight into how something occurs. One hope is that the analyses will provide research questions or even hypotheses for future research (Strauss & Corbin, 1990; 1998). This study delved into an untapped area in doctor-patient communication

research: normative behavior and account-giving. Several hypotheses and research questions emerged throughout the process of analysis, especially during the last stage. The following paragraphs reveal the findings and detail how they surfaced.

A doctor relaying to a patient, “If I were you, I’d do the hot compresses and Tylenol® for a few days and then see if the swelling goes down” is clearly providing a suggestion for the patient to follow. The IINs as suggestions were actual recommendations of what the doctor would do if s/he were in that situation. A question, however, arises as to the effectiveness of IINs as suggestions compared with EINs. The first hypothesis that emerged from the analyses is as follows:

H1 Implicit injunctive norms (IINs) as suggestions are more effective in gaining patient compliance than explicit injunctive norms (EINs).

Another hypothesis is based on the fact that since IINs are not as direct, they are generally “softer” and preferred by patients over EINs. Descriptive injunctive norms used as implicit injunctive norms did not appear frequently in the data. It is not clear if this is because practice has shown them to be ineffective or, rather, doctors are not aware of this possible choice. One might ask if they were more aware of them, would doctors employ DINs more frequently? One might also ask if DINs might help gain patient compliance. In a recent study, Miller and Barnett (2004) found that adolescents were more likely to admit to being influenced to engage in alcohol and/or drug behavior if they thought others were doing it. That is, peer pressure certainly was found to be significant. Perhaps doctors could benefit from this idea. That is, if patients are made aware (or more aware) of what others are doing that is good and effective for better health practices, then it would seem that patients would exhibit higher levels of

compliance. Therefore, it seems important to determine the effectiveness of descriptive norms used as IINs. Therefore, the first research question is asked:

RQ How effective are descriptive implicit injunctive norms in gaining patient-compliance?

It is also interesting to explore how doctors respond to patient excuses, justifications, refusal and admissions. This author found it surprising that only twice did a physician (same physician but two different patients) follow-up or address an excuse or justification offered by a patient. In one instance when a patient said she forgot to take her pre-natal vitamins, the doctor suggested putting them with her toothbrush to take while brushing her teeth. Another patient had not registered for childbirth classes and said she did not have time or a car and was too tired. The doctor continued to insist throughout the rest of the visit that she sign up for the classes. Refusals and admissions, on the other hand, appeared to draw re-statements of EINs and/or explanations. Perhaps further research should explore patient excuses and justifications in other studies to determine if this is a common phenomenon. Therefore, the following research question is asked:

RQ2 Do doctors follow-up or address patient excuses and justifications?

If the previous research question results in an affirmative answer, then the next research question is offered:

RQ3 How do doctors manage patient excuses and justifications?

Finally, in these data, doctors' questions as injunctive implicit norms elicited more patient accounts (especially excuses and justifications) than any other IIN. Questions innately are face-threatening¹⁹ (Ting-Toomey, 1994; Tracy, 2002), particularly if a

¹⁹ See Ch. 6 Page 160 for more on face-threatening.

patient is not engaging in good health practices. Interestingly, the compliance data suggests that authoritative style of the physician was more significantly related to compliance (with injunctive norms) than was affiliative style (Buller & Buller, 1987; Street & Wiemann, 1987; Vermeire, Hearnshaw, Van Royen, & Denekens, 2001). Perhaps doctors should capitalize on this. When patients give excuses or justifications, it would be good for the doctor to remind the patient at that moment of the importance of adhering to the injunctive norm. Since authoritative style seems to be related to gaining compliance, perhaps doctors should respond to patient excuses and justifications. One idea is to train doctors in these linguistic cues and then audio record the doctor-patient interactions after the training to see if doctors implement the response strategies when given excuses or justifications. The last hypotheses arising from the data included:

- H2 Patient compliance is increased when doctors respond to patient excuses and justifications.
- H3 Physician training in detecting and responding to patient excuses and justifications increases compliance rates.

Psychosocial Issues

A concern raised by analyses of the conversations in this data set is the same one raised about a separate set of conversations by this researcher several years ago (Barnett-Theodori 2001). In both data sets, the researcher found that doctors avoided talking about psychosocial issues, regardless if anti-depressant medications or admission of depression were among topics discussed. To illustrate, in the current data set, one patient admitted that she was depressed and upset about getting older and having her hair fall out; nevertheless, the doctor never questioned her further or even addressed these psychosocial matters. Instead, the doctor continued the history-taking.

Another example for the current set of conversations entailed a patient for whom the doctor had prescribed the anti-depressant Zoloft. The patient decided she was not going to continue taking the medication because of the side effects. The doctor never argued with her, tried to persuade her to try another medicine, or even asked her how she was feeling. Instead he switched to another topic and never re-visited her depression.

Psychosocial issues arising in the doctor-patient interaction require further study and detailed discussion. Perhaps doctors need to be trained in how to pick up on these cues and/or medical care facility policies altered. As forms of Eastern medicinal traditions such as acupuncture, acupressure, and certainly chiropractic care gain more acceptance in Westernized health care practices, perhaps the importance of mental well being in addition to physical well being can be emphasized more in medical schools to the students as a means of ensuring better overall patient health.

Limitations

Three main limitations were found. First, due to in-depth analyses in a direction different than originally proposed, the study findings did not answer any of the former research questions. Additional research would be necessary to explore further and test former research questions.

Another limitation was the length of time taken to produce the findings. Transcription alone took a total of three and a half years (including the nine months in which no transcription or analyses could be conducted due to IRB investigations). The extra work of transcribing the words with diacritical markings for the paralinguistic cues was laborious and took much longer than had transcription of words alone. However,

an ex-committee member had insisted the data be transcribed at this level at earlier stages of the project since discourse analysis originally was proposed as the primary method of analysis. Nonetheless, In the end, that level of transcription was not needed for the type of analyses performed.

Finally, like any other qualitative study, the findings cannot be replicated. However, the purpose from the beginning was to investigate doctor-patient communication strategies and derive models which could then be tested with quantitative studies down the road. The study outcomes including hypotheses and research questions were not anticipated but may prove valuable to future investigations.

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Peer Reviewed Publications: Journal Articles and Book Reviews

Barnett, J. M. (2002). Review Note: Benjamin Crabtree & William Miller (Eds.) (1999). *Doing Qualitative Research* (2nd ed.). *Forum: Qualitative Social Research [on-line journal]*, 3(1). Available at: <http://qualitative-research.net/fqs/fqs-eng.htm> [Date of access: Month, Day, Year]

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