

A description of some of the features of general practice consultations in a clinic in India with reference to the Clinical Skills Assessment (CSA) of the United Kingdom Royal College of General Practitioners

**A thesis submitted in partial fulfilment for the degree of
Doctor in Education (EdD)**

Kay Mohanna

Institute of Education, University College London

2016

Abstract.

This thesis describes some of the features of general practice consultations in a clinic in India with reference to the Clinical Skills Assessment (CSA) of the United Kingdom Royal College of General Practitioners. There is a significant difference in the success rate in this postgraduate licensing assessment between those doctors trained in India and those trained in the UK, the reasons for which are not known. Some doctors from India feel that this is in part due to family medicine being performed differently in India. The results presented here first explore the reported experience of doctors working in family medicine in India through focus group and interviews looking at contextual aspects of practice; and then through conversation analysis explore the work done by talk-in-interaction in video recordings of actual family medicine consultations in India; a unique study.

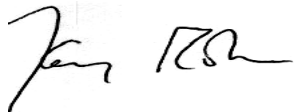
The CSA heavily emphasises the assessment of talk as used in three domains - data gathering, clinical management and interpersonal skills. I will propose a definition of 'interactional fluidity', based on the expectations of RCGP examiners about markers of competence, and consider its implications in this high stakes assessment process. Using a model that differentiates between 'core business work talk', 'work-related talk', 'social talk' and 'phatic communion', which last two are grouped as 'small talk', the talk in these consultations will be analysed. The impact of Indian societal norms and the risk of examiners mistaking unfamiliar patterns of talk for lack of medical competence are discussed.

Reflecting on the journey from clinician-educator to practitioner-researcher the thesis describes the impact the study has had on the personal practice of the author and also the implications for maintaining fairness in training and assessing international medical graduates within the UK.

Declaration

'I, Kay Mohanna, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.'

Signed

A handwritten signature in black ink, appearing to read 'Kay Mohanna', written over a faint, light-colored rectangular stamp.

May 2016

Acknowledgments

I am grateful to have received funding in the form of a Travel Fellowship from the Association for the Study of Medical Education in Europe and from Keele University School of Medicine.

Doctors and patients in the Nationwide Clinic generously opened up a window into their private consulting spaces without which this work would have been impossible.

Thank you.

Reflective statement

Re-reading my portfolio and Institution Focussed Study I am struck by the truth of the words spoken by Leo Colston in *The Go-Between*: 'The past is a foreign country: they do things differently there' (Hartley 1953, p5). I certainly feel, in re-reading my own words, that they come from a different place - so much time having passed. The reflective statement written in June 2010 that accompanied my portfolio is largely descriptive whereas a professional doctorate seems to require a more explicit discussion of the linkages between the academy and professional practice including reflection on the difference in the nature of knowledge itself in those two settings. So if my first reflective statement reads more like a description of what was done and why, in this second piece I will attempt a more critically reflective account which aspires to look forward by integrating all sources of learning and perhaps, even, synthesising a new identity. After all, if the past is a foreign country, then certainly as a traveller from that place, I must be as a foreigner to myself in this place.

There are elements in my portfolio that foreshadow my less than smooth journey from IFS to thesis. But there is also a risk of revision of personal history in the light of subsequent events so in order to minimise any such revisions or distortions I rely on my research diary to augment my imperfect recollections. I will consider the tensions between what counts as 'knowing' in the two settings of academic and professional life; the process of meaning-making both within and outside these pages and the impact of the emotional and transformative effect of such a prolonged period of study.

What would I say to my earlier self, starting out on the EdD? I might say, 'avoid choosing a research site 5000 miles away which is going to cost a minimum of £1000 for each field trip; avoid having to learn a brand new research skill with which professional researchers spend whole careers getting to grips; choose a field with a well-delineated literature, preferably one that is not being added to daily; and take care to keep an eye on your time line'. However knowing that then, as now, I would have been very likely to ignore such advice, this statement reflects on the impact of these and other factors.

What does it mean to 'know'?

My portfolio, IFS and thesis are by a 'researching professional' not a professional researcher. They focus on aspects of a real-world challenge with the specific aim of altering rather than just exploring or even explaining practice. Professional knowledge is characterised by being situated and contextual; academic knowledge might be said to be decontextualized and theory driven. A professional doctorate seeks to make links between these two types of knowledge. Expert practitioners are said to be able to demonstrate, or aspire to 'phronesis' - practical wisdom

constructed from personal experience, which might be tacit or not even reach the level of consciousness, and which through practice leads to *unconscious* competence (Eraut 1994). So there might be a sense in which the state of knowing exists in tension with, requires a period of, or even ends up as, a form of not-knowing. I found that at several points this non-linear, seeming contradiction in unpicking and examining professional practice started from, responded to, or ended up with me 'not knowing'; but whereas the not-knowing state of professional expertness results either from a form of not naming, or 'forgetting', the aligned state of academic not-knowing for me was closer to never-having-known and resulted in a 'flight into knowledge' as I will show below. I set out on my IFS very optimistically, having achieved ABAB grades in the taught component. I found a way to hold the tension of 'not knowing' in terms of social science research methodological expertise by presenting three forms of analysis in the IFS as a 'research training exercise'; that also achieved an A grade. It seems to me now that this could be characterised as a presentation of the self that worked to minimise the cognitive dissonance of moving out of a familiar role.

The feedback on MOE I and II had spoken of the need to engage more thoroughly with methodology and methods and, on MOE II in particular, the markers draw attention to weak theoretical underpinnings and a preliminary or even unfinished analysis. Feedback on the IFS continued this theme and included criticism of the lack of depth of analysis with any of the methodologies employed. The warning bells that this collective feedback should have sounded went largely unheeded.

What followed after the success of the IFS was a series of setbacks in my personal life, loss of any peer support such as the EdD study days, and considerable difficulty fixing on a way to approach the thesis. I failed to achieve support from my home institution in terms of identifying a research sponsor for funding, possibly related to the perceived sensitivity of the research topic. I took nine months before submitting a thesis proposal, which was rejected in May 2012. I clearly recall writing it in clinic between surgeries; hardly a way to create enough space and focus to generate a thoughtful proposal let alone develop an environment that was conducive to meta-cognition about the nature of knowledge. It was thus inadequately theorised, this latter being exactly what appropriate attention to previous feedback should have protected against.

The process of meaning making

This failure led to a significant loss of confidence. I carried out a pilot/scoping study in June 2012 but after returning from India progress was still very slow as I was undecided about continuing with the EdD. Looking back now with the enhanced clarity that time and distance has brought, it appears that my doctoral work, rather than bring together and make links between the knowledges of academic and professional practice, was put to one side, almost

forgotten about, as my focus turned to purely professional activities where I could reassert my identity as 'knower'; the flight into knowledge had started and the time line continued to slip. I had an abstract accepted for the conference of AMEE, the Association for Medical Education in Europe, in Lyon in August and a joint abstract with an Australian colleague for BERA in September 2012 and AARE (Australian Association for Research in Education) in December 2012. I ran two invited workshops drawing on the ideas generated by my initial IFS work in November 2012 and January 2013 and in February I was invited to be a peer reviewer for an Economic and Social Research Council bid by the RCGP and Kings College London in a Knowledge Transfer Partnership in a similar area of research. I published (Allen and Mohanna 2012, Mohanna 2013, Mohanna 2015). In this activity, I can see echoes of the actions of candidates for the CSA who, no longer called doctors but 'International Medical Graduates', respond to their loss of professional identity by making a flight into the biomedical model of medicine to avoid the epistemic uncertainty of a new consulting model.

Slowly however I found opportunities for discussion that rekindled my interest and reinforced the importance of pursuing my research in order to impact on practice. I felt all along there was a risk of a significant injustice being perpetrated by my profession on some of its members and was driven to explore that so I could argue for change from a position of knowledge or 'expertise'. I took some study leave from clinical practice which freed up three days a week to give me chance to breathe, read and think. I resubmitted my thesis proposal in April 2013. This time the feedback was positive and encouraging. The thesis workshops started up and I even found someone to lick wounds with who had a similar story around the defence of his thesis proposal. I attended some student-led workshops on research methodology and enjoyed having people to talk to with whom I could share ideas.

A crucial turning point was reached in July 2013 when I was accepted onto a residential linguistic ethnography course at Kings College London. My research diary contains an entry at this point that highlights the move from teacher to student status again and the liberation this brought: 'what a joy not to be responsible for ensuring the group goes well but to be able to focus on and soak up what others are saying'. As part of that programme we were required to create a poster of our proposed research and I think it was through the medium of being critically challenged to explain why I thought my work was important and would affect professional practice that the research questions started to crystalize.

Emotions and transformations

On at least two occasions in my EdD journey I have been reduced to tears; once, publically, during the first ill-fated thesis review the day before the funeral of a dear friend but once very early on, privately, after hearing an account of an experience of racism. My Initial Specialist

Course was transformative, giving me tools to think differently about what this latter emotion might represent. I have heard examiners and others reframe discriminatory practices based on an irrelevant difference (race) into an argument that the lack of progress of international medical graduates is in fact due to factors that are important to patient care (eg poor language skills). We might consider the RCGP to be a *defended organisation*. This use of a frequently asserted, superficially valid discriminator (poor communication getting in the way of patients' understanding) I suggest, is a defended observation resulting from resistance to the idea of white privilege. Through the lens of psychoanalytical theory, using Freud's work in Mourning and Melancholia, I looked at how we might predict that deep-seated resistance to change may result from uncovering the hidden grief arising from introjection of the racialised other. In acknowledging, explicitly, whiteness as a site of privilege, the resulting guilt may derail the process of change. This might explain the paradoxical outcome of the judicial review into the CSA where the RCGP was found both 'not to be racially discriminatory nor in breach of its public sector equality duty, but [at the same time] to be putting South Asian doctors at a disadvantage'. I learnt from this that if we seek change, we need an intervention that will minimise such resistance.

Final thoughts

The autobiography is the first of Brookfield's lenses through which we can become aware of the 'paradigmatic assumptions and instinctive reasonings that frame how we work' (Brookfield 1995, p29). As Brookfield also points out however, referencing Mezirow, 'I am always trapped inside my own meaning scheme and perspectives' (Brookfield, 1995, p33), unless we strive to 'look at ourselves from as many unfamiliar angles as possible' (Ibid p28). The EdD has enabled me to look at the CSA from many unfamiliar angles. In this reflective statement I have similarly tried to think about my practice from different angles, using Brookfield's other lenses of critical conversations with others (such as tutor feedback) and engagement with unfamiliar literature. The process has changed me. The researcher identity I have assumed has been created out of the eclectic approach of combining methodologies; in that approach I found a rationale that parallels my professional identify as a generalist.

The changes in me that have resulted from pursuing my EdD have affected both the academic and professional aspects of my role. I look for more reflexivity when assessing students' written work, and expect from them a close, critical, engagement with the theoretical literature. Teaching in the clinical setting I seek to facilitate greater insight into the work of talk itself. The next steps are to ensure dissemination of my findings about the nature of talk in the family medicine consultation and to engage productively in the political debate about the nature of a valid and reliable assessment tool for clinical skills, mindful of the difficulties of engaging a defended organisation.

Contents

	Page
Title Page	1
Abstract	2
Declaration	3
Acknowledgments	4
Reflective Statement	5
Contents Page	9
Index to figures, tables and data clips	12

Chapters

1. Introduction: 'It's not like this back home'

1.1	Overview	13
1.2	Context of the study: Problematizing assessment in British General Practice.	14
1.3	General practice as the site of healthcare delivery	17
1.4	General practice consulting: does one-size fit all?	18
1.5	Assumptions and limitations of existing research on the features of medical consultations	21
1.6	The introduction of a contextualised linguistic perspective into the study of medical interactions: the theoretical and methodological perspective being adopted	24
1.7	Conversation analysis, its critiques, and the contribution of thematic analysis to a conversation analysis	26
1.8	Rationale for the research strategy	32
1.9	Rationale for the selection of <i>interactional fluidity</i> as a focus for the analysis	33
1.10	Overview of the thesis structure	36

2. Literature Review: Doctors and patients talking

2.1	Introduction	38
2.2	Categorising activity in the consultation	39
2.3	Moving towards interactional analysis	41
2.4	Adoption of the methodology and extension to further areas of	42

Investigation	
2.4.1 Integrating gesture and body movement	42
2.4.2 Looking at the effect of technology	44
2.4.3 Gaze and eye contact	46
2.4.4 Openings, transitions and closings	47
2.4.5 Patient participation	49
2.4.6 Looking at content not structure	50
2.5 Conversation analysis and intervention studies	50
2.6 Conversation analysis outside the UK	51
2.7 Conclusion	54

3. Methodology and Methods 1

3.1 Introduction	56
3.2 The case study clinic	57
3.3. Ethics approval, consent and confidentiality	58
3.4 The participants	60
3.5 The three methods of data collection	62
3.5.1 The focus group	62
3.5.2 The interviews	63
3.5.3 Video data collection	64
3.6 Impact of the decision to video record consultations and to do so in English	65
3.6.1 Data omission	65
3.6.2 Language in the consultation	67
3.7 The two stages of the initial analysis	68
3.7.1 Transcription conventions	76
3.8 From transcription to analysis	78

4. Exploring the context: Methods 2 and outcomes

4.1 Introduction	79
4.2 Approach to the data	81
4.3 Thematic analysis	82
4.4 Conclusion	97

5. Results: A focus on talk in interaction

5.1	Introduction	101
5.2.	Identifying the form and functions of talk	105
5.2.1	Core business work talk	105
5.2.2	Work-related talk	107
5.2.3	Social talk	109
5.2.4.	Phatic talk	112
5.2.5	The risk of small talk	115
5.2.6	Enabling transitions	117
5.3	Creating alignment	119
5.3.1	Small talk as cultural story	119
5.3.2	Creating a space	120
5.4	Conclusion	122
6. Conclusion		124
7. References		132
Appendix:		146
A1	RCGP Generic indicators for CSA assessment domains	147
A2	Looking at general practice consulting around the world	148
A3	Ethics approval and consent forms	159
A4	RCGP CSA Grade Descriptors	164

Index to figures, tables and data clips

	Page
Table 1.1 CSA pass rates since introduction	15
Box 1.1 Foundations for Conversation Analysis	29
Table 3.1 Pseudonymised participant data	60
Clip 3.1	66
Clip 3.2	67
Clip 3.3	68
Clip 3.4	70
Clip 3.5	71
Table 3.2 Instances of talk that appear to be non-work-related.	73
Figure 3.1 Screenshot of CLAN in use	75
Figure 3.2 Screenshot of Praat in use	76
Box 3.1 Transcription Notation System	77
Table 4.1 Themes and codes	83
Clip 5.1	101
Clip 5.2	102
Clip 5.3	106
Clip 5.4	108
Image 5.1	108
Image 5.2	110
Clip 5.5	110
Clip 5.6	113
Image 5.3	114
Clip 5.7	116
Clip 5.8	118
Image 5.4	118
Clip 5.9	120
Clip 5.10	121

Chapter One: 'It's not like this back home'

1.1 Overview

This project started with a concern for fairness in the Clinical Skills Assessment (CSA) component of the licensing exam for United Kingdom (UK) general practice as organised by the Royal College of General Practitioners (RCGP). International Medical Graduates (IMGs) have a much higher failure rate in the CSA than UK graduates and very little research has been done to look at general practice outside the UK that might shed light on the challenge faced when coming to the UK for training. In part this lack of research is because in many countries there is no setting comparable with British general practice. In my Institution Focussed Study, I interviewed IMGs training for general practice in the UK and the quotation forming the title of this chapter derives from one of those interviews, suggesting that the respondent felt there was some significant difference in some aspect of medical practice that made it problematic for those moving into UK practice.

This thesis reports a unique study. I carried it out in India, the country of origin of the largest single UK group of overseas candidates and asked the research question: what are the features of the family medicine consultation in one clinic in India? Such research as does exist from other countries is largely interview or questionnaire based. This thesis, in contrast, analyses video-recorded consultations alongside interviews and thus constitutes a distinct perspective and contribution to the field.

This study combined the contrasting and complimentary productivity of conversation analysis of recorded consultations and thematic analysis of interview data. The CSA is an assessment of consulting with a strong emphasis on interpersonal skills, so from the beginning I wanted to look closely at video recorded data from actual doctor-patient consultations in general practice. The main literature review for my work thus focusses on methodological aspects of conversation analysis to explore the productivity of, and familiarise myself with, this method. In applying conversation analysis to video recorded consultations my aim was to focus on the fine detail of the form of consulting that doctors and patients use to create and sustain successful doctor-patient-relationships in this Indian clinic; relationships that in themselves then become part of the wider environment within which those consultations take place. The clinic was selected because of its strong reputation as a site of good clinical practice and its success in terms of its rapid growth in list size in recent years. Over the course of several visits to the research site I took the opportunity initially to immerse myself in the activity within the clinic, to explore as much as possible the drivers that influence practice. I held a formal focus group which I followed up with interviews with key respondents. Later, in talking and writing about the consultations I was analysing, I found I was drawing on this data to augment or contextualise that gained from the

conversation analysis. Information gathered by being present and talking to respondents was helping to inform the development of an analytic focus for the conversation analysis. It then seemed important to systematically analyse that early data in a more formal way. Through a thematic analysis of the focus group and interview data I sought to identify patterned meaning in the descriptions of features of the context from the perspective of the doctors in the clinic, across the data set.

Conversation analysis focuses on what can be observed and asks the questions 'why this now' and 'what happened next' to seek to make sense of observed conversations. Although it is said to set aside all reference to external context, it is enhanced by knowledge of the context to enable sense to be made - in particular, for example, when observed practice deviates in some way from expectations. Thematic analysis depends on analysis of self-reported experience and is subject to the meaning-making of the doctor as she reports what that experience means to her, and also a second loop of co-created meaning as the interviewer influences by questioning and interpreting what is heard. By looking for patterned meaning, we can see whether and to what extent those conclusions or observations are shared across the whole data set and might represent elements of a collective understanding of how practice is experienced. Thematic analysis can offer a way of looking at how practice is perceived, or how the felt experience of that practice is described, not all the time or by all players, but at least some of the time by some players. Conversation analysis addresses the limitation of this, filtered, subjective experience and can allow us to see how those experiences might be built up and perpetuated in the microcosm of individual conversations. Thus the two approaches potentially combine to give a broader insight into the 'features' of general practice consulting.

1.2 Context of the study: problematising assessment in British General Practice.

The CSA is a two hour simulated surgery where the candidates see 12 role-player patients. Candidates are fully qualified doctors who, before they are allowed to sit the assessment, have undergone additional higher specialist training of at least three years including a minimum of eighteen months in general practice.

International Medical Graduates (IMGs) make up around 35% of those taking the CSA. For those taking the CSA for the first time in 2011/12, the year I started this thesis, the pass rate was 90.1% for UK graduates and 34.7% for non-UK graduates, 30.6% for those graduating from South Asia (RCGP 2012, p29), see table 1.1.

Table 1.1: CSA pass rates since introduction

Country of Primary Medical Qualification	Annual overall pass rates %						
	2008	2009	2010	2010/11	2011/12	2012/13	2013/14
UK	91.8	93.8	94.2	91.8	90.1	92.5	91.8
Non UK (Total)	75.2	63.9	52	40.8	34.7	40.2	49.2
South Asia	56.4	59.4	51.2	36.9	30.6	36.3	45.2
Ref to RCGP annual reports	p17	p23	p20	p28	p29	p32	p35
Notable change			Last year of 'number needed to pass' standard setting	First year of 'borderline group' standard setting			First year after judicial inquiry

Summarised from RCGP annual reports, available on RCGP website <http://www.rcgp.org.uk/training-exams/mrcgp-exams-overview/mrcgp-annual-reports.aspx> , accessed 17.2.15

In my institution focussed study (IFS), this difference was ascribed by some of those in a sample of doctors who had failed this exam to being in part because, as they put it, 'It's not like this back home':

It's different here, the two countries are very different, the ways doctors are seen is very different. If I do the same consultation [like one for UK practice] back home in India honestly no patients would come back to me after if I ask them what do they think is going on. If I say 'what do you think is wrong, what do you think might help?' They'll think 'this doctor she doesn't know anything, I won't come back.' Whereas it's like 'you are the one who has gone through training you should know what is wrong with me.' It's more doctor centred, we have a duty to tell them what to do

Respondent 001, p4, IFS p52.

This difference arises in part because of the complexity of the doctor-patient relationship:

It involves the interaction between people in unequal positions, often non-voluntary, often addressing vitally important issues, emotionally laden, and requiring close co-operation

(Edwards and Elwyn 2009 p3).

In order to address this complexity a consultation model has evolved from which the RCGP has derived its assessment tool. This model has largely been derived in western settings and often derived via a delphi process of 'asking the experts' rather than by asking patients or by observing the work done in effective consultations (eg RCGP 1972).

It may be that some international medical graduates struggle with the CSA exam of the RCGP because the CSA is not flexible enough to recognise different ways in which the doctor-patient relationship is performed. If there are differences outside the UK, where over a third of doctors currently working in the UK are trained, there are implications for the movement of doctors between countries. The literature describes a 'linguistic penalty', derived by Roberts from notions of the 'ethnic penalty' and 'linguistic capital' to reflect the disadvantage a linguistic minority group might face, particularly in job interviews (Roberts 2010). This penalty derives from the fact that "selection and assessment depends crucially on face to face interaction, that these interactions are constructed of language interaction, but that what this means for linguistic minorities is almost never analysed nor accounted for" (Ibid p5). If a 'linguistic penalty' applies for these doctors it might be said to exert a 'gatekeeping role' (Roberts 2010, p4-5).

Whilst representing a personal and professional difficulty for IMGs, this is also one of growing controversy for the RCGP. The UK has both a diverse population where 13% of usual residents were born outside the UK (ONS 2012) and a globalised workforce which means both doctors and patients are increasingly mobile. The UK is an important site for the higher professional training of international graduates. In the face of a barrage of criticism from internationally trained doctors including some who are now UK trainers, plus legal action brought by the British Association of Physicians of Indian Origin (BAPIO) and the British International Doctors' Association (BIDA), the College is failing to maintain confidence in the CSA as an element of the licensing exam and is perceived by some as unfair (Sidhu 2012). In April 2014 in a judicial review of the exam Mr Justice John Mitting rejected a claim by BAPIO that the CSA should be declared unlawful. However it is of note that the judge warned the RCGP that although he found it to be neither racially discriminatory nor in breach of its public sector equality duty, he said that he was satisfied that the CSA put South Asian doctors at a disadvantage. This outcome was widely publicised in the professional and lay press (Siddiqui 2014). The review argued that since there is a disparity in results between different groups the RCGP should take action:

If it does not act and its failure to act is the subject of a further challenge, it may well be held to be in breach of its duty under section 149 [the Public Sector Equality Duty section of the Equality Act 2010] for that reason alone.

(Royal Courts of Justice 2014, paragraph 32).

In response to this 'call to act' the RCGP has continued its ongoing examination of the CSA, its rationale and scientific underpinnings as an assessment methodology. At the time of the Judicial Review, the Judge was able to draw on 18 peer reviewed papers from academics and statisticians that have looked at aspects of the exam. In terms of understanding the background training of IMGs however it is of note that the wider medical literature includes hardly any work that has looked at the nature of the general practice consultation outside the Western context. Indeed, during his judgment, Mr Justice Mitting echoed the view of respondent 001 cited above when he went on to hypothesise that:

[...]foreign graduates may lack familiarity with the approach expected by patients of general practitioners in the United Kingdom because of the nature of their training and the nature of medical practice in the country in which they trained

(Royal Courts of Justice 2014, paragraph 22, point 4).

1.3 General practice as the site of healthcare delivery

General practice, a primary care system of first patient-contacts delivered by generalist physicians and other healthcare professionals, is well recognised in the West, particularly in European and Scandinavian countries, Australia and North America. The primary healthcare service provision in those countries exists alongside formal training and regulatory structures, Whilst exhibiting some variation in emphasis, generally the function and recognition of general practice or family medicine as the location of much of the healthcare delivery, at least 90% in the UK, and as a filter and gatekeeper to further, more technical or specialist care, is well developed. A considerable evidence base exists to demonstrate the healthcare benefits as well as the efficiency and efficacy of such a structure (Starfield 2005) which ensures it continues to be reinforced and funded.

In other countries in South America, Africa, Asia and the Middle and Far East there is a much less well organised State primary care service infrastructure which means it has been developed by individual entrepreneurs, often in isolation, and in the private sector. General Practice in India is currently unregulated, there is no licensing examination and for the vast majority there is no formal postgraduate training. In order to earn a living however, and compete with other providers, doctors in primary care must develop an approach to healthcare that satisfies their patients, and in order to co-exist within a secondary care led healthcare model they must stay up-to-date and maintain standards of practice to support their patients. Thus centres of excellence do exist in primary care in India and my research setting was chosen as one of them.

The specialty of family medicine has been recognised in India since 1983 but there is virtually no exposure to the primary care setting for medical students or inclusion in the undergraduate curriculum (Kumar, R., interviewed in Pandey, R. 2013). For every medical school graduate there are overall only 0.3 postgraduate training places of which nationally less than 200 are for general practice. For a country with an estimated population of 1.27 billion there are 54,000 graduates from medical school annually of whom only 27,000 can enter specialist training forcing up to 8,000 doctors, estimates of actual numbers vary, to migrate every year to seek postgraduate training (The Healthcare Alliance 2014 p6). The rest have the option to leave medicine altogether or to set up their own clinic directly on leaving medical school. We can see that those coming to the UK for postgraduate training are unlikely then to have had opportunities to develop the same type and range of skills of generalist practice, compared to a UK graduate, whose medical school is very likely to have had considerable placements in primary care, perhaps as much as 26 weeks in total (see for example Keele University¹).

However, increasingly, the Indian government is recognising that an emphasis on primary and community care can reduce health inequalities. For example in the Indian Government Twelfth Five Year Plan the government aspires to Universal Health Coverage and recognises that the increasing burden of non-communicable disease in particular is best addressed by increasing the capacity in primary care and that expenditures on primary healthcare should account for at least 70 per cent of all healthcare expenditure (Indian Government Planning Commission 2013, p 20). Over time, if this aspiration is achieved and the opportunities in general practice increase, then the numbers of Indian GP trainees coming to the UK for postgraduate training might well decrease. Until that time, in order to achieve recognition of their professional status, doctors come to the UK and aspire to a British qualification, even when they plan to return home to practice.

1.4 General practice consulting: does one-size fit all?

In my Institution Focussed Study trainees raised further questions about the universal applicability of elements said to reflect a successful consultation. As an example, it is instructive to consider one of these, patient-centredness, as a 'good' of consultation. The term 'patient-centredness' was probably first coined and introduced into the medical literature in 1969 by Enid Balint, (Balint 1969) who contrasted it with 'illness-centred medicine'. Balint worked closely with her husband Michael Balint during the 50s and 60s at the Tavistock Clinic in London and he had previously drawn attention to the prevailing approach of doctors at that time that he named 'the Apostolic Function' (Balint 1955, p684).

¹ http://medicine2.keele.ac.uk/resources/course_brochure.pdf (P11/12)

It was almost as if every doctor had revealed knowledge of what was right and what was wrong for patients to expect...as if he had a sacred duty to convert to his faith all the ignorant and unbelieving among his patients

(Balint 1957, p216).

Balint, a psychoanalyst, suggested that individual doctors would very likely be unaware of how their own views ('the revealed knowledge') on illness could influence how they responded to patients. He suggested they would see their interventions as 'the only possible, the only natural or the only sensible way of dealing with the problem at issue' (Balint 1957, p215). He introduced the idea that collaboration with patients in a patient-centred form of consulting might be an alternative way forward; that a joint exploration taking into account the patient's understanding might be more fruitful. For this he coined the term the 'mutual investment company' (Balint 1957, p133) to describe the close understanding a patient and their doctor might develop, each of the other, over time and with attention to what we might these days call the world-view of each.

As the origins of a way of thinking about the doctor-patient relationship, this led to a model of consulting highly privileged by the RCGP (RCGP 1972), which would go on to underpin the CSA assessment (See Appendix A1, especially section 3). Roberts et al looked at videotaped consultations from the CSA in 2014 and showed that the exam has a specific linguistic 'fingerprint':

There are some words and phrases that are particular to the CSA, suggesting strong 'formulaic' differences from aspects of everyday spoken English ...[which] cluster around the social/interpersonal work of the CSA and show that it has a strong patient-centred model

(Roberts 2014, p123).

The key meaning of patient-centredness here is one of shared decision making. General practice training in the UK is built around the Calgary-Cambridge model of health communication (Kurtz et al 1997). A staged, structured model, this is derived from a whole person approach and requires the physician to consider the patient, rather than the disease, to be the focus of the consultation. It also requires the physician to work towards uncovering the patient's understanding of what is wrong, to engage the patient in shared decision-making leading to a mutually agreed formulation, with the co-production of an action plan.

For such a central theme in the literature, it is surprising that there is little direct evidence that increased patient involvement and shared decision-making can produce beneficial health results, or for its universal applicability. As a synthesis of work in this area a Cochrane

systematic review (Lewin 2001 updated in Dwamena 2012) used the outcome measure of 'shared treatment decision making' as a marker to select randomised controlled trials to review. It showed that it is possible to train healthcare providers to be more patient-centred, by which they meant the locus of control was shared with the patient and that care focused on whole-patient care, and also found that this increased patient satisfaction with the consultation. This paper however excluded trials of cultural, disability, sexuality or other sensitivity training areas where perhaps we could argue it would be even more important to foreground patient-centredness. However, Dwamena noted that 'the improved patient-centredness of the consultation did not lead to changes in patient behaviours or in health status outcomes where those were measured' (Dwamena 2012,p26). Indeed the review went on to state that there was evidence that the very opposite of patient-centredness, namely 'explicit physician-instruction in disease-specific management skills' may improve both health behaviour and health status in some settings.

As Skelton points out, much of the research into medical communication has been carried out in a western setting (Skelton 2001) and little is known about the appropriateness of applying patient-centred models such as the Calgary-Cambridge in non-western settings. Indeed even in the West, as Enid Balint herself commented, although a doctor might learn how to "ferret out [a patient's] carefully hidden secrets and fears...not every patient will be responsive to [that] sort of approach" (Balint 1969 p273-4).

There is increasing recognition that mutuality or shared decision-making may not suit all types of patients and furthermore, it is often not easy to achieve (Edwards and Elwyn 2010 p4). Experiences of decision-making are likely to be highly influenced by personal preferences, experiences, and relationships, and differences such as class, education and socio-cultural factors. They will also vary over time as people are more exposed or familiar with involvement in decision-making.

By considering just this one feature which is very important in terms of how integral it is to the RCGP assessment system, that of patient-centredness, we can see that it might not be safe to assume that effective general practice consulting has the same features in all settings. In this thesis I do not propose to consider the professional, ethical and political aspects of patient centredness, or its relative prevalence as a consulting style either in India or indeed the UK. Rather, by raising it, I am drawing attention to the fact that the RCGP in privileging it as an important feature of the assessment process has made a normative assumption that features of doctor-patient consultation, such as patient-centredness and shared decision-making, are both universally applicable and easily identifiable when present. However, as my exploration of the issue aims to demonstrate, these assumptions are not supported by evidence.

In particular it seems likely that the way doctors and patients talk together will be governed by a wide range of factors which might include their understanding of who has the most claim to applicable, relevant knowledge to draw on for problem solving. It might also be affected by a pre-existing, or developing, relationship of trust between them or the extent to which either feels able to present and defend their perspective. And both of these aspects might affect the degree to which each considers the other to have authority or responsibility to lead that discussion.

With this understanding then of some of the ways in which doctor-patient consulting might differ in different contexts I posed the research question:

what are the features of the general practice consultation in one clinic in India?

In carrying out the analysis my focus on the features of consultations was defined in relation to possible areas of contrast with the criteria used by the CSA assessors. The sub questions were

what does a thematic analysis of focus group and interview data tell us about the context of general practice in this clinic?

what does the conversation analysis tell us about those consultations?

how might thematic analysis frame a conversation analysis of recorded video data?

1.5 Assumptions and limitations of existing research on the features of medical consultations

The few studies that have set out to look at doctor-patient interactions outside the western world have used a range of methodologies leading to sometimes conflicting findings in relation to patient-centredness or aspects of the medico-social hierarchy. These findings were useful as background to my study both in pointing towards flaws in the assumptions made about the universality of the 'ideal' consultation style and also about appropriate research methodologies for such an investigation (See also Appendix 2).

For example, the attitudes of Nepalese medical students and doctors to aspects of doctor-patient communication in a teaching hospital in rural Nepal (Moore 2009) were compared to earlier findings on patients' attitudes in the same setting (Moore 2008). Agreement about the importance of a patient-centred approach was affirmed in the staff survey by self-report. When patients were questioned it seems their stated views on the importance of patient engagement were just as strong, with patients expressing a need to be listened to, not rushed and to be fully

informed. They also liked to be given clear instructions on what to do, however, an element missing from a more western patient-centered model. Moore found that Nepalese patients expected doctors to take control of the consultation and a 'caring' relationship was more important than one in which power, or decision making, was shared (Moore 2008,p42). We might speculate that this discrepancy arises from an inability of the doctors to convincingly engage with patients, as they try on the new model of shared-decision making. Or it might, as Moore concludes, mean that wholesale adoption of a western model of patient-centred care does not meet the needs of the population he studied (p40, 42). In particular Moore concludes that a strong social hierarchy affects the doctor-patient relationship in this setting. This work is limited as it does not observe the communication within actual consultations and is restricted to questionnaire data and interviews, but it nonetheless offers an interesting insight into the challenges these doctors and patients face, including that of consulting in a second language.

I noted a similar discrepancy between the stated ideal and observed practice in a questionnaire survey of general practitioners in a pilot stage during one of my first visits (Bangalore, June 2012). During the pilot, I was testing out the feasibility of the study and gathering background data to inform my knowledge of the setting. When asked, the clinic doctors almost universally volunteered 'patient-centricity' as an important feature of good consulting. However, the enactment of this concept, as defined by me for this purpose as an explicit and visible involvement of the patient in decision-making, was absent in nine out of the ten pilot video-recorded consultations that I gathered during the same visit. When I raised this in discussion with the doctors, one commented

The problem is here they see doctors as gods. Even we do try to treat them like as we have been taught, but they always want us to just tell them

Dr I.S. Nationwide Clinic June 2012.

This was similarly echoed in Moore's paper

The medical students were prepared to say that patients saw doctors as 'second to a god' and 'synonymous with god'.

(Moore 2009, p40)

Moore's observation about social hierarchy seems to be reflected in a body of work from Indonesia, which is the site of some of the only research into doctor-patient consultation style from Southeast Asia. Clarimita (2013b) states that in this region a variety of factors affect the way people communicate:

Southeast Asian culture is characterized by a hierarchical social structure. A large power distance between people of higher and lower social status is combined with a

collective rather than an individual orientation. This results in less autonomy for individuals in making decisions, and for patients, strong involvement of their family in medical decisions. High value is placed on nonverbal expressions of etiquettes of politeness

(Clarimita 2013b p147).

Clarimita's views are informed by her position as an insider-researcher, as a family physician and PhD student in Indonesia. One of her earliest pieces of work presented results from a mixed interview and observational study reporting on 393 observed, but not recorded, consultations (Clarimita 2011a). Here, Southeast Asian stakeholders (doctors, medical students and patients) stated they valued a partnership style of communication but observation of patient contacts looking for examples of "shared decision-making" showed that a "paternalistic style" prevailed (ibid p76). These authors speculate on the reason for the gap between stated and observed practice and, from additional interviews with patients and doctors, identified four potential barriers. Firstly the gap was generated in part by the volume and pressure of workload and the perceived time constraints this generated. Secondly patient participation seemed to be considered an artificial academic expectation, at odds with cultural expectation based on the social hierarchy. Since the doctor exists in a higher social rank than the patient, s/he is expected to control and direct the conversation and the medical decision-making. It might show itself in the patient feeling unable to disagree with the doctor, or express their lack of understanding. A related observation is the inequality of educational background between doctor and patient. Clarimita notes that in Indonesia although half of the population complete primary education only a small proportion progress further. Finally the authors found some evidence that the doctors were simply ill-prepared and trained in how to generate a more patient-centred approach.

This was followed up in subsequent work from the same lead author (Clarimita 2013a) who interviewed 20 doctors and 20 patients in outpatient clinics. The authors conclude that:

Using a partnership doctor-patient communication style as generally recommended in Western medicine is no easy task in a culture in which communication is determined by accepted social differences and indirect communication patterns aimed at avoiding conflict and maintaining a pleasant atmosphere (Ibid p27).

The cross cultural usefulness of the Calgary-Cambridge model was explicitly tested in one study which seems to contradict this conclusion (Kiguli 2011). Three focus group interviews and three key informant interviews were conducted with 24 caregivers of sick children in Mulago Hospital Kampala, Uganda. The theoretical frame in this study was a variation of grounded theory and the methodology a qualitative analysis of interview data. This was secondary care rather than

family medicine, but the authors' analysis identified a theme suggesting some similarities of expectation about what constituted effective communication skills. This study generates useful insights by using solely a thematic analysis approach to in-depth interview data despite not observing what happens in practice. The productivity of this approach arises from the alignment with the research question which here sought to explore patients' and care givers' expectation or insights into what talk in effective consultations should look like.

The literature on doctor-patient consulting outside the West is largely based on interviews or questionnaires and mostly done in secondary care settings (hospitals and out-patient clinics). This latter aspect arises in part from the lack of formal general practice or family medicine settings in which to observe such consulting; but a further limitation of the existing work is that methodologies that look at sense-making by respondents after the event are not also accompanied by observational work. This requires respondents to say what they do, and arises from a subjectivist epistemology that aspires to understand behaviours by reconstructing the self-understandings of respondents. This can be a powerful way of seeking to understand, in the subject's own terms, what a medical interaction meant to them. However, on its own it does not help us see how an interaction develops between two people and what the features of that interaction might look like. Uniquely, in my thesis, a combination of approaches seeks to bring together the strengths of an observational methodology and a thematic analysis of interview data seeking to compensate with each, for the limitations of the other.

1.6 The introduction of a contextualised linguistic perspective into the study of medical interactions: the theoretical and methodological perspective being adopted

In this thesis I take as my starting point the perspective that the consultation is a socially constructed event which is likely to include a shifting and variable balance in the exercise of and response to power relationships which will be socially formed and culturally bounded, just as alluded to above (Clarimata 2011a, 2011b, 2013a). The doctor-patient relationship sits in the context of the status of doctors in a society, is affected by the locus of knowledge and thus power within the dyadic relationship, is enacted and enabled through the social norms dictating behaviours of both actors but is also created through the interpersonal skills of each acting together. Together their actions will co-create and perpetuate what is seen as culturally appropriate and effective consulting.

It thus seems appropriate to use an approach that can look at the discursive production of meaning plus one that looks also at the felt experience and meaning made from that experience by participants, and there are some examples in the literature which demonstrate a similar approach. A previous RCGP assessment, the viva voce exam, was analysed in one of the earliest pieces of work based on an ethnographic discourse analysis of medical assessment to

be published in the mainstream medical literature (Roberts 2000). Interactional and linguistic analysis was combined with knowledge of the participants gained from interviews. Here Roberts introduced the concept of 'slippery areas' in oral assessment and the risk of hybrid discourses that conflate the personal, professional and institutional discourses in such assessment. For example she found it was common for questions posed in one discourse – the personal, for example, as in 'how would you feel if a patient...' to be answered in the institutional discourse, 'we have a procedure for dealing with that' - but for examiners not to recognise the shift in discourse or be aware of how any errors in an expected answer might have arisen. Roberts' paper demonstrates the utility of a socio-linguistic approach in facilitating an analysis of a complex area, here revealing how examiners and candidates co-construct what happens in an oral exam through questions, leading to answers, leading to the next question, that might also be applied to discourses situated within a range of complex contexts. Perhaps foreshadowing the future events of the judicial inquiry, Roberts warned of the potential for appeal by overseas trained doctors who may be disproportionately disadvantaged by the challenge such talk in assessment represents.

Around the same time Roberts was the analyst on a paper that showed the utility of conversation analysis for looking at video-recorded assessments of simulated consultations with medical students, which revealed that examiners (and their institutions) may not always be aware of hidden processes or subtle differences in talk that leads to success or otherwise in exam performance (Wass et al 2003). There was some alignment found in this work between the views of examiners and role player in judging students, a tendency for some of those candidates judged by examiners to have performed less well to be felt by the role players to have 'distanced' themselves from the patient and failed to build an effective 'interactional climate'. But, in an outcome that has some similarities with Moore's findings regarding patients in Nepal (2009), some candidates were rated highly by white examiners when the role players, from ethnic minorities, disagreed. This tended to be where there was more meta-communication or 'talk about the talk' and candidates deferred giving explicit guidance for the 'patient'. Here, role playing patients, just like the Nepalese patients, expressed a preference to be given full instructions by the doctor. Thus in these instances, the examiners rewarded textbook style 'good' consulting, but some of the role players from minority ethnic backgrounds disagreed.

The same data was further analysed by the application of interactional sociolinguistics, drawing on ethnography and conversation analysis, to describe 'communicative styles' that lead to performances being rated 'good' or 'poor' in the exam (Roberts 2003). This paper is interesting for several reasons apart from the findings of the research. It is published in a medical education journal, not a specialist journal from the world of discourse analysis, which reflects the growing awareness of the applicability of this kind of analysis in medical education. It is long, ten pages, and contains technical details about conversation analysis not usually seen in

medical journals, which positions it as an instructional opportunity for others seeing the utility of such analysis and considering applying it. In the face of this increased interest, Roberts and Sarangi went on later to issue a reminder that linguistic research should strive to be recognisably and practically relevant to practitioners, not ‘irrelevant or fanciful’ (Roberts and Sarangi 2003, p356) after expressing disappointment that they might ‘only’ have achieved ‘meaningful problematisation’:

There is a fine line between claiming usefulness because of raising awareness and recognising that such awareness might be ephemeral and soon gone with the wind. After all how many busy GPs want ‘meaningful problematisation’ rather than a solution?
(Roberts and Sarangi 2003, p356)

The literature review reveals that there has been no similar linguistic analysis of general practice consulting in India, making my research unique. Bearing in mind the reminder to strive for ‘practically relevant’ research I will now lay out the analytical tools for this research, first through a discussion of the principles and practice of conversation analysis.

1.7 Conversation analysis, its critiques, and the contribution of thematic analysis to a conversation analysis

In this section I set out some of the principles of conversation analysis and its productivity, but also critiques of the approach, and an argument for the productivity of combining conversation analysis with additional contextual data.

Some of the earliest analyses of doctor-patient consulting (eg Byrne and Long, 1976) took an approach that counted and coded activity in a way that that has added a great deal to the understanding of how doctor-patient encounters are constituted. However, this approach risks losing the context, generated in the ‘here and now’, of the relationship co-constructed between *this* doctor and *this* patient. In addition it requires the observer to make a judgment from an etic perspective about what is ‘meant’ by an utterance and to label such talk from ‘the outside’, the observer’s perspective. This is particularly problematic, for example, for such an internally-experienced aspect as empathy or rapport.

In the conversation analysis approach it is the displayed understanding of the intended recipient by their subsequent actions, including further talk, that reveals the meaning of the received talk. The starting point is that the work that talk does is the reaction it provokes, that talk projects meaning, but also that it displays an understanding of what will come.

This is of great relevance to the medical interaction, since we might claim that all that matters is the action of the hearer: will he stop smoking - what came before was understood as a warning, take the medicine - what came before was orientated to as an offer, or a suggestion, feel better after the consultation - what came before was felt as kindness, or reassurance.

Conversation analysis is the study of the development of meaning and context by looking at talk-in-interaction (Cameron 2001, p87). It is particularly a way of looking at how the social order, 'what things are like round here' is perpetuated through talk (Garfinkel, cited in Cameron 2001, p48). That the social order, the system of values, customs and practices in a given setting, can be considered to be created and perpetuated through talk was explored in the lectures of Sacks (Sacks (1964-72) cited in Heritage 1998, p3). Sacks also made the important claim that talk generates mutual understanding through sequencing. When people talk, what they say could be said to be precipitated by what has been said immediately before (ie it arises out of the context) and it then enables what is said afterwards (ie it renews context). In responding to what went before, participants demonstrate the understanding between them and, in a conversation analysis approach, this meaning is said to be generated independently of any external influences. Schegloff in particular held the view that unless these influences are made explicit by the speakers they cannot be looked to to make sense of what is being said (Schegloff (1972) cited in Heritage, 1998, p3). It is within the strict order of utterances that meaning is co-created.

It is clear however that doctors and patients will be influenced by social, political or other aspects of the setting governing what sorts of things, and in which kinds of ways, topics are considered 'correct', permissible or appropriate to bring to the doctors. In this thesis I attempt to explore this with the parallel emphasis on thematic analysis. Garfinkel identified such features of a setting as the 'background expectancies', and named a process of inexplicit 'practical reasoning' by which interactants 'know' which norms pertain (Sidnell 2010, p7). A data-gathering method such as interviewing can explore the extent to which respondents are aware of these differences.

Conversation analysts seek to understand what meaning is inferred by the hearer, which might also include projected meanings arising from choice of reply-preferences embedded in an utterance. To understand this, consider the conversation analysis concept of adjacency-pairs. An adjacency-pair is a conversational unit made up of one turn of speech by each of two people, and with an expectation that the first speaker will stop to allow for the second-pair part. For some first-pair parts, there is a commonly expected second-pair part, the 'preferred' response - statistically, not psychologically preferred. This gives us a way of thinking about turn taking: how as a patient do we know when it is our turn to talk, how it comes about that we don't speak at the same time as the doctor, or interrupt (and why it feels impolite when we do). It also

allows us to note when a preferred response is not forthcoming and take some meaning from that. The underpinning theory of how conversation analysis works is that a conversation is mutually negotiated by the interactants, in taken-for-granted ways, that they may not even be aware of, but echoes of which can be found if you look closely enough at the talk. So conversation analysis has the effect of rendering visible the invisible machinations of how we make sense of the things we hear. On a broader scale the whole social structure could be considered to be constituted through people's actions, and by studying the orderly properties of talk, we can come to see how social order is made as a conversational activity.

Sacks initially developed conversation analysis as a tool to look at conversations with callers to a suicide help-line in the 1970s and by the 1980s it had been taken up and applied to the analysis of institutional talk including the medical consultation. Drew and Heritage (1992, p22) identified the three differentiating features of institutional talk as compared to 'ordinary conversation' to be a goal-orientation by the participants, some form of constraint as to appropriate features of the talk and the use of particular 'inferential frameworks' within the talk. In general, discourse analysis can work both 'at the level of whole encounters and at the micro level of detailed features of talk' (Roberts and Sarangi 2005, 638), but conversation analysis as a form of micro-analysis can be seen as particularly useful where it helps foreground 'hidden' aspects of interpersonal communication that might create or perpetuate inequalities or misunderstandings. Such a study relies on being able to interpret language-in-action and enables us to examine how language constructs medical practice (Roberts and Sarangi 2005).

Ways of being polite, showing interest, raising concerns, arguing, all require interactants to understand the correct degree of '[attention] to the right things, at the right moments and conveying just the right degree of involvement' (Sidnell 2010, p7) and Goffman coined the term 'interaction order' to describe how the rules of social interaction apply in these ordinary, everyday contexts (Goffman, 1983, p2). If the person you are speaking to does not follow these rules, for example by not maintaining the expected degree of eye contact, or reciprocity, you may conclude at best they are not really listening, or at worst are uncaring or disrespectful. To Goffman this was not just a study in 'politeness' but as the way in which social identities are produced as ordered categories and confer our legitimacy as social participant. But what might result if these two people come from different countries, where politeness or respect are signalled by completely differing degrees of eye contact? If you are in an assessment situation, attempting to persuade an examiner that you are a safe and effective doctor, whilst consulting with an actor who is pretending to be a patient, you need to be able to reproduce, and make visible, the appropriate degree of smooth, un-selfconscious involvement that conveys the meaning 'Good Doctor'. Any lack of such skill, might not be recognised as a particular context-specific interactional competence, but rather as poor-performance.

Goffman also suggested that interactants work to project an idealised version of themselves, the sort of 'self' they want, or need to be seen as. If the 'veneer' (Goffman, 1959, p9) is cracked or slips for example through an error or moment of inattention, there may be a resultant loss of face. Out of politeness or tact this may be ignored by the hearer, but if this is an assessment situation it might affect the outcome. Crucially, in the assessment situation, to project an appropriate and believable definition of the situation requires the candidate to have knowledge of its requirements.

It was the work of Sacks that created a tool-box of methods for looking at *how* this work was done with talk (Sacks, Schegloff and Jefferson 1974). Interactants generally talk one at a time and take turns to speak but at times overlapping speech and interruptions occur which can give insights into how the interactants are making meaning. Certain elements of talk exhibit regular patterns, predict certain types of response, can be pre-empted and do particular types of work. Similar patterns also exist with gesture, bodily movements and gaze and have become of particular interest to later generations of conversation analysts. In applying these rules and noting deviations from these main principles we can find clues to how each understands the other and their mutual context, purely through what is said and done in the here and now. They are said to develop intersubjectivity, a display that they understand each other, not simply through any prior understanding of their setting or the task before them or any external influence, but through the way they recreate in every new occurrence and by displaying through their response when it is their turn to speak, that they have understood what has gone before. Sacks et al credit Garfinkel with their insight that:

...the most general principle which particularises conversational interaction [is] that of RECIPIENT DESIGN...a multitude of respects in which the talk by a party in a conversation is constructed or designed in ways which display an orientation and sensitivity to the particular other(s) who are the co-participants (Ibid p727, original emphasis).

The foundation for the discipline of conversation analysis can be summarised in the 14 themes of the original work, (Sacks et al, 1974, p 700-701), paraphrased in box 1.1

Box 1.1 Foundation for conversation analysis

1. Speakers take it in turns to talk
2. Nearly always one person speaks at a time.
3. It is common that people do talk at the same time, but this is brief
4. Generally speakers give up the floor with no gaps, a short gap or a short overlap
5. Turn order is not fixed but varies
6. Turn size is not fixed but varies

7. Length of conversation is not specified in advance
8. What parties say is not designated in advance
9. Speaker turn is not designated in advance
10. Number of parties can vary
11. Turns can be continuous or discontinuous
12. Turn allocation occurs, either by the speaker selecting the next person (eg with a question) or the next speaker self-selects
13. A 'turn-constructural unit' is the unit of speech and can range from a single word or non-lexical utterance, up to a sentence or more
14. Repair mechanisms exist, for turn taking violations or 'interactional troubles'. eg if two parties find themselves talking at the same time one will stop thus repairing the trouble.

Conversation analysis and its founders were not without critics, eg Power and Dal Martello, 1986, who were particularly concerned that the reader is asked to take on trust that examples were typical, with no statistical measures of frequency to back them up (ibid pp30,34,36). Additionally they critique the absence of emphasis on gesture, intonation and the syntactical organisation of a turn and disagree with the proposed method of turn, or speaker, allocation, suggesting an alternative explanation that they might be 'due instead to general pragmatic principles of efficiency and consideration of others' (Power and Dal Martello 1986 p39).

However in their original paper Sacks et al stress the contingent nature of their theory:

It is certainly correct that in several respects the proposed model is incorrect or insufficient. But...the appropriate model for turn taking in conversation will be this SORT of model... A LOCAL MANAGEMENT SYSTEM...AN INTERACTIONALLY MANAGED SYSTEM'

(Sacks et al, 1974, p725 original emphasis)

Thus they re-state their belief that management of the rules of a conversation arise, and are managed interactionally, between those in conversation without reference to external rules or constraints.

In what might be characterised as 'paradigm wars', or at least interdisciplinary debates, objections to the philosophical approach of conversation analysis continued to be debated alongside linguistic, sociological and psychological perspectives. In the late 1990s proponents of discursive psychology criticised conversation analysis for its foundational claim that it sets aside reference to a broader sociological context; for example 'the way in which Schegloff marks the boundaries around conversation is unhelpful and unproductive' (Wetherell, 1998,

p14). Wetherell in addition seems to consider conversation analysts in general, and Schegloff in particular, as unclear or even disingenuous in the extent to which they are looking at text from the participant's perspective only, without imposition of pre-formed theoretical constructs. She points to the example of preferred-dispreferred responses as being of necessity pre-formed and calls for a more 'synthetic' approach which takes into account more explicitly a sociological frame and the 'situated flow of discourse' (ibid p28) – a call for greater recognition that conversation depends for much of its sense-making on the context. After all, in order to make sense of 'what happened next', an analyst might be said to need an understanding of what usually happens in order to note any deviation from those norms. In my thesis, the inclusion of the thematic analysis sets out to provide just this sort of way of 'situating discourse' to provide a basis for the analysis.

Schegloff's response to this included a claim that conversation analysis was misunderstood or misread (Schegloff 1999, p559). Writers from a critical discourse analysis tradition engaged in more than one back and forth trans-Atlantic episode of published debate (eg Schegloff 1997, Billig 1999a, Schegloff 1999, Billig 1999b) about the claim and counter-claim of 'epistemological naivety'. In this debate we see both sides stake a claim to the importance of starting with observation of fine-grained detail, but differences in the belief to which such an analysis starts by 'not knowing'. Critical discourse analysis is offered as a way of applying prior theorised social concepts to thinking about how a social reality drives how actors act, whereas its proponents suggest conversation analysis as a 'frame free' way of looking at how individuals co-create that reality 'bit by bit' (Schegloff 1999, p567). It seems likely to me that a critical discourse analytic approach does reflect in some ways the way examiners might make assumptions about what they see in the CSA, based on a pre-conceived understanding of the social reality of 'doing being a good GP'. However by comparison with the way in which judgments are made in the CSA, ie by observation and analysis of talk minute by minute as it happens, conversation analysis seems to be a useful tool for this project.

It is difficult to ignore the influence that context must have on what an individual doctor-patient dyad sees as appropriate behaviour in the consulting room. Indeed that was the starting point for this project - 'it's not like this back home'. We have seen the reported impact that social hierarchy, education and norms such as politeness can have on how doctors and patients act. Whilst an analysis of observed data looking at the sequential ordering of a conversation seems to offer a robust way of looking at how that social order might be created and recreated, it risks losing a focus on how those invisible, taken-for-granted elements then impact on practice. An associated thematic analysis can bring additional productivity by looking at the reported understanding interactants claim has developed from being immersed in a setting. Each form of analysis has aspects that it cannot compensate for by itself: the thematic analysis relies on self-report and the subjective experience and the conversation analysis alone cannot speak to

context directly. The need for such a combined approach became increasingly clear as I spoke and wrote about the initial findings from the formal conversation analysis phase of this project. I was calling on my, albeit patchy and inadequate, knowledge of the context to shed light on what I was observing. Although, as summarised by Heath et al, there is some debate about the extent to which ethnographical data may be incorporated into conversation analysis, I agree with their conclusions that:

Sometimes, however, it is important to take into account information about the interaction that is not derived directly from the recordings and that is drawn from fieldwork, interviews and so forth

(Heath et al 2010, p107).

Indeed Heath goes on to state that analysis of interaction might in fact offer:

a 'proof-procedure' where participants can be shown to be orienting to particular features of context in the very ways in which they produce and coordinate their actions
(ibid p108)

1.8 Rationale for the research strategy of combined thematic analysis and conversation analysis

The research strategy developed pragmatically using two methods of data collection with thematic analysis and conversation analysis. Best practice in research dictates that the methods be chosen to align with a prior chosen research question although pragmatically the question and methods might develop together, as happened here. The particular analysis of features presented in this thesis were selected in response to the features foregrounded in the interview and focus groups material. Thus two different types of analysis to look at both these aspects were used.

The particular model of research employed here is that of triangulation:

[the] use [of] two different methods in an attempt to confirm, cross-validate, or corroborate findings within a single study.. to offset the weaknesses inherent within one method with the strengths of the other method. ..[data collection]is concurrent, happening during one phase of the research study. This design usually integrates the results of the two methods during the interpretation phase.

Creswell et al cited in Tashakkori and Teddlie 2003, p183.

This 'triangulation' here refers to the use of the interview and focus group data to contextualise or lend strength to the arguments derived from the interpretation of the interactional data. Within this thesis, my aim is not to create a specialist researcher identity through mastery and application of conversation analysis, nor is it solely to use it to look at the features of the consultations on their own terms. There would be significant productivity in that approach for advancing our knowledge of the nature of general practice consulting in India, but in this thesis the lens is that of a UK based CSA trainer and the question is chosen to focus on those features that seem to have relevance for examiner decision-making. Just as the general practitioner in the clinical world of primary care has created a valid professional identity through application of a range of clinical approaches developed in other realms of practice, this thesis mirrors that and demonstrates the development of a professional researcher identity through combining methodologies borrowed from social science to provide insights into professional practice.

To borrow still further, from language learning, 'principled eclecticism', a phrase I have adopted and re-purposed to mean research methodologies that are 'coherent, pluralistic', (from Mellow 2002, p109) requires the choice of methodologies to be mindfully chosen. It is important to avoid the trap described by Widdowson (cited in Cushing-Leubner and Bigelow 2014, p248): "If you say you are eclectic but cannot state the principles of your eclecticism, you are not eclectic, merely confused". The elements of the eclecticism in this project are thematic analysis and conversation analysis and these elements were chosen mindfully to illuminate both context for, and detail of, the features of general practice in the study site that might specifically be of interest in considering CSA outcomes.

1.9 Rationale for selection of *interactional fluidity* as a focus of the analysis

We have seen that little is known about general practice consulting outside of western countries and this research adds a perspective on the talk in such a setting derived from a unique analysis of video-recorded data consultations in one clinic in India. Using the lens of the CSA to examine the consultations it gradually became apparent that talk, and in particular the distribution of small talk, seemed to occur in a series of particular ways in these consultations from the Indian clinic. Although caution should be exercised in drawing conclusions from one setting about what happens in a second, this difference might speak to outcomes from the CSA assessment process. Analysis of video recordings of simulated consultations from live CSA exams has shown that managing what Roberts called 'everyday social chat' is an 'important component of success in the CSA' (Roberts et al 2014, p42). In a review of 198 cases with detailed analysis of 40 cases across the dataset, these authors noted that successful candidates use 'conversationalising strategies' more than unsuccessful candidates, 'small markers that make the consultation more informal' (ibid p47) and that 'sustaining social relationships is a highly indicative feature of talk in the CSA' (Ibid p35).

Some additional supporting information that it is the interactional domain that causes IMG candidates difficulties comes from the information the RCGP publishes every year about the prevalence of the 16 standard feedback statements given by examiners on candidates' case performances. For example in the 2014-15 diet of 33,995 UK graduates candidate-cases and 14,092 non-UK graduates candidate-cases, the third highest ranked feedback statement for IMGs was 'Poor active listening skills and use of cues; consulting may appear formulaic, and lacks fluency', which was given to 13.5% of the IMG candidates and 4.2% of UK candidates. 'Does not use language and/or explanations that are relevant and understandable to the patient' was given to 12.9% of IMGs and 4.3% of UK candidates and 'Does not appear to develop rapport or show awareness of patient's agenda, health beliefs and preferences' was given to 9.4% of IMGs and 3.6% of UK candidates. 'Does not develop a shared management plan, demonstrating an ability to work in partnership with the patient' was given to 13.8% of IMGs and 6.4% of UK candidates.

It is of note that the assessment domains are not orthogonal. It is within the 'interpersonal skills' domain that the degree of patient centredness displayed might be explicitly assessed, but the competence of managing talk is one of the resources for success in the other domains too. Thus we might imagine that a particular candidate's weak interactional competence will affect the other two domains since this is the resource through which the first two domains are enacted. There is a risk then, of a form of 'double jeopardy' for candidates who struggle to demonstrate interactive fluidity; they may be unable to demonstrate their competence in the first two domains as well as in the interpersonal skills domain.

Small talk is not directly recorded in the CSA marking schedule and specific evidence for the impact of informal talk and 'conversationalising' on exam success is weak, coming from just one study (Roberts et al 2014). However the literature ascribes a range of functions to small talk that suggest it might support candidates aiming to demonstrate the co-construction of a successful, in CSA terms, doctor-patient relationship. It is an area that would seem to merit further investigation. As Coupland avers, 'institutional discourse typically involves a dialectic between institutional frames and social-relational frames for talk' (Coupland 2000, p6). In particular she cites several writers who have noted the complex interplay between so-called small talk and work-related talk as it not only builds rapport, but creates a space within which that rapport can itself further the institutional goals (Coupland, Robinson and Coupland 2004, Fisher 1991, Regan in Coupland 2000).

In a general practice consultation much of the work of the interaction may be being done by so-called 'small' talk as it is used, among other roles, to build relationships that act as the foundation for current and future medical work. From the first rudimentary treatment on the pro-social function of such 'phatic communion' (Malinowski 1923, p315) to the communicative

function of small talk (Laver 1975, p216) including work on politeness and ideas of face (Brown and Levinson 1987 pp 13-14) and rapport management (Spencer-Oatey 2008, p11), to the form and function of small talk in a variety of social settings (Coupland 2000) including at work (eg Holmes 2000, p 32) and in health-related contexts (eg Coupland et al 1992,1994) and with the understanding of the importance of small talk that 'oils the wheels' at work (Holmes 2000, p50) but that it can be problematic in cross-cultural settings (eg Mak and Chui 2013 p119), small talk is of growing interest.

Roberts et al also noted in the CSA an association between a successful outcome and:

overall emotional tone - whether the candidate sounds warm, involved, responsive etc- and overall behavioural smoothness – whether the interaction progresses without jarring or uncomfortable moments or not (Roberts 2014, p101).

Proficiency in all forms of talk will contribute to the success of the consultation, but this 'behavioural smoothness' also seems important by building what I have called 'interactional fluidity' in the doctor-patient conversation. Roberts et al noted that:

the more conversational means of communicating help glue interactions together....when these features are used...candidates are usually rated highly...Candidates who sound a little awkward or whose interactions lack smoothness attract low marks (Roberts 2014 p96/7).

Interactional fluidity may be one element that enables the patient and, in the CSA, the examiner to form a judgment that the doctor is trustworthy, or competent. In addition to reviewing video-recorded CSA cases, Roberts et al also interviewed examiners whilst reviewing videos together and noted:

It is the assessment of the 'manner' of candidates, both how they sound, how they interact and how clear they are in longer stretches of talk that has such an impact on their marks (Roberts 2014, p101)

We have seen that the RCGP privileges patient-centeredness and the two concepts of small talk and interactional fluidity seem to come together as potentially important elements of how a candidate might demonstrate interest in the life-world of the patient and use that as the basis for realising a context-specific enactment of an effective doctor-patient consultation.

Such reference as there is to small talk in the medical literature does seem to confirm that doctors use small talk when talking to patients. Coupland et al (1994) propose the phrase 'the

medical in the context of the social' and have looked at the importance of small talk in consultations between patients and doctors in geriatric clinics. There is however very little work published on small talk in the healthcare setting and none at all looking at recorded consultations in general practice. The form of talk in this Indian clinic, as highlighted in both the thematic analysis of focus group and interview data and the conversation analysis of actual consulting, is the unique contribution produced by the analysis of my data. I will expand the list of features of small talk already described in the literature to show that some elements of small talk in the medical conversation can also carry some institutional roles through the way in which, in particular, relational talk can also be task-orientated. The thesis will develop an argument that the talk that expert practitioners use to work towards alignment, a state of mutual understanding between doctor and patient and through which they display their intersubjectivity, will be different in different settings.

1.10 Overview of the structure of the thesis

In chapter two I will describe the process and outcome of the literature review looking at what is known about general practice consulting from published research. Through this I will trace the development of an analytical approach from identification and labelling of functional phases, to the interactional features of the consultation. This chapter focuses on what is known about the general practice consultation but also the rationale for and the utility of the use of conversation analysis as a method.

Chapter three reports how I carried out the study. This will include the methodological approach and rationale for using the combination of conversation analysis with thematic analysis. I will describe the features of the research site and the volunteer doctors, the process of ensuring a robust approach to consent and confidentiality and the approach to data collection. I will discuss methodological considerations affecting the analysis and show how both sets of data were prepared for analysis and focus particularly in this chapter on the conversation analysis.

The thematic analysis of the focus group and interview data is presented separately in chapter four. It is in this chapter that I describe the rationale for and utility of using thematic analysis. A table of the five themes and 21 codes created from the data is presented with an analysis of the multi-faceted story they tell about the expressed views of this group of doctors.

Chapter five describes the form and function of some of the talk as it occurs in the video-recorded consultations between the doctors in this clinic and their patients illustrated by clips of data transcribed under the conventions of conversation analysis.

The conclusions drawn from the research project, both about the research outcomes and my development as a practitioner-researcher are explored in chapter six.

Appendix A 2 contains the results of a further literature review looking at what is known about general practice consulting around the world, This does not directly address the research question but I include it here because it was important in the early stages of this project and contributed to my understanding of the broader question of what is known about general practice consulting world-wide.

Chapter Two: Literature review

2.1 Introduction

This chapter focuses on the conversation analysis element of this mixed methods project and I carried it out to learn more about how general practice consulting has been analysed previously and how I could apply it as an analytical tool. It reviews the development of the analysis of general practice consulting from the starting point in the 1970s of identification and labelling of functional phases, to a focus on the interactional features of consultations to understand them as social phenomenon, and an exploration of the uses to which conversation analysis has been put to illuminate a variety of aspects of the consultation. In this way I hope to highlight both what is known about the consultation but also the utility of conversation analysis as a method. The chapter can be seen to lay out an 'analytic map' of existing work done in the field and follow on from the introduction of the methods of conversation analysis in chapter one, as a way to focus my research question from a professional concern to a descriptive question that can be addressed in part with this form of analysis. In this chapter I will identify those constructs within conversation analysis that I will later go on to apply in my data analysis of the video-recorded consultations in chapter five.

The literature search on which it is based used the databases Medline, EMBASE, ASSIA, ERIC, CINAHL, Psychinfo, HMIC, Academic Search Complete, Web of Science, Index to Theses, NDLTD (Theses) Ethos and Google Scholar. In addition the personal bibliographies of Emanuele Schegloff, Christian Heath, Jeffrey Robinson and Doug Maynard were searched.

The search terms were:

- 1 "Discourse analys*" OR "conversation analys*" OR "talk in interaction" OR "talk-in-interaction".af; (13,937 results).
2. FAMILY PRACTICE (10,662 results)
3. "general practic*" OR "practice general" OR "family practic*" OR "primary care physician*" OR "family doctor*" OR "family physician*" OR GP.af; (163,872 results).
4. (doctor* OR physician*) ADJ6 ("primary care" OR "primary health care" OR "general practice").af; (33,759 results).
5. 2 OR 3 OR 4; (202,004 results).
- 6 1 AND 5; (96 results)

This list of 96 papers was then hand searched to exclude duplicates which produced 82 unique results. I was looking for papers that described research, so books, reviews and papers on

methodology were excluded (12) which brought the number to 70, of which nine were theses. The nine theses also gave rise to some of the papers that are also included in the analysis.

For the published papers, the abstracts were read where available and a further 17 excluded that were not about the outcomes of conversation analysis on authentic consultations, leaving 44 for the analysis. The location of this conversation analysis work was British General Practice in 28 papers, America six papers, Denmark contributed three, Finland contributed two, Holland two and Norway, Japan and Korea one each.

2.2 Categorising activity in the consultation

Conversation analysis emerged as a discipline in the decade between 1964 and 1974 and in the analysis of general practice consulting by the early 1980s. Up to this point interest in the interactive nature of work in professional practice was led by sociologists and tended to be ethnographic, for example based on interviews and/or observations. One of the earliest conversation analysts in this area was Christian Heath, who joined the department of General Practice at Manchester University led by Patrick Byrne in 1974. Heath's first chapter appears in Atkinson and Heath (1981) with a collection of other ethnomethodological studies, and is able to draw on no other general practice publications at that time.

Byrne, a GP, with Barrie Long, a lecturer in adult education, published a seminal book, *Doctors Talking to Patients, a study of the verbal behaviour of general practitioners consulting in their surgeries*, funded and supported by the Department of Health and Social Security (Byrne and Long 1976). This context is important because attracting a DHSS grant for such work was a significant contrast to the type of research generally carried out in medicine at the time.

It is worth reflecting on the work of Byrne and Long as it will have influenced the conversation analysis work of Heath. Heath entered a department that had noted the 'paucity of information in the form of literature and research' to help guide the development of insights into what they termed the 'behavioural science' approach to patient problems (Byrne and Long 1976 p7). In addition they noted that:

Few doctors are able to view the "process" of a consultation in such a way that they are able to make judgments not only about "what they are doing" but also about "how they are doing it". Few doctors for example understood the concept of the "dynamic" of the consultation (Ibid p8).

The goal of Byrne and Long was to seek ways of analysing the doctor-patient consultation that focussed on how the consultation was managed, that could then inform GP training. The DHSS

funded the programme as part of a series of initiatives to improve the quality and scale of general practice provision in the UK. Byrne and Long, with two civil service researchers, gathered audio-tapes of 2500 patients in England in consultation with 60 GPs from the United Kingdom, plus five Dutch and six Irish GPs. By listening at what doctors actually did they sought to define or describe the structure of consultations in general practice as *it was practiced*.

The problem that faced Byrne and Long was that no one had yet developed an analytical tool that might apply to the dyadic format in the consulting room. Their solution was to categorise utterances into 'units of sense' (p31) which loosely corresponds to the idea of a 'tactic' such as a question, a summary, or making a suggestion. With this they derived 55 types of doctor utterances that they divided into three categories: doctor-centred such as 'challenging'; patient-centred such as 'using patient ideas'; or negative behaviours such as 'refusing to respond to feeling'. Using these categories, including 'confused noise', they could code most of what they heard in a consultation. They tested, through repeated listening, to see whether these codes could account for all activity in the consultation and noted that the consultation generally fell into six phases- but that not all of them would necessarily be present in all consults, or in a consistent order.

It was important work, widely quoted up to the present day, and used as a basis for teaching about consulting which, in general practice, is seen as the main 'technology' of expert practitioners. Their schema, or model of consulting, was however a descriptive checklist of verbal behaviours based, not on the interactional work that a 'unit of sense' was doing in a particular instance, as might be determined by looking to see the reaction in the next turn, but on how certain phrases appeared to the researchers.

This was the first observational piece of work aiming to describe the general practice consultation as performed 'in the field'. Before that, the consultation was defined through 'expert consensus' on what the good doctor ought to do (eg RCGP 1972, Heron 1976) and for at least the next decade a series of models of the consultation were devised based on a similar checklist-based approach (Stott and Davies 1979, Pendleton 1984, Neighbour 1987).

Within four years of the 'check-list' approach to analysis seen in Byrne and Long's work, the Roter interaction analysis system (RIAS) was developed, which has since been extensively applied in a variety of medical contexts (Roter 2004) (See also Appendix A2). The RIAS system is a software programme that helps summarise talk in a consultation. Usually video or audio data is directly uploaded into RIAS and each utterance is coded by trained coders according to a 41 category checklist. This contains items such as 'laughs, tells jokes', 'shows approval',

'shows concern or worry' and 'unintelligible utterances'. The system displays summary statistics such as proportion of time each interactant speaks for and duration of the consultation.

In a Kenyan RIAS study based in family planning clinics (Kim 1998, 1999) providers were found to speak on average 66% of the total number of sentences in a session, and clients 34%; patient interjections tended to be much shorter, and often one word, answers to direct questioning. The authors state that 'the relationship between doctor and patient is highly unequal, based on differences in knowledge and social background, and patients are accustomed to being "recipients" of medical care rather than "participants"' (Kim 1998 p 15). However neither concordance with medical advice nor satisfaction with the encounter was looked at in either paper which weakens the findings. Labelling talk in this way, without looking to see the response of the hearer, has significant limitations depending, as it does, on volume of talk defined by number of utterances, and an interpretation of meaning by the observer.

2.3 Moving towards interactional analysis

Mehan, in Atkinson and Heath, (1981, p107-127) draws attention to the utility of conversation analysis, over coding systems, through analysis of the interactional difficulty caused by doctors' use of 'jargon'. Mehan is not a doctor but, working in the Centre for Criminal Justice of Boston University School of Law as a sociologist, noted that previous work culminating in advice to medical professionals to minimise the use of jargon in interaction with patients was derived from interview data showing patient dissatisfaction rather than analysis of practice. In introducing his use of conversation analysis he draws attention to how a coding system of analysis would have been insufficient for his work as he looked at instances of troubles-repair following use of unexplained technical medical terms. He specifically refers to the de-coupling of the original recorded data from its representation on the page and the resulting problem that 'what is consequential to the participants in situ has not been preserved for analysis' (Mehan p108). It is a feature of the orderly and ordered nature of talk in interaction that misunderstandings tend to be repaired in standard ways. In particular Mehan demonstrated that next-turn-repair initiators by the 'other' (the non-speaker of the trouble source) is a dis-preferred response following on only if other options such as patient's silence, failing to answer, or anticipatory self-repairs from the doctor within-turn still do not achieve sufficient understanding of the jargon. The important contribution of this paper is through the way in which conversation analysis 'proposes a treatment of the problem' (Mehan, p106) not just a statement of it; and this only four years after Schegloff et al outlined the issues of troubles repair (Schegloff, Sacks and Jefferson 1977).

One important contribution of the conversation analyst has been to show that, as Heritage and Maynard put it, 'medical practice...is laminated on to the socio-cultural base of interaction and

cannot be separated from it' (Heritage and Maynard 2006 p20). Institutional interaction shares many of the normative features of every-day interaction.

2.4 Adoption of the methodology and extension to further areas of investigation

In the sections which follow I will describe the way in which conversation analysis has been applied to different aspects of general practice consulting. My aim is to examine and organise published work into topics to show the versatility of the process and its utility as a way of making 'visible the invisible' in terms of the organising principles of interactions between doctors and patients. One of the aspects that becomes apparent through this overview is that the use of the term 'conversation' analysis can be misleading, since it has been used to consider the impact of various elements of an interaction, not just talk. In this section we will see examples of the effect of gesture and body movement, gaze and eye contact, interaction with the paper notes and object adapters and at the interface with technology.

2.4.1 Integrating gesture and body movement

The categories of Byrne and Long were derived from analysis of audio tapes alone:

There is, as far as we can see, little to be gained...from visual examination of the consultation, so that the simple device of the audio cassette recorder will be adequate
(Byrne and Long 1976 p143).

By the time Heath joined the team, the emphasis had switched to a combination of audio and video-recording which brought different affordances to the analysis. Heath set out to explore 'the coordination between body movement and speech, the visual and vocal aspects of the interaction between the doctor and patient' (Heath 1986 pvii).

Heath refers to conversation analysis as:

...a form of inquiry that can handle both rigorously and formally the detail provided through audio and video recordings of everyday events...that allows us to explore the social organisation of human interaction and the production and coordination of action and activity

(Heath 1986 p5).

In 1981 Heath published an analysis of how the medical notes facilitate the openings of medical consultations (Atkinson and Heath 1981 p71-90) and in particular how the addition of the video images enabled a close look at how the openings are 'delicately designed with respect to the

occasioned characteristics of the particular client' (ibid, pxi). This paper particularly focuses on recipient design which is defined as the alteration in communicative activity depending on who the listener is. It is from the ability to note and incorporate the direction of gaze into the analysis that Heath has been able to carefully unpick how the doctor tailors his opening comments – his 'topic initiator' - to the particular circumstances of the patient. Heath started to do something the Finnish sociologist and psychoanalyst Anssi Perakyla describes as a way of determining how the 'ingredients of the cake come together in the medical consultation' (Perakyla 1997, p207).

The incorporation of video data into analysis led to Heath's observation that 'movement performs locally' (Heath 1986 p10). A gesture on the football field can be dismissive or inflammatory and might be 'read' in either way by the players and the referee with predictable and unpredictable consequences. A doctor picking up the cuff of a sphygmomanometer is understood to be asking to take the blood pressure and the patient who extends an arm is understood to be giving consent. A woman who holds her hand to her back – within the consulting room - might be signalling both the location of a symptom and expressing the need for that symptom to be noted, not for sympathy, or exemption from activity, such as she might expect from the same gesture at home, but for diagnosis. Through his work using conversation analysis, Heath is able to state that:

Action and activity through movement are far from idiosyncratic, characterless or determined; they are accomplished and interactionally coordinated anew on each and every occasion

(Heath 1986 p18).

The video work in general practice conversation analysis continued to develop to include a focus on gesture and movement to link the psychology of pain experience with the sociology of behaviour (Heath 1989, Heath 2002). The patient has to balance a justification for seeking help ("I am in pain") with a need for objective 'evidence' of such pain which might not be being generated on examination. This can be done either by demonstrating 'embodied' expressions of pain (eg grimacing) or imbuing talk with pain references and Heath noted how gesture transforms symptoms from story into demonstration or re-enactment. Enactments and demonstrations personalise the experience of this (my) symptom which might otherwise be thought mundane, and legitimise access to medical care and the sick role. Gestures as revelation and management of experience also work to make symptoms visible by transiting them into the consultation where doctors are also transformed not just to witness but become involved in the production and revelation. If symptoms do actually occur in the consultation those symptoms can be put to work to reinforce the fact of suffering, or can be mimicked if not noted by doctors. Without the video record, all this richness would be lost to the reviewer.

This multimodal analysis is a stepwise move away from privileging simply the words in an interaction. Bezemer and Jewitt (2009) note that verbal and non-verbal behaviour are not usually completely separate channels and work together, but getting the balance right is important:

‘conversation analysis’ ... may be based on moment-to-moment analysis of speech, including all intonational nuances, and largely ignore the direction of gaze; a ‘multimodal’ analysis may include speech as well as gaze patterns but largely ignore the intonational nuances of speech. Too much attention to many different modes may take away from understanding the workings of a particular mode; too much attention to a single mode and one runs the risk of ‘tying things down’ to just one of many ways in which people make meaning

(Bezemer and Jewitt 2009 p16).

As Goodwin pointed out ‘different kinds of signs-phenomena instantiated in diverse media, what I call semiotic fields, are juxtaposed in a way that enables them to mutually elaborate each other’ (Goodwin 2000, p1489), and by extension shed light into the context.

With the growing emphasis on video-based conversation it is worth pausing at this point to reflect on the ethical challenge that started to arise in the literature of conversation analysis. There is a difficulty in recording video data in a way that enables the reader to judge the rigor of the analysis, so in Heath’s book on body movement and speech in medical interaction we see the inclusion of line drawings from the videos (Heath 1986). This raises particular issues of consent and confidentiality. In Heath’s chapter on the physical examination element of the consultation we see drawings of a case in which a female patient is having chest auscultation and breast palpation. Twenty years later the same case is presented in a chapter on ‘Body work’ an analysis of the physical examination, but this time with no pictures (Heath, in Heritage and Maynard 2006, p191) which seems to represent a growing sensitivity to the identification of research respondents in published work, an important factor to take into account when recruiting into these sorts of studies. In chapter five I have reproduced stills from my video data, having explicitly gained consent so to do.

2.4.2 Looking at the effect of technology on the interaction

Researchers continued a focus on movement and activity, as well as speech, with a move towards application of conversation analytical techniques to discuss the effect of equipment or technology on the interaction. Greatbatch et al (1995) looked at how desk-top computers affect the doctor-patient interaction. Their work was in one Liverpool practice of seven GPs, looking at 100 video-recorded consultations before, and 150 after, computers were introduced to the

practice. They noted that doctors showed a 'preoccupation with the computational task-at-hand by, minimal responses to patients, delaying their utterances until appropriate junctures in their use of the system, and withholding their gaze from patients' (Ibid, p35). Patients also showed an awareness of this inattention and aimed to coordinate their timing for the initiation of conversation with, for example, pauses in typing. This work accords with the later findings in Robinson and Stivers' work (see below) that verbal and non-verbal behaviours are noted by both actors and built into the pattern of activity; conversation analysis can reveal this 'In situ socialisation' as both parties come to know what to do and how to act (Robinson and Stivers 2001).

Ten years after Greatbatch et al, Ara et al (2005) made claims that their work also used conversation analysis to look at the impact of electronic medical record within the consultation, and concluded that rather than inhibit communication the use of the computer actually stimulated more discussion, particularly around prescribing issues. However their work has more in common with the descriptive checklist approach of Byrne and Long, applying the idea of 'a distinct exchange that conveyed one main idea... identified as the basic unit of analysis' (Ara, 2005,p15). Using a content analytic approach, rather than look to see what was achieved through the use of these researcher-defined phrases, they then coded and counted and constructed a matrix that they then quantitatively analysed, for example creating frequency distributions of 'types' of exchange. The conclusions they draw are in effect around the administrative support computers can bring, rather than their effect on the interaction of consulting.

By contrast, three years later the use of electronic medical records in primary care diabetes consultations run by nurses was subjected to a conversation analysis approach (Rhodes et al 2008) to consider the effect of orientation towards the electronic medical record. They concluded that nurses can use their gaze towards the 'independent authority' of the EMR to control what is legitimate to bring up, and is attended to. They use line drawings to 'avoid compromising anonymity' (p1262) to describe the orientation of the nurse to the computer or the patient and look closely at the process of the consultation and the interactions within it. They compare their work with that of Berg's discussion of the paper medical record used by doctors, where he found the doctors'

'writing and reading as such are instrumental in the shaping of the way turns are distributed, 'relevant' issues to pursue are distinguished from 'irrelevant' issues, time to speak is distinguished from time to be silent, and shifts between stages in the consultation (as between 'question' and 'investigation') are marked

(Berg, 1996, p. 508 cited in Rhodes 2008, p.1248.)

This observation, that the computer impacts and alters the course of interaction much as a third party participant in the conversation would, is also seen in the work of Newman et al who looked specifically at the effect of computer-generated pauses on topic changes (Newman et al 2009). In a mixed-methods analysis which calls on a variety of paradigms, including the physiology of respiration and utilising observation of computer use in the home as well as at work, Newman and colleagues demonstrated through a close and careful analysis of turn-taking that when conversation pauses to enable consultation with the computer, a preferred maximum window of ten seconds was available for the conversation to be resumed. Longer than that, a pause seemed to require one party to do something to break it. Within the ten seconds if the pause was longer than five seconds, then a restatement of topic is needed or else a new topic could be opened. This, the authors suggest, could lead to conversation analysis having very practical application by influencing the way perhaps that IT solutions are designed for practice.

Whereas the Rhodes paper is published in the Journal of Qualitative Health Research and the Newman paper is in the International Journal of Human-Computer Research the most recent publication looking at the impact of computer templates on chronic disease management is published in the medical mainstream British Medical Journal (Open) (Swinglehurst et al 2012). This is of note because of the way it signals the acceptance of conversation analytic techniques as part of a linguistic ethnography approach to explore the medical consultation. The paper explores the constraints when data inputting becomes privileged over attention to patient narrative. The highlights of the paper are where conversation analysis is used to examine the minute to minute creativity of the expert nurses and how 'being a good asthma nurse' is performatively shaped by the external monitoring.

2.4.3 Gaze and eye contact

There is but brief mention of eye contact within the paper from Rhodes, and it is one element of gaze likely to carry different meanings in different cultures. Robinson reports counterintuitive findings from the literature that equate increased eye contact with decreased rapport and concludes that it rises from the dissatisfaction of the patient with the degree of engagement of the doctor with the patient-in-bureaucracy and hence attention to the history and information in their records (Robinson 1998). We might equally speculate however that it might arise from an unsettled feeling generated by being under intense gaze and this might be culturally determined. Neither conclusion can reliably be determined by conversation analysis alone but seems to be an interesting area for further study.

2.4.4 Opening, transitions and closings

The work of Robinson (1998) applies conversation analysis of video data to look at how patients know, and how doctors show, they are ready to start an interaction. This appears to be mediated through direction of gaze (and head orientation) as well as body orientation. The lower body, being more stable, indicates the longer term focus of engagement and Robinson draws attention to a spectrum from head and body alignment towards the patient (full focus of attention on the patient) through head directed towards the patient and body orientated elsewhere, eg to the desk, (temporary engagement), to head and body oriented elsewhere, eg to the computer, (showing lack of engagement with the embodied patient but engagement with their history). Robinson analysed British general practice consultations and looked at both audio and video tapes of 86 consultations gathered during 1990. Robinson noted that the start of a consultation is usually doctor-initiated as a consequence of the need to balance non-collaborative tasks, such as checking the identification of the patient, with determination of readiness to start. An interesting element of his argument, as alluded to in the paragraph above, is that the patient is present both in embodied form and as patient-in-bureaucracy in the notes, so consulting the notes could still be considered to be engaging with the patient in this distributed form. Similarly as a doctor reads the notes, the patient's gaze may also be directed to the records and be said to be engaging with the doctor-in-bureaucracy.

The opening sequence of general practice consultations was further considered, this time to look at how openings might facilitate mutuality in decision-making (Garafanga and Britten 2003). By an analysis of audio tapes these authors set out to determine if any consistent rules governed the opening sequence. The Garafanga and Britten paper is published in a main stream general practice journal yet presents a detailed discussion of features of consultation analysis: the normative function of social-interaction rules and repairable or strategic deviances from such rules. By analysis of subsequent turns they are able to conclude that attention to such rules is important in the construction of mutuality since an un-repaired (or deliberately broken) rule, leads to mis-alignment in a consultation making concordance harder to achieve.

With Heritage, Robinson continued to look at openings with work on 302 problem presentation phases and analysed the structure of patients' presenting concerns for the 'completion relevance' of current symptoms (Robinson and Heritage 2005). They suggest that there are effectively two ways a patient can tell their story, chronologically ('it started last Thursday') or with a presentation of the here and now ('I have got this terrible headache'). The challenge, interactionally, is that with the former, unless the story continues uninterrupted until right up to the symptoms of the present moment, we cannot be sure the story is complete and the physician should hesitate to interrupt for fear of not gathering the 'whole story'. On the other hand, allowing a patient to continue uninterrupted might be seen by the doctors as time-

inefficient or risk a disorganised telling of the story with excess irrelevant detail. Through application of the foundational conversation analysis device of 'what happened next' Heritage and Robinson show seven types of evidence that the presentation of the current symptoms in the here and now generally represents the end of the opening and is recognised as such by both patients and doctors. The authors claim that, through this, conversation analysis has made a tangible contribution to how doctors might be trained, optimal timing of interruptions can be made and incomplete presentations can be minimised.

A year later the same data set was analysed to look at how physicians' opening questions affect this problem presentation (Heritage and Robinson 2006) and identified five types of question and their effects on how the problem is presented. The implications for British General Practice are limited by the extent to which these papers draw on consultations between doctors and patients in either Pennsylvania or Los Angeles, America. In Britain there is generally no similar system of nurse triage or history taking, so the equivalent questions such as 'I gather you have had a headache' 'the nurse tells me it's your sinuses' would be less common than 'so, tell me what seems to be up' and this is likely to affect how openings are structured.

In the work of Robinson and Stivers on activity transitions, the shift from one phase of activity to another, 24 out of 40 transitions from history to examination were seen to be managed without verbal reference, such as a request to examine (Robinson and Stivers 2001). Instead this might include 'preparing their hands (e.g., freeing them of pens and records), approaching patients (e.g., getting up from seated positions), and, if necessary, preparing examination tables and retrieving and readying examination-relevant tools (e.g., tongue depressors)' (Ibid p 280). The productivity of video in conversation analysis has been to illuminate the place of non-verbal actions, not in behavioural terms but in terms of work achieved in generating meaning.

Robinson and Stivers' paper is important for the way it distinguishes between the information-content and the relationship dimensions of a message created by verbal and non-verbal features and also for the emphasis on the role of 'object adapters', such as pen activity. Moving a pen from a writing position between the thumb and fingers, to a 'storage' position across the palm within a folded fist, or into a top pocket, can signal the intention to move from history taking to some other activity and, taken with other embodied signals such as standing up, a patient can orientate to that as a sign that the next step is an examination. They also suggest that where there are verbal instructions or requests such as 'so, can I just examine you?' when the transition to the examination phase has already been precipitated by the work of a non-verbal, then the function of this request is to allay anxiety or uncertainty in the patient. There are other possible interpretations for the role of the late verbal utterance however, such as whether it might reflect the fact that the doctor has not recognised that the leakage in her behaviour has already effected the start of the transition.

Robinson's trio of papers on 'beginnings, middles and ends' of consultation was completed with an examination of the transition from the business of the consultation to closure techniques, looking for those that enhanced the chance that a patient would be actively involved and not leave the consultation with unvoiced concerns (Robinson 2001). In this paper he showed that the terminal sequence shows two types of pre-closing elements: *arrangement related*, including a proposal of future arrangements and a request for patient confirmation, and a *final concerns sequence*. In order for new concerns to be introduced patients needed to either overcome the barrier that they might not be 'allowed' more than one problem in a consultation - for example because the doctors time is important, or they might be judged to be too concerned with their health - or the barrier of fear for what the unvoiced concern represents, or overcome the interactional barrier of an appropriate time to bring it up, when it can be 'fitted' naturally to a prior utterance. The second of the two types of closure sequence is more likely to do the work of allowing a second concern to be voiced, but Robinson notes it also requires added authenticity from non- verbals to convey attentiveness and genuinely allow new concerns to be topicalised. Similarly just saying 'is there anything else' carries a negative polarity, meaning it expects a negative reply, and might not work as a genuine invitation and instead be heard as a closing-down.

2.4.5 Patient participation

In 2003, Robinson drew some of his earlier work together and looked in overview at factors that influence patients' readiness to participation in decision-making, concluding with a proposed schema for an interactional structure that might shape or facilitate such participation (Robinson 2003). In some ways this brings us back full circle to the work of Byrne and Long who attempted to describe the structural elements of the activity of the consultation in the service of being able to teach better consultation skills. However the difference here is in Robinson's use of conversation analytic techniques to look at the *work done* by activities, in order to determine what that activity 'is'. He relied on a demonstration that 'participants orient to current activities as relevantly progressing toward, and being in the service of, particular next activities' (Robinson 2003 p33).

Other work contributing to the theme of encouraging, recognising or supporting patient involvement looked at how new topics are introduced by patients either by pre-announcements, or in-situ announcements such as 'by the way' door-handle remarks (Campion and Langdon 2004); on an examination of 'decision trajectories' to look at the impact of doctor actions on patient involvement (Collins et al 2005); a study on the location of epistemic authority (Ariss 2009); the first comparative consultation analysis comparing channels of communication by audio-taped phone and face to face consults in general practice (Hewitt, Garafanga and

McKinstry 2010) and on the recognition and identification of 'teachable moments' for health behaviour counselling in primary care, found to be present in 9.8% of cases (Cohen et al 2011).

In his paper looking at what are sometimes now called 'expert patients' and what he refers to as 'frequently attending patients', Ariss presents results with implications for the involvement of all patients in their own care - especially as the number of patients living with long term conditions and becoming 'expert' is increasing (Ariss 2009). The paper claims that conversation analysis revealed that asymmetry in medical consultations is collaboratively achieved by the participants and there are mechanisms through which the appearance of agreement is systematically maintained. Although patients can sometimes legitimately claim greater knowledge or expertise, it seems both actors take steps to limit this and collaborate in avoiding debate and quickly closing down disagreement, particularly in the 'interpreting' phase. GPs take a more active role in determining the trajectory of the interaction with expert patients, particularly through abrupt topic changes. By making this visible and describing the mechanisms, this paper makes information available to both parties that deserves wider dissemination in order to encourage not just patient participation in, but involvement as directors of, their care.

2.4.6 Using conversation analysis to look at content, not just structure

The literature on the use of conversation analysis is also growing by turning from the structure to the content of GP consultations, which further demonstrates the utility, and acceptability, of this approach. Conversation analysis has been used to look at aspects of smoking cessation (Pilnick and Coleman 2003, Pilnick and Coleman 2006, Pilnick and Coleman 2010); the expression of aversion to medicines (Britten et al 2004); talking to patients about alcohol (McCormick et al 2006); paediatric consultations in primary care (Cahill and Papageorgiou 2007); the use of 'small talk' to facilitate interactional disattentiveness (Maynard and Hudak 2008); and an analysis of the reasons and prompts for patient disclosure of medical misdeeds, such as using another's tablets or not following a healthy lifestyle (Bergen and Stivers 2013).

There has been some use of conversation analysis to look at multidisciplinary comparisons of care such between doctors and nurses (Collins 2005) and psychiatrists and general practitioners (Davidsen and Fosgerau 2014; Fosgerau and Davidsen 2014).

2.5 Conversation analysis and intervention studies

In a departure from the observational or descriptive use of conversation analysis, and still concerned to help doctors ensure they enable patients to disclose all their unvoiced concerns, Heritage and Robinson later attempted an interventional approach to look again at this aspect of preference organisation as it affects the disclosure of patient concerns (Heritage et al 2007). By

substituting 'some', a word with a positive polarity, instead of 'any' which expects the answer 'no', they randomly assigned doctors to ask the phrase "Is there anything else you want to address in the visit today?" (the ANY condition) or "Is there something else you want to address in the visit today?" (the SOME condition). They then used conversation analysis to describe what happened next and determined that the some condition reduced unvoiced needs from 37% to 15%. In a commentary paper on their own work (Heritage et al 2011) the authors call for 'eclecticism' in such applied studies. It seems surprising that in both the published account, and this later explanation of their thinking, the authors have failed to report on the balance of verbal and nonverbal elements in the consultation including the use of gaze, body posture and orientation as the questions are posed. They state that physicians were instructed to 'gaze directly at the patient [and to] avoid looking at the patient's record' whilst asking the intervention question, but do not report if that was carried out consistently in the control and both types of intervention consultations. The failure to pay attention to gesture and other channels of communication limits the claims of this paper because of the important interaction between them that might have affected patient response (eg Goodwin 2000). Nonetheless what this unique paper adds is the principle that interventional studies can be set up with conversation analysis used to examine the outcomes.

2.6 Conversation analysis outside the UK

Conversation analysis of general practice consultations, as described above, has been used in few other western sites outside of the UK and North America. In a similar type of investigation, researchers state they applied the 'speech-act model' to look at two short clips of audio-tape from Norwegian general practice to describe how talk performs diagnosis, treatment and prognosis mediated by the 'medical gaze' and the asymmetry of the doctor-patient relationship (Nessa and Malterud 1998). The transcription process differs from that generally applied; rather than represent the words and the way they were spoken, they give an account of them. For example these would not be the words used by the actors:

D: asks if it hurts when she palpates his abdomen. P: states that the examination is painful
(Nessa and Malterud 1998, p212)

In a paper from Dutch General Practice, Joosten et al (1999) describe how general practitioners and patients in their sample relate physical symptoms to psychological causes and look at whether this could be shown to affect subsequent management. It is not clear whether the consults were in Dutch and subsequently translated before analysis or whether the transcription and analysis was done in Dutch and the clips are rendered into English just for publication. This is likely to be important as there is some attempt to transcribe rising and falling intonations which may well connote differently in Dutch and English. Dutch general practice was also the

site of work by Schouten et al (2009) who make claims about ethnicity and orientation to autonomy that they say have been derived by an analysis using their own assessment of mutual understanding (MUS) of physician-patient encounter. In this paper the authors state that: 'intercultural consultations are thus markedly distinguishable from intracultural consultations by the GPs lack of *'adequate communicative behavior'* (p468) (emphasis added). This conclusion is drawn from analyses based on a system of interactional involvement styles devised for use with medical students in England (Roberts and Sarangi 2002). The imposition of a judgment of 'adequate' without an emic understanding of what adequate might look like for these doctors and patients, and how that relates to observed interaction, and then extending that conclusion beyond the observed consultations seems to need further justification than is given in this paper.

Ohtaki, Ohtaki and Fetters (2003) set out to compare doctor-patient communication in America and Japan in the setting of family medicine (USA) and university hospital outpatient clinic (Japan) and make claims about those differences in terms of time spent in each phase of the encounter, number of categorized speech acts, distribution of question types and frequencies of back-channel responses and interruptions. It has much in common with the early work of Byrne and Long since instances of activity are defined by the researchers and then counted, rather than analysed by the work done by the interventions. Summary data only is presented, although the authors describe their research as a 'quantitative discourse analysis' and do recognise that a more 'qualitative' form of conversation analysis might answer more questions. By contrast, ten years later in Korea, a more familiar application of conversation analysis was carried out on Korean medical encounters (Park 2013). Here the author draws on the work of Robinson (2001) and showed that on the rare occasion that it happened, and notwithstanding some cultural differences, gaze, body orientation and talk were all used to focus on negotiating last minute concerns during the closings. In her doctoral work Park looked at 60 videos and identified only three that showed last minute concerns (seven percent). Like Ohtaki et al she describes cultural differences of an involved conversation style, with much use of back- channel talk, and provides an emic view of the social acceptability of gaze and eye contact. As well as being a robust application of the analytic technique, the importance of this paper is in its suggestion that, in the aspect of raising unvoiced concerns at least, despite it being a much less common activity, the social interaction in a medical consultation appears to be stable across two cultures, American and Korean.

In a paper which is presented in Finnish and English, consultation analysis is used to look at the unusual occurrence of second story telling as an affiliative response to troubles-telling in medical practice (Ruusuvoori 2005) This time the author states clearly that the analysis is based on the untranslated Finnish version and also provides a word by word translation as well as a 'looser', sense-making translation. The identification of affiliative utterances is facilitated by

her attention to detail and brings about a discussion of how empathy and sympathy might be performed. This author is also an author on a second Finnish study looking at orientation of patients to diagnostic statements as negotiable and the implications of resistance for concordance using conversation analysis (Ijas-Kallio et al 2010). In this second study we start to see how conversation analysis can show the 'interactional constituents of concordance' (p518) which will be a tool that can be applied in other settings to start to see whether such constituents are universal or context-specific.

Conversation analysis work continues in the Scandinavian location with work from Nielsen in 2012 which draws on the figure of 40% quoted in the 'Some' versus 'Any' paper of Heritage and Robinson (2011) for the proportion of patients who may bring more than one concern to the consultation. In an echo of Robinson's earlier work of 2001 this looks at when and how Danish patients initiate the presentation of further topics. Presentations of additional concerns are found to be orderly interactions that can be predicted; they come at certain times and in certain ways. Mechanisms for transition to additional concerns include confirmation, preliminary announcement and ratification maybe in response to pre-closing remarks (Nielsen 2012). By mirroring the work of Robinson (2001) the importance of this paper is also in its suggestion that, for the second time as with the work of Park, some of the elements of the social interaction in a medical consultation might be seen to be stable across two cultures, here American and Scandinavian.

Finally, although not outside the UK, one pair of papers used a discourse analytical approach including conversation analysis to look at how narrative accounts are constructed with patients in London using non-standard or non-local English to consult with general practitioners. The papers draw on the same data set and use the same illustrative excerpts from transcripts but have a slightly differing focus. They are about the difficulties that result when patients struggle to make themselves understood and the problems doctors experience when they don't understand the patients, rather than the more usual other way round. In the first paper (Roberts et al 2005) the authors report that they had identified that 31% of their video-recorded consultations contained misunderstandings of which two-thirds were with patients with limited English. So 20% of all consultations contained misunderstandings where talk itself was the problem. When they looked at these often major and often extended misunderstandings they arose from differences in pronunciation and word stress; intonation and speech delivery; grammar, vocabulary and lack of contextual information; and style of self-presentation. They included illustrations of patients and doctors mutually constructing the performance of 'being at the doctors' and show problems in this process being generated by the unavailability of sufficient mutually-understood talk to do the work needed for that.

In the parallel paper the discourse analytical / ethnomethodological approach, rather than pure conversation analysis approach, is revealed in the acknowledgment '...our interpretation owes much to his [the doctor's] detailed feedback after video viewing' (Moss and Roberts 2005 p417). The authors conclude that patients work hard to design explanations and avoid or repair misunderstandings but that they also need skilful general practitioners to allow time to listen to that narrative.

Explanations can be produced interactionally— provided GPs allow patients time and space to capitalise on their resourcefulness—even where patients' English is limited and talk appears to be problematic

(Moss and Roberts 2005 p415).

The interactional trouble and implicational trouble engendered by these factors appear to result from a direct contravention of Grice's co-operative principle (Grice 1975 cited in Cameron 2001, p75) and resulted in a tendency for explanations or social talk to be closed down as doctors became frustrated or confused by patient responses. The use of conversation analysis in both these papers can be seen as adding a very important dimension to the previously existing literature that favoured 'cultural' or 'health belief models' as the vehicle for misunderstandings, in consultations between doctors and patients from different backgrounds, rather than talk itself.

2.7 Conclusion

In this chapter I have explored what has been published on the use of conversation analysis to look at general practice consultations, which has demonstrated the flexibility of it as a method and the productivity it can bring to the analysis of video data. It also shows how important it is to use a tool such as conversation analysis able to render the 'invisible visible' with the power to bring into focus important elements of the consultation; those 'unexamined...socially standardized and standardizing, "seen but unnoticed," expected, background features of everyday scenes' (Garfinkel, 1967, p36).

The last two papers presented (Roberts et al 2005, and Moss and Roberts 2005) particularly usefully focus on how interactional and implicational trouble might arise from talk itself rather than explanations appealing to 'cultural differences'. This background review has informed my own approach to the analysis of consultations between doctors and patients in India which will be laid out in chapter five.

One further element to be discussed before I move on in the next chapter to describe how the data were gathered, concerns the fact that conversation analysis is a form of social observation that shares an interest with other approaches looking at the discursive production of meaning, from which it might also be useful to borrow concepts. In particular in the discursive psychology literature we find 'interpretive repertoires', described by Potter and Wetherell as '...recurrently

used systems of terms used for characterising and evaluating actions, events and other phenomena...often... organised around specific metaphors and figures of speech (tropes)". (Potter and Wetherell 1987, p.149. Also p138, p146).

The presence of such figures of speech in conversations between doctors and patients are interesting to focus on since they do call on a shared background understanding. The crucial distinguishing feature between this approach and conversation analysis is that interpretative repertoires are considered to carry pre-existing, not created-in-the-moment meanings. It is of relevance to this project because one archetypal, or canonical, example might be 'talking about the weather' which might be considered shorthand for 'small talk', and bring with it certain common-sense meanings. Similarly we might also find phrases that we might consider to be drawing on a 'professional language', or 'register', one contingent on the context of the medical consultation, that by contradistinction might help illuminate when talk appears to be not so dependent. Such an approach is consistent with my strategy of 'principled eclecticism' though I am aware of the strong feelings that can be evoked at disciplinary boundaries (eg Schegloff 1997, Wetherell 1998, ten Have 2005).

Chapter Three: Methodology and methods 1

3.1 Introduction

This study uses conversation analysis of video recordings of doctors and patients plus a thematic analysis of a focus group and interviews, to address the research question 'what are the features of family medicine consultation in one clinic in India'. This chapter describes the overall research process and data collection, and then focuses on the specific methodological considerations of the conversation analysis. Because of the significant differences in the methodology between this and thematic analysis I have chosen to separate the methodological discussion into two parts and chapter four looks at the thematic analysis.

Working with a private provider of family medicine in Bangalore I made four visits to the case study site augmented by internet video conversations. I gathered video-recorded data from 18 doctor-patient consultations amounting to over four and a half hours of data; had discussions with all the doctors who were videoed; ran a focus group with 11 family doctors and interviewed five key respondents.

In this chapter I will describe the respondents and the research site and its features, its similarities to and differences from other settings in India including the degree to which it might be considered representative of family medicine in India, if at all. I will cover aspects of access to and impact on patients, issues of consent for the doctors and for the patients and the considerations that flow from the decision to use video observations including the need for English to be used as the language of the consultation, since I do not speak any Indian languages. The chapter will end with a discussion of the process of 'converting' visual data into a form that can be worked with through transcription of the words and gestures and an overview of the process of the video analysis.

As Potter points out, the mapping between research question and methodology is not one to one (Potter 1996 p132-4). There is often a process of 'toggling' between research question and methodology as the question is refined through consideration of the methods and the methods are chosen because of the affordances they bring to a consideration of those questions. It is not uncommon in qualitative research that 'questions may change within the course of the enquiry and the dialectic between theory, interpretation and data is maintained throughout' (Hymes, 1996, cited in Rampton et al 2014 p3). Although the programme of research is presented here as if linear the reality of my experience, as this project unfolded, was one of iteration.

3.2 The case study clinic

Nationwide Primary Healthcare Services is a chain of family medicine clinics set up in India in 2010². I first met the clinic leads when I was speaking at a conference in Delhi. They have built staff development into their corporate ethos including video-recording consultations for training and through our mutual interest in training grew the invitation to base my study in their main clinic in Bangalore. As judged by its growth as a chain of clinics and a market leader in the provision of family medicine services, it is a success, and there are markers of excellence in training such as regular tutorials, reflective review of cases and patient satisfaction surveys.

Bangalore is the capital of the State of Karnataka in the South of India and is sometimes referred to as 'Silicon Valley of India' due to its importance as a major centre for IT services. In 2012 The Economic Times of India placed Bangalore ninth in the world in terms of entrepreneurial activity (Jayadevan 2012). This affects the type of patients seen in the clinic who are likely to be urban-dwelling, young professionals and their families, who are well educated and often well-travelled. Consultations are very often carried out in English. Patients pay the clinic 200 rupees for a walk-in appointment for un-registered patients or take out an annual plan³. These plans range from a basic one that requires a joining fee of 2,500 rupees and an annual fee of 600 rupees then a charge of 1000 rupees for a home visit, 200 rupees per family physician consultation and up to 40 free telephone consults. The highest level plan offers free consultations and up to 12 home visits for an all inclusive price of 54,000 rupees per annum.

There is no federal (national) provision of health care in India, it is delegated to the individual state level, and very few states provide primary care services. For those patients who do have any access to family medicine, the private medical sector remains the principle source, either independent practitioners or providers such as Nationwide. Nationwide is however an urban provider for patients who can afford its prices and this is very different from the setting of most front line medical care in India, which is usually direct to hospital services in the government sector.

I spent a week carrying out a feasibility study at the Nationwide clinics in November 2011, observing clinics, attending meetings and talking to administrative, managerial and clinical staff. Staff and clinicians were keen to participate in the research project and addressed one of my early concerns by confirming that 80 percent of everyday consultations were carried out in

² <http://www.nationwidedocs.org>

³ At the time of writing £1 sterling is equivalent to 92 Indian rupees. For comparison a junior family doctor in a private clinic like Nationwide earns around 150,000 rupees a year (roughly £1,700 a year) and a Big Mac costs 117 rupees.

English which meant I would be able to gather the English language consultations I would need for analysis, without that being an artificial constraint on doctors and patients.

3.3. The ethical approach to research: consent, confidentiality and the role of insider researcher

The project received ethics committee approval from the Institute of Education and also from the Board of Governors of Nationwide (see Appendix 3). I was invited to the regular Executive Committee meeting early on in the planning stage and I took the opportunity to seek their advice on organisational issues and how best to implement the project.

As a practicing clinician and trainer my role was close to that of an insider researcher. Although the clinic was not my own workplace, I am a member of the broader 'family medicine community'. The setting was familiar and comprehensible in structure and function bringing the advantage that I could call on much transferable background knowledge and quickly become immersed in the day to day activities. Certainly my professional status as a doctor gave me privileged access to medical staff and to clinics that might not have been so for a non-clinician researcher. The extent to which my presence as a white, female, university academic from the UK affected what I was told or what I was able to observe is unknowable but it will have had some effect. These factors brought a risk that a bias might arise from my assumptions about the extent to which practice was similar or different to my own and the particular risk arising from the difficulty of moving out of my own professional positioning. This was particularly of note in my early review of the video-recordings requiring increased reflexivity to move beyond my tendency to make comparative judgments. It also risked bias in the extent to which respondents made assumptions about what I knew or understood about their context. To minimise this I was careful to spend time in public places, eg waiting rooms as well as doctors' and staff meetings and listen to feedback from participants. I shared initial data with respondents and others, aimed for triangulation in the methods of gathering data and minimised the extent to which I shared my own opinions which might have influenced the way respondents spoke to me.

The main area of ethical risk was loss of privacy and potential breach of confidentiality and it was important to explain that participation by the doctors was voluntary and to ensure that both doctors and patients understood the nature of the research and freely consented to be videoed.

Access to and consent from doctors

I held a meeting with all the doctors on my first visit to talk through the project with them. Not all doctors were comfortable with being videoed involving, as it does, having their practice exposed and potentially judged. The clinic has a system of appraisal and performance-related pay based

on patient feedback and peer assessment and although this was not voiced, it was possible some doctors thought their decision to participate or not might influence this in some way. None actively voiced their intention not to give their consent to participate but in the end, six out of the ten doctors accounted for the 18 videos which will have been due to a variety of factors including availability of patients willing to be recorded on the days they were in practice as well as their own enthusiasm or reticence.

Access to and consent from patients

Letters of invitation were drawn up with separate information sheets for the receptionists and patients. Importantly the consent process included consent to use images (but not names) in final written work and presentations arising from the work. From later discussions I had with receptionists it seemed this last requirement put off some potential participants who would otherwise have agreed to take part but was an important safeguard to ensure that participants understood the use to which I would be putting their images.

Soliciting patient consent was through a three-stage process. Initially on booking an appointment in the study period with a doctor who had agreed to participate in the study, the receptionist gave an information sheet to the patient and explained that the study was taking place. They could decline to participate at this point but, if they agreed, they still had time to consider the implications before arriving for their consultation, when written consent was taken. After the consultation, patients were asked again if they were still happy for their consultation to be analysed. Sometimes patients did withdraw their consent after being filmed; once because the patient unexpectedly became tearful in the consultation and once when the consultation was joined part way through by the patient's mother-in-law also seeking medical advice. Doctor and patient signed the same sheet to indicate they had both consented.

There was a risk in the project of a form of 'symbolic harm'; that the videoing could project a meaning to patients and to clinicians that the project was designed in some way to 'check how good the doctors were' compared to UK doctors. I was careful to ensure the language of the study literature used a discourse of difference not of deficit about what I was trying to observe, that is the project was looking for the features of Indian practice, to describe them, not compare them with English doctors or some idealised, standardised practice. By providing pre-prepared information sheets for receptionists to distribute I attempted to safeguard against them or other health centre staff using language that might characterise the study in a way that undermined the local doctor-patient relationship. For example, a receptionist might say 'is it alright if we film your consultation to check how the doctor is doing?' which might imply it was a form of service evaluation of the doctor. Experience from training in the UK has shown that, inadvertently, reception staff can influence whether patients agree to be seen by doctors in training depending

on whether they describe them as ‘new doctors’ or ‘trainee doctors’ so it seemed likely that language might play a similar role here in the invitation to participate and the written invitations were designed to minimise this.

As patients arrived the doctor first decided on a case by case basis if they themselves wished to be videoed. If they did, they instructed the receptionists who took initial consent from the patient. It was agreed in initial discussions between me and the senior doctors in the clinic that receptionists as the initial point of contact were likely to present the least risk that patients might be coerced into taking part due to an inability to say no to a doctor. Once initial consent had been obtained, the doctor then also discussed the project with the patient to further explain and minimise any risk of misunderstanding.

Videos were stored on encrypted memory sticks, in a locked filing cabinet. Electronic transcripts were stored on a password protected lap top. The transcripts and consent forms are linked to the videos by code numbers and not stored together and the key for the pseudonyms is stored separately.

3.4 The participants

Table 3.1 contains a summary of information about all staff who participated in one or more phases of the study. Of the interviewees, Dr Daya (pseudonym) was neither videoed (she was not in clinical practice) nor took part in the focus group. They are all Indian medical graduates, except where stated. MBBS, Bachelor of Medicine and Bachelor of Surgery, is the standard undergraduate medical degree in India. Each respondent was given a pseudonym to protect their identity ⁴.

Table 3.1: Pseudonymised participant data

Name	Position	Qualifications	Experience and training
Shankara (Male) Aged 43	Founding partner and Chief Executive Officer	MBBS 1993 MRCP (UK) 1997 MBA (INSEAD) 2003	University Hospitals of Leicester and Johnson & Johnson. Responsible for general strategy, investor relationships and medical recruitment strategy.
Daya	Head of operations	MBBS 2003	Seven years working on

⁴ In order to preserve anonymity, yet use appropriate names for age, religion and gender, pseudonyms were selected using <http://www.baby-names-and-stuff.com/indian-baby-names>. The name of each respondent was compared with the data base of most popular Indian baby names by year, and a name with a similar degree of popularity, selected.

(Female) Aged 33		MBA 2006 (Indian Business School)	strategic projects in pharmaceutical and medical device industry.
Sherif (Male) Aged 45	Founding partner and Chief Medical Officer	MBBS 1991 MRCGP(UK) 2003 DFFP 2003 MRCGP(Int) 2012	Ten years UK NHS experience up to GP principal, managing partner and PCT PEC Board level
Adhrushta (Female) Aged 44	Training programme Director	MBBS 1992 MRCP (UK), 2002 MRCGP (UK) 2003 DRCOG	Consultant and specialist in Family Medicine with experience in India and UK. MRCGP (Int) AKT examiner.
Girija (Female) Aged 33	Clinic Head	MBBS 2003 DNB Psychiatry 2010 MRCGP(Int) 2013 Certificate in Counselling, British Association of Counselling and Psychotherapy (BACP) 2012	Clinical experience working with both adult and childhood psychiatric illnesses; casualty medical officer
Vania (Female) 34		MBBS, MRCGP (UK) 2007 DRCOG DFFP DCH	Graduated with 5 gold medals. Passed PLAB. Trained and worked in NHS as full-time GP in Kent, UK.
Imran (Male) Aged 28	Trainee	MBBS 2008.	Three years in government hospital; supervised training for MRCGP (Int)
Risha (Female) Aged 29	Clinic Head and trainer	MBBS 2007 (Nepal). MRCGP(INT) 2013	Clinical experience in family medicine and paediatrics with residency in paediatrics
Paavan (Male) Aged 38	Head of Paediatrics	MBBS 1998 MD 2000 MRCPCH (UK) 2005 FRCPCH 2010	UK postgraduate training and experience for ten years in secondary care
Hetal (Female) Aged 30	Family Doctor	MBBS 2006	Resident Doctor in a Nursing Home for three years; secondary care experience in geriatric medicine

Rajender (Male) Aged 54	Clinic Head	MBBS 1982	Three decades of clinical experience as a general practitioner and previously Physician-in-Charge in the Army; on the panel of medical examiners for several health insurance companies and public and private sector organisations, including Air India.
Saguna (Female) Aged 32	Family Doctor	MBBS India 2004 DNB (Family Medicine) 2012.	Family medicine experience largely in secondary care
Aaron (Male) Aged 29		MBBS 2007 CMC Valore MRCGP(Int) 2014	Passed PLAB, 2 years in UK; single handed medical officer in a rural clinic and set up regional diabetes screening programme

Several of the study doctors had had training experience in the UK. Indeed both the clinic heads had international experience and had returned to India with the specific goal of setting up family medicine clinics. As we have seen from the dearth of postgraduate training opportunities in India this is far from unusual. Since this thesis does not have a comparative concern, but a descriptive one, the information in table 3.1 was not used to examine any difference in practice.

3.5 The three data collection methods

I gathered audio recorded data from a focus group of eleven doctors, and also from interviews with five key informants (the chief medical officer, the training programme director, the chief executive, a junior doctor and the head of operations). All interviewees were interviewed in clinic premises in Bangalore over a two week period. They were volunteers and I thanked each of them with a token gift of a university pen. I gathered video-recordings of consultations on two separate visits six months apart.

3.5.1 The focus group

The focus group was held in a protected learning time session when clinics were closed. It was opened with 'How would you describe the features of family medicine here'. I then made the minimum of interjections or comments:

...allow[ing] participants to generate their own questions, frames and concepts and to pursue their own concerns, on their own terms and in their own vocabulary
(Barbour and Kitzinger 1999, p5).

It was important to be aware of the risk that dominant group members might affect the discussion, either driving or censoring contributions. Barbour (2005) warns us to consider the probable impact of the history of the group itself when using a pre-existing group and this group contained senior and junior members of the clinic hierarchy some of whom were employed by other members. Although the discussion was initially between 3 key team members, after a very short time all members made contributions and responded to each other, expanding or disagreeing with comments and enabling an:

explor[ation of] people's knowledge and experiences [which] can be used to examine not only what people think but how they think and why they think that way
(Kitzinger 1995, p299).

Partly because of these group dynamics, focus groups do risk over-emphasising consensus. However, as Sim points out:

An apparent conformity of view is an emergent property of the group interaction, not a reflection of individual participants' opinions
(Sim 1998)

Despite my attempt to keep silent and make as little impact on the conversation as possible, the participants knew that the purpose of my exploration was linked to the RCGP CSA and their conversation did turn to expressions of opinion on what might underpin the differential success rate. Many shared their experiences of working and training in the NHS and following on from this I asked them a supplementary question, 'Please describe how GPs are prepared for practice in India'.

The group lasted 105 minutes. At the end, they were asked if anyone wished to withdraw their consent, which no-one did.

3.5.2 The interviews

Un-structured Interviews with five key respondents were carried out to further explore the themes arising in the focus group. They ranged from 15 to 35 minutes, were held in clinic time and were audio-taped.

Kvale describes the research interview thus:

The research interview is an interpersonal situation, a conversation between two partners about a theme of mutual interest. It is a specific form of human interaction in which knowledge evolves through a dialogue (Kvale 1996, p125).

We can see that the researcher is thus very much more a tool in the research process here than in some other forms of qualitative research. Her fore-understanding, her personal history, her preconceptions and personal experiences are a key element in the sense made. Kvale summarises the role of the interviewer thus:

The interviewer is him or herself the research instrument. A good interviewer is an expert in the topic of the interview as well as in human interaction. The interviewer must continually make quick choices about what to ask and how; which aspects of a subject's answer to follow up –and which not; which answers to interpret –and which not. Interviewers should be knowledgeable in the topics investigated, master conversational skills and be proficient in language with an ear for their subjects' linguistic style. The interviewer should have a sense for good stories and be able to assist the subjects in the unfolding of their narratives (Kvale 1996, p147).

The prompts for the interviews were derived from themes arising in the focus group, asking: how would you characterise the purpose of the family medicine consultation; what is the role of the doctor in your community; what is the model of health service provision in India; describe the training and career structure for family medicine.

The audio-tapes of the focus group were listened to repeatedly and I then transcribed them to prepare a transcript of the data for the thematic analysis which is reported in chapter four.

3.5.3 Video data collection

The decision to use video recording to gather data for analysis follows from the research question because, without direct observation, describing the features of the general practice consultation in India would be much more difficult. The literature review showed that there was very little observational data of general practice consultations outside of the UK and none at all published from India. However as a data collection method, video recording has weaknesses, the greatest of these being the loss of privacy for the patient, and also for the doctor, both of whom will find themselves exposed to a third party researcher. This might distort the very interaction it is set up to record. There is also a risk that the video record and the interaction become conflated in the eye of the researcher. The video is not the interaction, it is of necessity, because of camera angles and other deficiencies in the recording process, an incomplete

reflection of it. In the particular instance of my project, videoing consultations for my analysis required them to be carried out in English. Although patients and doctors volunteering to be recorded agreed to carry out the consultation in English, this did raise some observable methodological considerations which I will discuss below.

Although present in the clinic, I did not sit in on any of the consultations that were filmed, in order to minimise the intrusion and distorting effect of such observation. Recording was carried out using a high definition Sony camcorder mounted on a tripod and arranged to be out of the eye line of the patient and the doctor. Video, as a real-time sequential medium, enables us to observe different aspects of an interaction, not just the words and can also “preserve the temporal and sequential structure which is so characteristic of interaction” (Knoblauch, Schnettler and Raab, 2006, cited in Jewitt 2012, p3). The camera was placed to capture as much as possible of such gestures and the faces of both participants, with a microphone on the desk between the doctor and patient.

There are only three occasions in the corpus when participants make overt reference to the camera, however not commenting does not mean it has not been noted, or affected behaviour. Lomax and Casey argue that participants ignoring a camera could be interpreted as ‘an active state of not paying attention rather than not noticing’ (Lomax and Casey, cited in Jewitt 2012, p9). It is very likely that knowing they were being filmed affected both doctor and patient in some way but to an unknown and unknowable degree although any impact is likely to have pushed them in the direction of trying to be the best that they could be. Heath et al however, having carried out research using video recorded data for nearly 25 years, including in general practice, conclude that participants can rapidly accommodate to the presence of the camera and any effects, such as self-censorship in patient narrative, alteration in normal consulting manner, quickly wear off (Heath, 2010, p49).

3.6 Impact of the decision to video record consultations, and to do so in English

3.6.1 Data omissions

The decision to use video recording means that there are necessarily omissions in the data. Asides to, or comments from, third parties who are out of shot or the range of the microphone risk being missed, and participants occasionally move in to or out of shot, as in clip 3.1⁵.

⁵ Data clips in this chapter appear here minus most of the transcription conventions of conversation analysis, for ease of reading. Square brackets which are generally used to show over-lapping speech, when enclosing words in *italics* are used to show where the interactants are not speaking English and for how long.

Clip 3.1: Male doctor, father and two sons, one initially off camera (Child 2)

- | | |
|------------------------------------|---|
| 1. Doctor | And the weight gain, when has it been, if I ask you? |
| 2. Father | He is having considerable weight gain, always like this |
| 3. Doctor | Like from the beginning? |
| 4. Father | ((turns his head to second child, off camera, hitherto un-noted)
You know what is his age? He may be equal weight with him
((returns gaze towards doctor)) |
| 4. Child 2 | No I am not |
| 5. Father | He is only ten |
| 6. Patient | I am eleven ((stands up and moves out of shot)) |
| 7. Father | Eleven. He may be around, maybe 60kg. Pick him up and see |
| 8. Doctor | (Laughs) That's fine. But I would really like to know something about the diet, like what kind of food they are taking |
| 9. Father | They don't take that much of junk food, junk is very less. But morning regular one is maybe some idli or something like that. I take two idli but he takes ten idli |
| 10 Child 2 and patient, cross-talk | [He has cornflakes
[I like fruits
[I don't eat
[I eat cornflakes also |
| 11 Father | Quantity is more otherwise sometimes he has cornflakes |

The father is comparing his two sons and is concerned about the weight of the patient. Child two is out of shot so we cannot see him as he responds to his father's gaze, but it has the effect of inviting him to join the conversation at line four. After hearing his father get his age wrong, the patient walks off and out of shot so that the next time the two boys talk, in overlapping cross-talk starting at line 10, neither are on camera and we cannot attribute the speech to the correct brother and ascertain who has the rice cake, who has cereal and who has fruit.

Secondly, in order to minimise the intrusion, no physical examinations were videoed. As soon as it became clear that the doctor needed to examine the patient, the doctor turned the camera off and turned it on again when the examination was finished. Thus any conversation during that time was not available to me. If I had been present in the room, I would have been able to hear the ongoing interaction, even if carried out behind a curtain in the examination room. At times it becomes clear in the video data after an examination that elements of the ongoing conversation had been effectively 'rehearsed' off camera. For example in clip 3.2 the doctor and patient have already discussed, off camera, that the patient is worried about his blood pressure. When the camera is on again, after the examination, the doctor prompts the patient to recall what he has already said:

Clip 3.2 Female doctor, male patient

- | | |
|------------|---|
| 1. Doctor | So like what I am saying is (2.3) can you ask again what it is you just asked |
| 2. Patient | (.6) About the blood pressure? |
| 3. Doctor | Why you think your BP is on the high side? |
| 4. Patient | Like I said I am getting headaches and eye strain in the work |

3.6.2 English as the language of the consultation

Although local dialects and languages are very important in India, English is one of the national languages and features in the national school curriculum, particularly for science subjects, and is often the only language people from different regions have in common. Most people can speak at least two languages but English is the principal language of the professional and business class from which Nationwide draws a large proportion of its patients.

The fact that doctors and patients were required to use English however for these consultations did emerge as an interesting issue in the process of analysis. Very few native Indians speak English as a mother tongue and although some might describe English as their 'first language', by this they often mean it was their 'first language of instruction', ie in English medium schools. Some of the differences this produced did not have an obvious impact on the transcription or analysis. For example Indian-English contains some vocabulary and forms of address that persists from British colonial times, but which are considered old-fashioned in British English, such as *thrice* for three times and *good-name* rather than first name but can be understood easily. It also contains some features that have derived from grammatical forms present in native languages such as the use of *even*, as in "even I don't know" instead of "I don't either", whereas *itself* is often used for even, as in "they go to hospital with a viral fever itself". These are easy to learn through observation.

The impact of code switching between languages however is another methodological consideration that can give rise to data omissions. In clip 3.3, when the focus of the doctor's attention is not on the patient, the patient and her husband appear to pursue a private conversation. The doctor, having declined help from the patient's husband on working the computer, is reading from the screen for a prolonged period of time. After an initial pause the patient and her husband then push their chairs away from the desk and the doctor and converse together in Kannada, quietly, as denoted by the ° ° symbols.

Clip 3.3 Female doctor, patient and her husband

- | | |
|---------------------------|---|
| 1. Husband | ((looks at computer screen and presses button)) [if you |
| 2. Doctor | [its ok I
can see that ((turns lap top round, presses keys and reads from
computer screen)) |
| 3. | (3.8) |
| 4. Patient and
husband | ((move chairs back away from desk))
[°Kannada ° 124.0] |
| 5. Doctor | When was this done |
| 6. Patient | Someone came to my place to collect the sample
I didn't notice |

The physical movement at line 4, the quietened tone and the change to a local language suggest a moment of intimacy between the couple from which the doctor is excluded. This has implications for the data analysis since the researcher is also excluded and we can't know what was said in this exchange. When addressed in English, it is as if the professional atmosphere has been re-evoked by the doctor and the patient unhesitatingly reverts to English as well.

The clips in this section speak to methodological issues but also to features of the general practice consultation in this clinic, which I will return to below. However, because of the choice to video-record the consultations and turn them into data for analysis, the methodological requirement to consult in English language becomes an additional issue for some patients and some doctors.

3.7 The stages of the initial analysis**Stage 1**

Videoing has the advantage that there is a permanent (until erased) record of an interaction that can be repeatedly viewed and bring into focus elements that could not be noted if an interaction was just watched once in real-time. It does however have to be transcribed to render it in a form suitable for conversation analysis. My video data amounted to four and a half hours and covered 18 consultations. Taking on average 5 hours for every hour of consulting time this initial transcription of the data was enabled by watching and re-watching, initially focussing on capturing the words laid out like a play-script using the VLC media player ⁶ and Microsoft Word ⁷ to get an overview of the shape and content of the consultation.

⁶ VLC Media player™ available for free download from VideoLAN

⁷ Microsoft® see www.microsoftstore.com/UK

McDermott and Goldman describe the process of 'data discovery' (McDermott and Goldman 2007, cited in Jewitt 2012, p6), a painstaking, often collaborative process of creating data out of the videoed information. I shared the videos and transcripts in a password protected drop-box with each doctor. This helped with aspects of the transcription such as unfamiliar words (references to foods, locations and medicines by local brand names) and code-switching between languages.

Initially I sensitised myself to the data through a process of 'unmotivated looking', as described by Psathas,

The variety of interactional phenomena available for study are not selected on the basis of some preformulated theorizing, which may specify matters of greater or lesser significance. Rather the first stages of research have been characterized as *unmotivated looking*

Psathas, 1995, p45.

This preliminary work of watching the videos repeatedly identified a range of features that might have been interesting to explore in more detail, I spent time looking at how the consulting rooms were arranged, noticing how many had third parties present and what their role appeared to be, the types of problems presented by the patients, the impact of computers on the consultation or where the use of language seemed to be a feature.

The consulting rooms in all the videoed consultations were clean and tidy but were sparsely furnished functional spaces. They all featured a light box for the viewing of x-rays although I did not see them used. Since the clinic did not have an x-ray facility these would only have been used for viewing films that patients might have had taken elsewhere and brought along for an opinion, just as they occasionally brought along blood test results for an interpretation. They showed an absence of any decorative features to soften the clinical environment such as pictures, plants or photographs, or any personal objects such as books or toys for children to play with. The doctors often sat behind a desk facing the patient, and occasionally they sat across the corner of the desk, at 45 degrees to each other.

Around half of the patients on video were accompanied and at times by more than one other person, the most I saw was four accompanying persons (two children, husband and mother-in-law). In one case a patient and her son were joined half way through by her mother-in-law who also wanted to be seen. Children were often accompanied by parents and paternal grandmother due to the prevalence of extended family households. It was not unusual for consultations to be interrupted by the staff bringing cups of tea for the doctor. It would have been interesting to

explore to what extent this represented a different emphasis on confidentiality in medical matters or autonomy and self-determination in managing such aspects.

The range of problems presented by patients in the consultations videoed is likely to have been affected by the participation in the research project. Patients with sensitive sexual health or psychiatric problems were not seen. In two presentations for fatigue the doctor did not probe for evidence of depression, which might have been an artefact of the video recording since there is still a taboo around mental illness that might have led to a lack of consent to be videoed. Cases included self-limiting conditions such as respiratory tract infections, metabolic and long term conditions such as diabetes, thyroid disease and obesity, and paediatric and pregnancy-related cases.

All consulting rooms had a computer with access to the internet, but these did not seem to impact on any of the videoed consultations. In the absence of electronic medical records the computer did not need to be consulted and thus rarely was in the line of sight of the doctor. In two consultations the patient brought along a lap-top or smart phone to show the doctor some test results. One of these were tests the doctor had previously requested and two were tests the patient had arranged themselves from other providers. When doctors were looking at data sometimes several minutes would go by without interacting with the patient (as in clip 3.3 above).

In this early first stage of initial analysis the impact of language began to develop as a feature of the consultations. We saw above the methodological implications of needing to video record only consultations carried out in English, such as the omission of data. Sometimes pronunciation became problematic. For example in clip 3.4 about a case of indigestion the pronunciation of the word 'sour' caused the patient a problem when the doctor pronounces it to rhyme with 'your', rather than with 'our'.

Clip 3.4 Female doctor, teenage, male patient and his mother

- | | | |
|----|---------|--|
| 1. | Doctor | Okay your mum said you felt the taste of blood can |
| 2. | | you tell me some (0.2) what does it taste like |
| 3. | Patient | only once when I burped once and I tasted iron |
| 4. | Doctor | Iron okay it was more of a sour↗ |
| 5. | Patient | Sorry↗ |
| 6. | Doctor | It was more of a sour (0.8) what do you speak at home
Kannada [or |
| 7. | Mother | [Hindi or English |
| 8. | Doctor | It taste of iron |
| 9. | Patient | Yes basically you know iron in the blood |

- | | | |
|-----|---------|---|
| 10. | Doctor | Okay okay was it like a lemon taste [or |
| 11. | Patient | [no a salty iron |

At line four the doctor says ‘sour’ but the patient does not understand and asks for it to be repeated. The doctor repeats her use of the word sour but, recognising the interactional difficulty indicated by a pause, assumes at first it is caused by vocabulary and asks the patient what languages he speaks at home, and therefore would be more familiar with. The patient’s mother replies for him and when they have established that English is their common language, the doctor repeats what the patient said at line three, that he thought the taste was of iron. The doctor however is still seeking to clarify whether the regurgitation is blood or acid and offers a comparator of ‘like a lemon taste’ to explain her use of sour.

When I first played this back, even with the expansion to include ‘like a lemon taste’, I had no idea what they were saying until I enlisted the help of a Kannada speaker who could hear it as ‘sour’ not ‘soar’. It is possible that other similar misunderstandings exist in some of the transcripts due to my ignorance, which are undetected. As well as causing a difficulty for me as researcher, this clip also starts to illustrate one of the features of the consultations in this clinic, that of the impact of multiple languages in play, which is also illustrated in the next clip, 3.5.

A feature of some of the videos was the ease with which doctors and patients could switch between different languages sometimes seemingly without noticing. For example clip 3.5 is taken from one of the paediatric consultations which were not included in my final analysis. The doctor had not realised until we watched the recording back together, that he had spoken in Tamil for most of the consultation. The consultation with a child and her parents who had come for routine vaccinations shows how the doctor slips easily between English and Tamil.

Clip 3.5 Male Doctor, parents, baby girl and paternal grandmother

- | | | |
|-----|-------------|--|
| 1. | Doctor | very good okay remind me your name |
| 2. | Mother | Arunajyothi |
| 3. | Doctor | and purpose of visit |
| 4. | Father | vaccination visit |
| 5. | Doctor | Okay |
| 6. | Mother | and then general consultation also (indicates paperwork) |
| 7. | Doctor | sure sure sure |
| 8. | Grandmother | [Tamil 2.6] |
| 9. | Doctor | [Tamil 0.8]= ((shifts gaze to grandmother)) |
| 10. | Grandmother | ((smiles)) |
| 11. | Doctor | = so 6 weeks [Tamil 2.2] there will be like five in one vaccine called Pentaxim [Tamil] painless vaccine I think it is around around fifteen hundred or eighteen hundred |

- | | | |
|-----|--|--|
| 12. | Mother | ((Gestures to papers)) |
| 13. | Mother | okay okay |
| 14. | Father | okay okay |
| 15. | Doctor | [<i>Tamil 1.8</i>] hepatitis B vaccine first vaccine |
| 16. | Mother, Doctor,
father and
grandmother | [<i>Tamil, several turns</i>] |

The consultation begins in English but, at line eight, the paternal grandmother of the child says something in Tamil, the doctor looks at her and makes an utterance also in Tamil and the grandmother smiles. Without a pause the doctor reverts to English but after three words gives a moderately lengthy utterance in Tamil before reverting to English for the jargon-laden description of the vaccine interspersed with one word in Tamil. Then at line 15 it is the doctor who speaks first Tamil and continues in English again to describe the vaccine before all four interactants make several exchanges in Tamil.

The presence of the Grandmother and her initial utterance in Tamil is followed by the doctor at line 9 with a shift in gaze that includes her into the conversation, but this also seems to have had the effect of opening up the conversation to the second language and increasingly the conversation between them includes Tamil. We can't know whether the whole of the consultation might have been carried out in Tamil if the camera had not been present. It is possible that the research project requirement for doctor and patient to consult in English, has had a disruptive effect on the extent to which the grandmother has been excluded from the consultation. Conversely we cannot know whether the research project had any effect at all and such a switch would have happened anyway. However, through the affordance of the camera we have been enabled to observe the ease with which the code switching happens, whether or not it was the videoing itself that provoked it.

Stage two: the shift to focus on talk itself

I gradually came to notice that the consultations seemed to contain very little less-formal, or social talk aimed at, or resulting in, relationship building. This initial noticing is possibly a direct result of my insider-researcher position referred to above, and a tendency to impose my own expectations on what talk might be present based on my own practice. However we have seen from the work of Roberts et al in analysing video recorded consultations from the CSA itself that 'successful candidates use conversationalising strategies more –small markers that make the consultation more informal' (Roberts et al 2014 p47). In addition, their corpus linguistic analysis of CSA tapes demonstrated that 'sustaining social relationships is a highly indicative feature of talk in the CSA...the most frequent CSA phrases were orientated to the relational work of the interaction' (Ibid p35).

To look at the talk more closely I needed to repeat the transcription process to create a more detailed transcript including the timing of pauses and the correct alignment of gesture, gaze and talk. So eventually, after experimenting with Transcribe! ⁸ and Elan ⁹, I switched to CLAN ¹⁰ as an integrated transcription tool. The frustration that CLAN only works with video files that can be opened by QuickTime¹¹ media player was overcome through the use of Handbrake ¹² transcoder to convert the files to a readable format.

The initial analysis of the data was done as an overview of all eighteen transcripts looking for any instances of talk that, at first sight at least, did not appear to be core medical task-related; that is, for this purpose, any utterances that were not directly related to history, examination, diagnosis or management.

Seventeen instances of such talk were found in nine consultations and thus nine consultations had no such talk. The mean length of consultations containing any episode of such talk is 12.49 minutes (range 2.45 -27.13). Those with more than one episode are the longest (see table 3.2).

Table 3.2: Instances of talk that appear to be non-work-related.

Consultation title ¹³	Duration	Number of instances	Gender of doctor/patient
Risha and Nitesh	27.13	2	F/M
Girija	23.32	3 4 doctor 'remarks'	F/F+ trainee
Hetal and lap top	19.35	2	F/F +husband
Hetal and thermometer	11.39	1	F/F + mother
Baskin Robins	8.13	1	F/F
Weather in Delhi	7.14	1	F/F
*Hasina	7.08	1	F/F plus father
*Paavan +2	6.46	1	M/2 boys and father
*Paavan and vac	2.45	1	M + baby, parents and grandmother

* Denotes a paediatric consultation

⁸ Available to be bought from <http://www.seventhstring.com/>

⁹ ELAN Linguistic annotator <https://tla.mpi.nl/tools/tla---tools/elan/>

¹⁰ CLAN: (Computerised Language Analysis) Integrated transcript editor freely available from <http://chilides.psy.cmu.edu/clan>

¹¹ Available free from www.apple.com/uk/quicktime

¹² Handbrake video transcoder <http://handbrake.fr>

¹³ All names of doctors and patients have been changed

One consultation contained three instances of several turns each, plus four short remarks that do not initially appear directly task-related and which are longer than back-channel interjections. Three were consultations with children (representing 75% of the four paediatric cases recorded). These paediatric instances were with the parents of a baby attending for routine vaccination on the subject of baby names and two directly with the child, one about favourite subjects at school and one joking about the doctor's name.

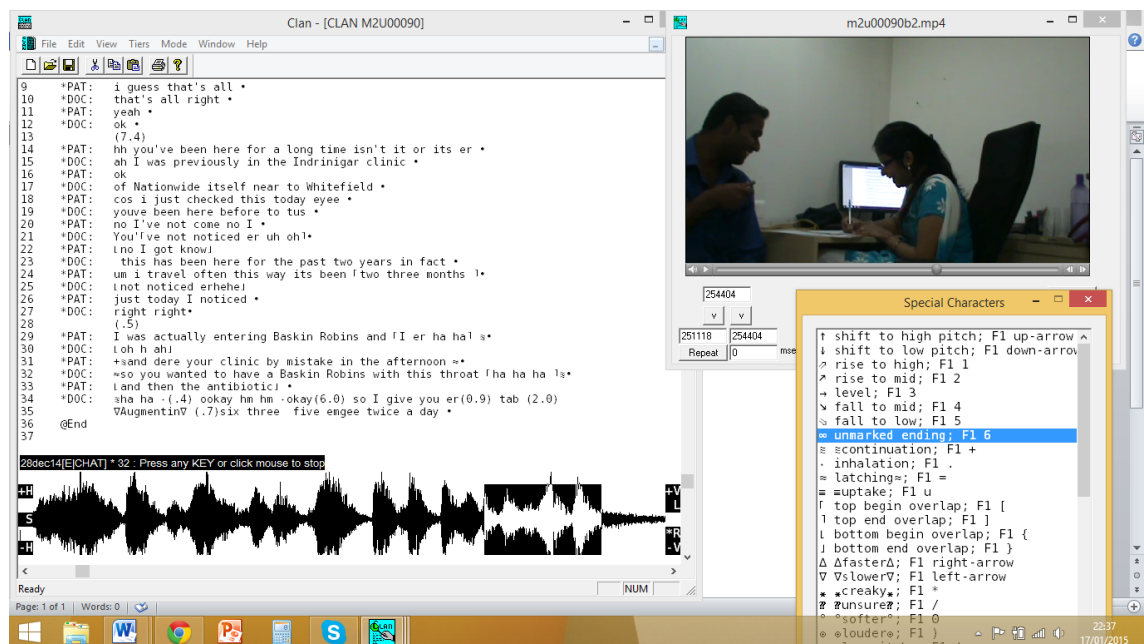
For the purposes of this thesis I have chosen to concentrate on the adult cases. It is possible that the work talk does is different when doctors talk to children although there is very little analysis of this in the literature. Certainly there is some suggestion that adults talk differently to children, adopting a more sing-song voice or 'mother-ese' (Tannen, D. and Wallat C.(1983) cited in Cahil 2007), although this is not universal (Cahil 2007a) and seems likely to depend on the age of the child. It certainly seems likely that the different tenor of the talk in doctor-child conversation might lead to the adoption of a different register in an effort perhaps to put the child at ease and encourage their contribution. Previous work has looked at the triadic consultation of parent-child-doctor and in their literature review Cahil and Papageorgiou (2007b) found 21 papers, none of which looked at the role of or work done by small talk directly. Papers in their literature review either counted turns of the child's talk regardless of content in a quantitative approach or else used a qualitative approach which judged or categorised talk (eg as 'largely social') and then timed contribution length. So there is a gap in the literature on the work done by talk between doctors and paediatric patients which might be a very interesting area of further study, but for the purposes of this work my data from paediatric consultations have been set aside.

The nine consultations that contain no instances of non-medical talk, as defined above, have a mean duration of 11.76 minutes (range 4.54 - 20.54). The four shortest of these are all with one, male, doctor, Dr Parrath, (duration 4.54, 6.58, 7.07 and 9.44 minutes) and the two longest with Dr Saguna who is female and which lasted 20.54 minutes, (including 2 minutes outside the room seeking a chaperone) and 17.53 minutes.

The consultation with the greatest number of instances of talk that looked to be non-task related talk was with Dr Girija, a female doctor, which lasted 23.33 minutes and as well as containing three longer instances of several turns, Dr Girija makes four short remarks. This was however not the longest overall consultation (which was with Dr Risha, also female, which lasted 27.13 minutes with two instances of small talk). The third of the three consultations that contains more than one instance of small talk also contained several episodes of silence (ranging from 17 seconds to a maximum length of over two minutes), when the doctor was consulting the computer, which has prolonged the overall length.

Having identified sections of the videos that appear to include non-work-related utterances, I then re-worked all these script sections with CLAN, transcribing all of these shorter sections, in much more detail. CLAN is an integrated transcription system that allows the analyst to watch the video and annotate the script without having to toggle between screens (see figure 3.1). It shows the sound wave so that utterances and pauses can be accurately measured.

Figure 3.1 Screenshot of CLAN in use

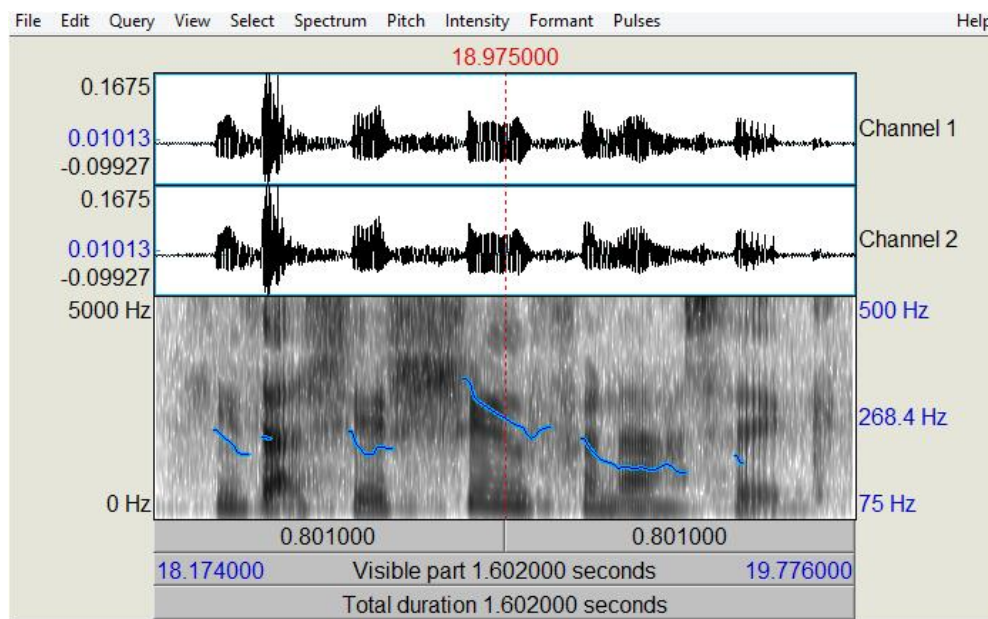


CLAN also interfaces easily with Praat¹⁴ which enables the sound wave of individual words to be crossed over to Praat from CLAN to enable a visual representation of pitch (Figure 3.2). This allows a closer look at prosody for very short segments where, perhaps, the sound is unclear and a pictorial representation can add clarification about intonation or inflexion as used to convey questioning.

Fourteen clips of video data were watched closely and re-transcribed noting gestures, gaze and bodily movements as well as speech and timings of silence.

¹⁴ Praat (named for the Dutch word for talk) can be downloaded from <http://www.fon.hum.uva.nl/praat>

Figure 3.2 Screenshot of Praat in use



3.7.1 Transcription conventions

In figure 3.1, to the right hand side, we can see a box labelled 'special characters'; these are an important part of the transcribing process. It is clear that the primary data are the videos but in order to analyse the interaction an annotation system is needed to render non-lexical aspects of the interaction available for analysis. The special characters utilise conventional punctuation symbols in a novel way to represent the para linguistic features of the talk. Pace, intonation, volume and additional features such as laughter, overlapping speech, pauses and gestures can be shown. CLAN has its own unique system which is based in the *Jefferson Transcription System* (Atkinson and Heritage 1984 pp ix –xvi). I have reproduced the common features in box 3.1.

Transcription notation aims to capture both what is said and the way it is said. Like musical notation, employing a recognised transcription system brings a formality that would enable two analysts to produce a significantly similar record of happenings and enables the reader to be able to reconstruct the features of an interaction reasonably consistently. Bearing in mind one of the assumptions of conversation analysis is that talk is an orderly process, representing that order faithfully is important to enable coherent conclusions to be drawn.

Box 3.1 Transcription notation system

(.)	A noticeable pause but too short to measure.
(0.5)	A number inside brackets denotes a timed pause, recorded in tenths of a second – here five-tenths or half a second .
[Square brackets denote a point where overlapping speech [starts and ends].CLAN can line these up automatically making it easier to follow where speech overlaps where one of the pair of speakers is speaking continuously
> < or △ △	The speech enclosed in arrows or upwardly facing triangles is markedly quicker than surrounding speech
< > or ▽ ▽	Arrows pointing ‘outwards’ from the enclosed speech in this way , or downwards pointing triangles, show the enclosed speech is markedly slower
()	A blank space enclosed by round brackets shows that despite multiple reviews, the words are unintelligible to the analyst. It may very well have been heard by the interactants however. They might enclose a guess at the word in which case alternatives might be presented separated by /
(?? ??)	A space enclosed by two question marks inside a round bracket indicates that the talk is in a language other than English
((shrugs))	Words in double round brackets are not spoken but represent gestures or additional contextual detail, such as ‘adjusts sleeves’
° °	Words enclosed between ° are quieter than the surrounding talk
WORD	Upper case denotes increased volume of speech
⏟ or ↗ or ↘	Demonstrates rising intonation or inflected speech such as accompanies a question (underlined colon denotes less marked)
⏟: or ↘ or ↙	downward arrow denotes a drop in intonation or a resetting of the whole pitch register (again order of symbols here goes from less to more marked).
Fu(h)nny	Laughter is indicated with from one to several ‘h’s. When a bracketed ‘h’ appears it means that laughter ‘bubbled through’ the talk. A series of ‘h’s can also represent some other aspirated sounds such as an intake of breath or a sigh
£ or ☺	This symbol present before a word represents a ‘smile voice’, ie a word spoken whilst the patient was smiling
≡	Continuous speech by one person might extend over more than one line when written down, and if this is ‘spoken-over’ by a second person this sign shows where the continuation leads from and to.
=	The equals sign is used to represent two turns at speech following directly on from each other with no pause, known as ‘latching’.
::	Colons within a word show it has been drawn out/extended

3.8 From transcription to analysis

The process of transcribing, annotating and making sense of what can be seen and heard in data is slow and painstaking. It should not, however, be mistaken for analysis.

Qualitative analyses share something important with quantitative analyses in that they both want to do something with the data. Neither is content merely to lay the data out flat. A quantitative researcher who merely presents the raw data from subjects in an experiment, without putting it to some sort of statistical testing, would hardly be said to have analysed it. So it is with qualitative data

Antaki et al (2003) p12.

As Rampton states, 'with a close analysis, the text will lift off the page, the players rise up and move, and start doing strange things' (Rampton 2013, personal communication). My conversation analysis attempts just such a close analysis and has rendered visible instances of talk that were simply not visible without it and went unremarked in the initial analysis. Those instances that seemed to be small talk are seen, under the conversation analysis gaze, to be doing interesting things.

In common with the (social) constructionist epistemology underpinning this research, much of the research process itself was constructed in an iterative and responsive way (as broadly discussed by Potter 1996 p132-4). By this I mean that I have shown how the initial research question determined the type of data to be collected but also how it was necessary to adjust my initial intentions about which data to formally analyse once some of that analysis was underway. I finalised the analysis in a back and forth process of consideration of what the methodology could show and did show in the early phases. I decided what data to collect and have shown here how I prepared the different data for analysis.

Antaki states:

Writers are not doing analysis if they summarise, if they take sides, if they parade quotes, or if they simply spot in their data features of talk or text that are already well-known. Nor are they doing analysis if their discovery of discourses, or mental constructs, is circular, or if they unconsciously treat their findings as surveys

Antaki (2003) p30.

In chapters four and five I will present the results of this analysis. I aim to avoid any of the six errors Antaki describes, but also aim to do more than 'laying the data out flat'. I will start in chapter four, with the thematic analysis.

Chapter 4: Exploring the context – methods 2 and outcomes

4.1 Introduction

This chapter reports the methodological implications of applying a thematic analysis to the focus group and interview data, and the outcome of that analysis. In this analysis, the primary interest was to formally generate theory from the reported experiences of respondents to complement the results of the video analysis that will be discussed in chapter five. This chapter thus describes some of the features of the broader context of general practice in this setting, which can be used to help interpret aspects of the video data.

The purpose of this two-fold data analysis was to address one of the challenges of using conversation analysis: that it relies on the everyday ‘technology’ of conversation and application of common sense to note, and consider the implications, when talk deviates from conversation norms. Such ‘common’ sense is however a problematic and contested term. At the minimum it probably relies on context-specific, internalised or even unconscious knowledge of societal features and rules or norms of talk in a given setting, which might not hold in cross-cultural settings such as professional to lay or, here, England to Bangalore. Maynard addressed this same need for some contextual knowledge when he looked at courtroom practices to inform his conversation analysis of ‘plea bargaining’ (Maynard 1984, cited in Have P ten, 1990, p30). Maynard started with an ethnographic study of pre-trial conferences in a municipal courtroom setting in order to ground his analysis of a corpus of tape-recorded negotiations.

ten Have also cites Moerman’s call for:

a culturally contexted conversation analysis, a CA that is deeply informed by an ethnographic study of the culture in which the interactions studied are embedded...CA can produce results that are quite ‘universal’ on the level of formal structures and mechanisms, but needs to be grounded in an intimate knowledge of the culture from which the interactions are produced. But whether this knowledge is gained by membership or by ethnography seems to be less important, a practical matter
(Moerman 1986, in ten Have 1990, p 30)

In what follows my aim is to demonstrate some progress towards recreating just such a *knowledge of the ‘culture’* in which the video data were generated. The themes developed in this chapter will provide a lens to look critically at examples of talk in chapter five and facilitate a closer analysis of the work such talk might be achieving. My aim is that by using this lens, the validity or authenticity of the conversation analysis will be enhanced.

4.2 Approach to the data

The key principle of this analysis is that any pre-conceived ideas about what the data might show, which might risk novel ideas being overlooked, are set aside and only - and all - the information in the data is used to develop the themes. However the impact of the perspective of an individual researcher as the lens through which the data are viewed is an important consideration and to acknowledge this, the data were independently analysed by a colleague and through a process of discussion between us we jointly agreed the themes.

We studied individual data units - sentences, phrases or words - both alone and in the context of their place in the data and also at times by tracking other comments by the same speaker to debate the meaning with each other. On occasion we went back to the audio recordings when we were unsure of the emphasis or interaction of the respondents. Between us, as we moved back and forth between the data and our constructed codes, we jointly formed the judgment that the data appeared to have reached saturation, no new themes were arising in later interviews and that we had not foreclosed too early on the analysis ¹⁵. This is not to say that the findings should be held to represent a pre-existing truth 'discovered' within the data, but they do represent a considered, negotiated and agreed version of the meaning we jointly took from the data units. This process supports the credibility or reliability of the findings.

The trustworthiness or validity of the results (Glaser and Strauss, 1967) requires similar strategies to be applied. The distance to the research site presented challenges but I was able to discuss findings and share the transcripts with respondents. This helped for example to further expand on a translation of the Hindi term 'jugaad' used by a member of the focus group. I was interpreting this loosely as 'inventiveness' as in the creativity needed to work in a resource-poor environment. One participant extended this translation to show it can also be taken to mean adaptable. If an Indian doctor is 'adaptable', this has implications for their movement between different healthcare contexts adding a further layer of meaning to the comment. By using a third party to discuss this aspect with, this became a triangulation of data sources as well as a form of member-checking. A process of peer-debriefing through early conference presentation of results, including discussion with family medicine experts as well as qualitative research experts, helped develop and refine the analysis. The trustworthiness of the analysis was enhanced by review by a colleague unconnected with the project looking to ensure the application of a robust methodology ¹⁶. The final analysis has been read by my key respondents looking for phenomenon recognition or 'face validity' and also by others working in family medicine in India. For example at this stage one of the key respondents expanded on the

¹⁵ I owe an enormous debt of gratitude to Dr Wynne Thomas RGN, EdD, as this represents several hours of work.

¹⁶ My thanks for this go to Prof Val Wass FRCGP, PhD

felt need for postgraduate qualifications to enhance professional esteem in response to the themes on education and training and recognition of family medicine. ("In India, a qualification, a few alphabets following your name, really matters a lot. GPs are desperate to get more recognition". SR.)

The text of the transcripts was systematically analysed to identify all meaningful units that seemed relevant to the research question. These units included individual words, 'empathy' for example, or phrases and whole sentence eg 'human touch' or 'understanding of the family as a whole'. As one measure to attempt to minimise selection bias in the reading of these units, each of these units was then labelled using the vocabulary of that data itself, by asking 'what is this segment about?' and seeking a phrase from within the data to label it. Such a label for these units above might be 'the doctor has to connect with the patient'. This was done repeatedly and systematically across the whole data set, adjusting these labels at times and combining them where they turned out to be labelling the same feature such as with the example of combining concepts of 'jugaad' and 'globizen' to give rise to the single code 'Indian doctors are very adaptable'. Similarly codes that conflated more than one meaning were split. For example 'medicine is mostly learnt in English' and 'multiplicity of regional languages' are different concepts, with important implications but were originally combined under one code 'language barrier'. Eventually through discussion between the two researchers, these labels resulted in 21 discrete codes which accounted for all the segments of data. The codes were then collated into potential categories or themes and, going back to the data segments themselves, the themes were tested to ensure the names of the themes were a good fit to the data. Each individual theme had to be distinct, and the themes needed to account for all the data that was relevant to the research question.

The number of codes needed to declare a theme and what the prevalence of data contributing to a code should be, seems less important than the face validity of such a theme in the light of the research question, and hence I present my findings through the prism of researcher judgment about importance that does not depend on the number of times an idea was expressed. There is no intention that it be considered a quantitative summary or content analysis of the data. In addition, the findings are affected by the epistemological approach I have taken, which is constructionist, and looks for latent themes 'beneath' those expressed. This proceeds from a perspective that interpretation by members of a community, the meaning they take from events or understanding they have of why things are the way they are, is socially produced. We can say that 'the way things are round here', or what Garfinkel called the set of 'background expectancies' that is used as a 'scheme of interpretation' (1967, p36-37), is both produced by and influences an individual's understanding of phenomena. Thus in the development of themes, I aimed to look beyond the words of the participants to seek out these taken-for-granted elements. Problematically, by the very nature of their taken-for-grantedness, such elements may not be accessible for the members to describe, if simply

asked. As a stranger in this setting, I can start to address this by perturbing the surface of the commonplace to make it less invisible but, importantly, I need to be aware that I am also influenced by and bring my own background expectancies and understanding of phenomena to bear on this.

4.3 Thematic analysis

The participants are family physicians working in the same clinic who had come together for a protected learning session and who voluntarily took part. Their time since qualification ranged from three to thirty years. Four out of the eleven in the focus group were female and five had worked in the UK (See table 3.1 in chapter three). The transcribed data were analysed according to the stages of the inductive thematic analysis model described by Braun and Clarke (2006). This model can be summarised in six steps: data emersion, familiarisation and identification of units of meaning; generating initial codes and collating data relevant to each code; grouping and labelling codes into potential themes; checking that the themes work both in terms of the codes and the overall data set; refining and naming themes, splitting and conflating if need be; the final analysis and creation of an overall narrative.

The final five identified themes and their codes are presented in table 4.1 and are:

1. 'Medicine reflects societal norms' which contains four codes;
2. 'Language is more than just words – but they help' which contains four codes;
3. 'Our education and training does not prepare us for practice' which contains four codes;
4. 'Recognition of family medicine/general practice' which contains four codes
5. 'The influence of money' which contains five codes.

In the discussion that follows, some of the illustrative quotes are taken from the focus group in which case they are identified with D and a numeral (eg D11). If the quote comes from an interview, they are labelled with Q and a numeral (eg Q3). The key for identifying the respondents was made very early on during the transcription process when the voices in the focus group were still very familiar and to ensure the second reviewer of the data, who had not been present during the recordings, could discriminate between speakers. In order to further illuminate the discussion, at times I have included my own observations and some further information from documented sources.

Table 4.1. Themes and codes

Medicine reflects societal norms (4)	Language is more than just words – but they help (4)	Our education and training does not prepare us for practice (4)	Recognition of family medicine/general practice (4)	The influence of money (5)
<ul style="list-style-type: none"> • The doctor is of high social status • The doctor is expected to 'know' • Collectivism vs individualism and autonomy • Barriers to taking a full history; sexual or psychiatric 	<ul style="list-style-type: none"> • The doctor has to 'connect' with the patient • Medicine is mostly learnt in English • Multiplicity of regional languages • We don't talk about the weather 	<ul style="list-style-type: none"> • We don't have communication skills training in UG • Indian doctors are very adaptable • There is no training programme in how to be a GP • There are few opportunities for CPD 	<ul style="list-style-type: none"> • Family medicine as a career is a default option • Lack of employment opportunities • Understanding of GP role in community is poor • Increasing recognition by government and other specialists 	<ul style="list-style-type: none"> • Not enough doctors means volumes of patients are high • Transactional vs relationship mode • Commodification of health • Compliance with medicine • Access to diagnostics

Theme one: Medicine reflects societal norms

The four codes in this theme are: the doctor is of high social status; the doctor is expected to 'know'; collectivism versus individualism and autonomy; barriers to taking a full history - sexual or psychiatric.

The doctor is of high social status

Although not developing the themes or codes by reference to volume of data or prevalence of the individual units of meaning, this theme contained the most individual units of data suggesting both the close link between how doctors see their role in society and that they and their patients are influenced by the way that society is ordered. Respondents felt that doctors occupy a place in Indian society that sets them on a pedestal, supported by both patients' and doctors' expectations:

They just see us as gods. D11.

On one occasion I witnessed something of a commotion in the waiting room where a patient was very upset that he had arrived for what he thought was an appointment for a blood test, only to discover the phlebotomist was not in that day. He was arguing with the receptionist along the lines of 'this is no way to run a business'. A doctor came out of one of the consulting rooms and his first comment was 'I am a Doctor', which had an instant quietening effect despite the Doctor, at 28, being probably 30 years the patient's junior. I discussed this with the doctor afterwards and at first struggled to reach a shared understanding of what my observation was; that if it were me, I might have started with an apology and attempted to fix it. In his view it was perfectly natural that a patient would not continue to shout in front of a doctor or it would be disrespectful.

This was echoed in the focus group where doctors expressed these views:

There is a superiority because the doctor is from middle class and the patient is coming from poor class and less privileged so the relationship is not equal and we learn the premises and practice medicine on that basis. D5

They are used to that the doctor is superior so I must not waste his time and I must get on quick. If we try to talk to them as we have been taught for MRCGP, to do the ICE¹⁷, they just want us to tell. D4

¹⁷ Elicit the patients Ideas, Concerns and Expectations

They just look up to you...you *know* you are superior to them. D7

In the first quote we see a matter-of-fact presentation of the impact of social class which, through the use of 'less privileged', suggests this doctor recognises a duty of care that arises from the difference in status. The quote from doctor D4 illustrates how this doctor thinks this differential affects the doctor-patient interaction, and the final quote simply states the difference, in this doctor's view, as incontrovertible truth. This feature of consulting in this clinic leads to a risk of reduced experience for doctors in dealing with patients as equals. Additionally, so pervasive is the hierarchy, that some might not recognise it, or realise the many ways it leaks out in language and behaviour.

The doctor is expected to 'know'.

Within this theme, the doctor was presented by some participants as the holder of what Balint called 'revealed knowledge' (Balint 1957 p216) and of being expected, and expecting of themselves, to know the 'answer' to a patient's concerns and what should be done, and with a duty or 'apostolic function' (Balint 1955 p684) to pass that on to the patient. If this is perceived as the basis of the compact between patient and doctor it might present a barrier to exploring the patient's knowledge or understanding, lest it be seen as ignorance on the part of the doctor:

I have to look confident and transfer that confidence to the patient therefore giving knowledge. D1

While the previous instances suggest doctors are responding to patient expectations, the doctors also had views about the extent to which patients could be involved in decision making. Educational opportunities vary across strata of Indian society and, particularly in rural areas, fewer than half of all patients might have gone beyond primary education. D4 who had spent two years setting up a diabetes service as a single handed medical officer in a rural hospital said:

There is a huge gap between what I know and what they know. And I only have two, three minutes with them. I can't educate them in that time. D4

Collectivism versus individualism and autonomy

The impact of social norms on the doctor-patient relationship also shows itself in discussions of collectivism versus individualism, and autonomy. Extended families are common in India and often exhibit a high degree of involvement with each other's lives. Several doctors spoke of the need to consider the patient as one element of the family unit and one suggested:

You need to involve yourself to care of patient as part of his family and not just as individual. It's like cells in the body you know, all working together, everyone has his place. D5

This kind of relationship was exemplified in a comment about the communication of bad news: the indigenous style of consulting when it is bad news is third party, with strongest family member delegated to hear any news and make any decisions. Even in educated classes it is like that. D9.

When I came back from UK I had forgotten how it is. Now if patient is educated then I might tell them first if I have bad news. But usually we tell the relative first. And then usually the family says my mum not to be known of what is happening, then we take it from them if we really need to tell or we don't need to tell. D5

The duty of confidentiality, in UK general practice, flows from the concept of autonomy; that an individual with capacity is usually the sole owner of information about himself. This approach to the delivery of a diagnosis via a third party is a feature of the general practice consultation that is very different from UK practice. Doctor D5 recognises there is more than one way to manage breaking bad news but the use of 'forgotten' shows his ability to change, take on and internalise the difference until it became second nature. This, more than acting differently, is *becoming* different. Closer examination of testimonies like this might be a source of future insights into how some migrant doctors can take on such changes to the extent they 'forget' other ways.

Some doctors in the focus group explicitly discussed the linked aspect of self-determinism in healthcare:

We are not much used to patient autonomy, we are not used to patients being the decision maker on the whole. You make the decision, the patients take the orders and then they report back following the orders, it's exactly like that. D4

I think it is right, I say that they must take a pledge to follow your orders. D1

The use of the word 'orders' here, is one we might replace with management plan, or even prescription but even then, to my ears, this is a very strongly worded description of care. D1 had spent many years as a military doctor which might have influenced his approach and D4 has spent some time as a single-handed medical officer in a rural hospital. It is not known from this whether doctors in an urban or civilian setting, would use the same language or have the same expectations. These two doctors however, working in very different settings, are

expressing agreement about the degree to which they understand their role to be the leader in the medical decision-making.

Barriers to taking a full history; sexual or psychiatric.

There is a social reticence about discussing sexual health matters and still a taboo around mental health:

‘We have a difficulty breaking the ice of inhibitions.’ Q3

This seems to have been reflected in the type of consultations patients consented to have video-recorded; in my video data there is only one reference to sexual health which was a request for contraception. In terms of mental health one consultation on fatigue does not explore depression, a condition a doctor might be expected to attempt to exclude.

These taboo areas are also impacted by challenges in terms of clinic infrastructure; many clinics are run with more than one consultation going on in the same room and with more than one doctor and patient at the same table. In such circumstances the consultation can be easily overheard. Consider this exchange between doctors D9 and D7 who are in agreement:

If you go back to what we were saying about our medical college training, we never had one on one doctor with patient. Say round this table four doctors are sitting and they will be seeing four patients. And the patients don't mind that we are speaking to them together, there's a huge crowd waiting outside, but= D9

= And a lot of time you skip sexual history you don't ask about it and you don't mention the word psychologist or psychiatrist= D7

= It becomes a no-go area... D9

In such circumstances, there seems to be a risk of a training deficit in enabling doctors to professionally and empathically deal with such sensitive topics, and learn appropriate skills to manage patients. This goes some way to explain the anecdotal difficulties UK trainers have found some Indian trainees to have, particularly with sexual health, which appears also to be supported by the work of Bow (2013) in Australia. These authors found, in a study in a simulated, training environment, that IMGs who failed an OSCE station on sexual health had failed to respond to a cue. They suggest the reasons for this are not clear but may include insufficient training in the home country so that doctors lack the terminology to discuss sensitive

issues. Additionally of note is that D9 here is furthering a claim that refers to how confidentiality – in certain areas of health - might be less privileged in this setting.

Theme two: Language is more than just words - but they help

This theme is about the various ways in which language can affect communication, and the consultation. The four codes are: the doctor has to 'connect' with the patient; medicine is mostly learnt in English; multiplicity of regional languages; we don't talk about the weather.

The doctor has to 'connect' with the patient.

The ability to 'connect' with a patient was identified by several of these doctors as being a crucial feature of the family medicine consultation. It was perceived as a pre-requisite for empathy and a function of good communication skills. Some of the ways in which the word 'connect' was used however suggest there might not be a consensus or shared understanding on what empathy means.

The most important thing about being a family physician is trying to connect, where you can interact with patient in a way the free flow of ideas can come. Getting to the patient to connect is very important, once you find that *then it's easy job to tell them what they should know.* D3

Sometimes this was about listening ('The patient should feel you have understood their complaints as they want them to be understood', 'the patient on the first hand want a good listener in their doctor', 'patience in hearing their stories') and sometimes it was about speaking as shown under the next two themes.

Medicine is mostly learnt in English; multiplicity of regional languages

The language of instruction in medical school was the one these doctors generally found it easier to connect to patients with.

All of us have several languages, I mean, about four each right? And not the same four. And whichever one we are more practiced in medicine in we will be better. For me in Tamil I can connect better even than my mother tongue because of the practice. I can get the medical empathy words because we learnt [medicine] in Tamil but not in my mother tongue. D8

We mostly learn medicine in English right? And all the theory about how to consult has

happened in English. It hasn't happened in Bengali. How do we know it works with our patients' language? For me to connect with patients in English is very easy but even Bengali, which is my mother tongue, I find it very tough. The right words I might not be able to bring out. D7

D7 here is making two points, the first of which reinforces the view underpinning my project, that the research on medical consulting has largely been carried out in the West, and it is probably not a safe assumption that it applies, wholesale, in all contexts. Both doctors here are illustrating the challenge they face switching register. On the face of it, it would seem strange that a doctor would feel she cannot connect to a patient so easily using her own mother tongue, when that is shared with the patient. It seems 'connectedness' here might be being viewed within the register of 'appropriate ways to talk to patients' however, which arises out of the language of medical instruction.

We don't talk about the weather

Doctors also discussed *small talk* as a way of building empathy or 'connectedness'. This was precipitated by one doctor's statement, related to the volume of work:

We do not [have time to] talk about the weather. D9

with which not everyone agreed:

In high-volume clinic, sometimes, 'Saapteengla?' [Have you had lunch?] is a very powerful shortcut to empathy, not just about the illness. Probably, as I can imagine, Saapteengla is not something that makes any sense to a British person, as an opening line in a consultation. D3

But I should say we do the small talk, like about their grandson's wedding which has caused sugars to rise. It's not all about extracting medical details from their life, because without knowing a patient as a person, a general practitioner's job is only half done. D4

Note that this quote is from D4, the same doctor who said there was no time in a 2-3 minute consultation to teach the patient. It is possible that these two quotes reflect on his two different types of practice to date – rural (less educated patients and faster pace of work) and in Nationwide, (better educated, less pressured clinics). It illustrates a recognition that a different skill set might be needed to manage the consultation in different settings.

This contribution provoked a similar observation on openers in different settings:

Yeah, its like, in Delhi, where they say Kaise yaad kiya? [What made you think of me?], who even says that? (Laughs) In Madhya Pradesh, where I grew up, my family doctor always would say Aapki dua hai [Your prayers keep me going] when dad would start off.
D7

It is likely that doctors using direct translations of these particular phrases as openers in the UK would indeed generate some initial confusion. But the transferability of the principle of non-medical topics as ice-breakers and openers is well illustrated here. These phrases can be seen to carry the same pro-social role as the UK equivalent 'how are you' which no more usually expects a factual account of a person's state, than the inquiry as to meals usually expects the reassurance that the patient is not hungry. This doctor, D12, seems to agree although D5 is less sure:

I'm not sure if I'm making things murkier or clearer, but what I wanted to say was that the CSA structure might not reflect the kind of bond-building that a typical Indian doctor is used to, not because we don't do small talk, but because we do small talk differently. D12

But in our small talk, the doctor is still in charge, and there's an unsaid, but very real power dynamic which fits in with the paternalistic role medicine has in the society D5

This illustrative quote from D5 is included here because the content is about small talk. However it also lends further support to 'the doctor is of high social status' and was coded under both codes.

An emphasis on language has arisen here because of the challenges these doctors were facing in their clinics and its crucial relevance for the achievement of 'connectedness.' Given the adaptability shown by these doctors and their mastery of different languages however, their flexibility might also be an asset when changing settings. Language, communication and adaptability are also topics that occur in the next theme on education and preparedness for practice.

Theme three: Education and training does not prepare us to do the job

Under this theme the codes are: we don't have communication skills training in undergraduate; Indian doctors are very adaptable; there is no training programme in how to be a GP; there are few opportunities for CPD.

We don't have communication skills training in undergraduate

Several of the doctors commented that they had had no training, or even discussion, in how to talk to patients, as undergraduates ¹⁸.

Even I went to CMC Vellore which is considered epitome of medicine where you learn the medical aspect of medicine very well, even there we have not been told how to speak in a soft way to patients. When I was in the UK I was technically superior analysing blood gases or something like that; straight away I can diagnose much better than them but after that its dealing with people that is different. D5

I remember when I went for PLAB [the UK entry level licensing exam for overseas doctors] it was like we had to look at everything for the first time. Even so small, small things like to rub your hands before you touch a patient not to touch them with cold fingers, offering tissues with bad news, these things were like new to us. D8

UK undergraduates have in-depth and recurring practice in communication skills, not least in general practice placements, and guided by the GMC outcome requirements for undergraduate curricula (GMC 2015, para 15) and Good Medical Practice (GMC 2013). These Indian doctors are saying they have identified a gap between the teaching of the technical discipline of medicine as science, and medicine as it is practiced. ('There is a point you get to with time when you transition to the colloquial language of real life' Q3). Without explicit reference during training and education to communication skills as a technical skill set, it is likely to be harder to study and perfect the consultation, or to have either the vocabulary or set of constructs to note, respond to or modify interactional difficulties.

Indian doctors are very adaptable; there is no training programme in how to be a GP; there are few opportunities for CPD.

The adaptability of the Indian 'globizen', the global citizen ¹⁹, was given as evidence that with the correct support and training, these doctors felt Indian doctors could flourish:

¹⁸ The results of a questionnaire I distributed in July 2012 to 38 new graduates at a seminar in Bangalore, who had graduated between 2002 and 2012, showed only one had ever had any training in communication or consulting skills, and that one was a postgraduate two day MRCGP (International) preparation course.

¹⁹ <http://www.thehindu.com/todays-paper/tp-opinion/are-you-among-the-globizens/article3177948.ece>

Indians are very adaptable, that is why they are becoming globizens. If you look round the world they adapt to so many cultures. But if you take someone from the Western world and try to settle here it is very difficult. Q3

All we need is the guidance, the channel to put our energy in. Like my knowledge base, I knew so many things but I never knew how to focus. Indian doctors are very adjustable...they adjust a lot faster, so just need training for the job. D7

The absence of a compulsory postgraduate training scheme or residency for family medicine was identified as a key barrier to raising both the standards in the practice of family medicine and the status of those taking it up, and also the knowledge and expertise of family physicians to do the job well. Respondents also raised the issue of the lack of continuing professional development after graduation.

If you take a medical officer post in a hospital you have to do the scut work because they know you can't be a specialist if you didn't make the cut. But even there, at least there are seminars and grand rounds you can go on and stay up to date. It is something we don't have. D3

Respondents noted that at Nationwide they were in a privileged position with in-post training offered by the employer, but this is highly unusual.

And it's not just about preparing for the exam. We do need that I am not saying no. But we need to be having preparation for practice that is the thing. D3

Continuing professional development is frequently sponsored by pharmaceutical or medical device companies which does not necessarily mean, but has the risk of being, biased towards or influencing prescribing decisions. Provision of courses is regulated by state government regulations which for example limit educational provision from international providers but also creates a bureaucracy around local course provision which puts up the costs and makes it inaccessible to some low earners. Whereas secondary care doctors have ongoing and regular clinical updates, this is less common for family doctors. This then in turn leads to a risk of de-skilling, which feeds into the lack of respect for the discipline.

Theme four: Recognition of family medicine and general practice

Under this theme are organised these codes: family medicine as a career is a default option ; lack of employment opportunities; understanding of GP role in community is poor ; increasing recognition by government and other specialists.

Family medicine as a career is a default option

In the past in the UK, many doctors recall having met with a mixture of pity and surprise when they said they were training to be a GP and the profession has fought hard to raise the status through measures that include robust selection and assessment procedures. The importance and scope of the role of GPs is however, even in the UK, not always recognised. In India, with the lack of training and formal certification, I heard in many conversations as well as in the focus group that it is very much more common for family medicine to be a second choice for most of those opting for it. Although doctors in general hold a high social position, the CEO of Nationwide stated that the medical fraternity tends to look down on family physicians. A doctor in India can set up as a GP straight after medical school if he has sufficient funds to set up a clinic and in the past it certainly was, and was seen as, the career option for those who had failed to enter other specialties. The term 'MBBS doctor' is still used disparagingly by some older doctors, using the undergraduate degree (MBBS) to reflect the fact that whereas fields such as surgery, obstetrics and gynaecology and paediatrics are protected fields, guarded by examination and licencing, family medicine practitioners have no higher qualification. This contrasts sharply with the position in Europe, where General Practitioner is a protected title with a licencing qualification such as MRCGP.

One quote that sums up the issue of professional respect comes from D1:

These days it is different thing in UK, with Royal College and whatnot, but here it is not that proper, not that much of esteem. D1

Lack of employment opportunities

Thus there are minimal incentives to enter the field for ambitious doctors keen to do well professionally, but also financially, due to the lack of career opportunities. Setting up a private clinic takes funding and in isolation could be years until such an enterprise starts to bring in a reasonable income. Some new graduates can afford this, if they happen to be drawn from that sector of society that can rely on family wealth. But this does not apply to all:

Even if they do pass, where can they work? There are no clinics and no one can afford these days to build their own unless they can join a government scheme. And those are all in the rural areas. If they are prepared to take their family out of the city where there are all amenities and schools etc, then they can go maybe for few years then come back when wife gets fed up. D4

Understanding of GP role in community is poor

The role of the GP is also not well understood by patients as well as medical colleagues. Respondents claimed that patients will save up to see a specialist even if it means long waits:

Part of the measure of how good a doctor is in patients' eyes is how many patients he sees, so if his OPD is full and you have to wait all night its good. I know one chap who consults at 2 am to give good impression. And his appointments are booked for six months, for the privilege of seeing him. Q3

If people could get the idea of family medicine they could be seen same day and it won't cost them 1000 rupees and that doctor would come to know them. Patients pay for every consultation, and if they could identify a good GP he will help in their long term health management. D12

Some respondents voiced their observation that patients were starting to use them to triage their complaint and avoid paying duplicate high fees to specialists by first making a short list of which specialist might be best placed to help them. Since patients frequently spend time and money in a circus of one specialist after another with little guidance or advocacy these respondents noted that patients would take their advice on likely diagnoses, before then consulting a specialist for confirmation and treatment. In India, as yet, there is no system of registered GP lists or concept of all citizens having access to 'their doctor', who guides them across the life course, in all aspects of health promotion. This is leading to increased frustration:

they need to know we are more than just see-and-refer doctors. D12

Increasing recognition by government and other specialists.

Some respondents however could see a more positive picture for the future of family physicians:

I am sensing some increasing recognition by government and even other specialties. Even if this is by in my clinic I can reduce their workload or manage the costs, it is still good for patients. I can see him and advise him what to do, what not to do and that saves him money and it saves government money. Q1

The training programme director at Nationwide has also seen a difference in the applicants to the clinic and their performance in training:

Its now the brightest entering [General practice] as well, there is a big difference. People travel, they see what happens in GP in the West and when they come back they want to bring that here. Q2

Theme five: The influence of money

This theme contains five codes: not enough doctors means volumes of patients are high; transactional vs relationship mode; comodification of health; compliance with medicine; access to diagnostics.

Not enough doctors means volumes of patients are high

Whilst comparisons of world-wide figures should be treated with caution due to different elements being included in the calculations, and in some cases difficulty of data collection, the latest figures available for each country show the average public spend on health and welfare (including pensions) in OECD countries is 22% of GDP, with the UK provision hitting that average, whereas in India the spend is 2.5%. This is lower even than other BRIC countries - Brazil spends 15% and China 7% ²⁰.

The low investment in healthcare by federal and state governments translates into numbers of doctors. There is one government doctor per 11,528 of the population in India. Even taking all registered doctors, which includes those abroad, those in private practice and those not working at all there are only 0.7% per 1000 head of population in India compared to 2.8 in the UK ²¹. This inevitably affects the workload of GPs:

Always on your head you have the pressure of the volumes [of patients] that we have.
D9

There is too much of everything here, too much of illness, too much of people, too much of stress. D2

Transactional vs relationship mode and comodification of health

One further outcome that also arose from this sheer volume of works was summed up by these comments:

²⁰ <http://www.oecd.org/els/soc/OECD2014-Social-Expenditure-Update-Nov2014-8pages.pdf>

²¹ <http://data.worldbank.org/indicator/SH.MED.PHYS.ZS>

There is something called transactional way of practice here, and there there is your [RCGP] relational model. Here the doctors do see it as they pay and you fix. And why don't doctors try to change the patient's health belief? There is no need because of the volumes sitting there. Just clear it up and go. D7

In the UK, the idea of a strong doctor-patient relationship that underpins current and future care, underpins the training in consulting that UK trainees are very familiar with. In the case of these Indian doctors however, it is possible that neither their training nor their experience brings them to the same understanding.

That is coming from the patient side too. Here in Nationwide we are really so wanting to make relations with patients but the patients look for quick transactional kinds of solutions: I am here to buy salt, I give you five rupees and that's it. Same here. They say I have come with a problem and that's it. D4

One doctor characterised the patient in the Indian family medicine consultation as:

A bargain hunter, looking for a quick fix for the here and now... Don't forget for the patient to be seen it means one day off his work, which means off his pay. The first agenda of the patient is can the doctor make me better quicker, he has thought nothing about what he is feeling and nothing about why he got the problem. The question about having a discussion there is gone. He just says 'I have to get back to work, doctor make me better'. D11

Compliance with medicine

Over 70% of all healthcare costs are borne out of pocket in India, paid at the time of access. This can bring about catastrophic, impoverishing outlay. There is limited state provision and limited social welfare although some private providers have set up in-house insurance schemes, or pre-payment plans. The respondents in this study felt that in India this impacted on-going care. Some of these doctors claimed that compliance with prescribed medication was poor, since even if patients could afford the consultation fee, they might not afford to continue with long term medication, such as anti-hypertensives or diabetic treatments. The harm from such asymptomatic conditions might be much less visible and the driver to continue medication, which might also bring side effects, is thus reduced.

Access to diagnostics.

The Head of Operations raised a broader issue of healthcare costs:

It is very common here that a single-handed doctor's income depends on kick-backs from where he refers his patient, so they get unnecessary tests, unnecessary scans and pay their heart's blood to a specialist for a total body scan or something like that. Q3

The doctors in this clinic recognised this picture of collusion between first contact care and referral services, but patients can also access diagnostic investigations directly. It is not unusual for them to come to see a GP to have the results of some high street tests interpreted.

They read on internet or TV that they need this or that test and they don't have an advocate to tell them, no, you don't need that. One simple symptom can open up a whole diagnostic paraphernalia all which is available direct to the patient and really adds to their costs. D3.

In my video data, several patients had brought the results of investigations for discussion. This might be a straightforward consultation, maybe an underactive thyroid for example which, if present, is likely to be clearly indicated in the results. But the issues of false positives or false negatives can be problematic. The diagnostic process requires a history to be taken and a differential diagnosis to be formulated with weighting or probabilities assigned to each. Any special tests are then used to help differentiate between those alternate possibilities. Some tests are open to quite different interpretations depending on the history or examination of the patient and some need to be measured with caution and with counselling beforehand. An example of this sort of low sensitivity, low specificity test would be screening for prostate cancer or deep vein thrombosis and the presentation of results without such a history can present a challenge for the doctor if he or she is not involved in selecting the tests in the first place. Its likely that this direct access to diagnostics affects the doctor-patient compact and risks turning the doctor into a technician trying to make sense of results. This in turn will influence the type of relationship between doctor and patient and the way they talk to each other.

4.4 Conclusion

Taken together, these five themes are telling a multi-faceted narrative that describes the expressed views of a group of doctors on their current context working in family medicine in India. Methodologically this process of thematic analysis, combined with insights derived from at least a degree of emersion to develop 'knowledge of the culture' (Moerman 1986, in ten Have 1990, p 30), aims to lend a cultural-context to the conversation analysis in chapter five.

The conclusion to this chapter is in two parts: it offers some anticipatory pointers towards features inside the consultation itself, and to the broader, contextual issues that impact on what happens in the clinic.

The experience of doctors: features of the consultation

This thematic analysis has raised the issue of language which has direct relevance for the next chapter on talk in interaction. A claim was made in the focus group that most doctors can speak maybe three or four languages, but there are 22 official languages alone and hundreds more in regular and widespread use across India. If the doctor and the patient do not have a first language in common, communication will be challenging. To an outsider it is hard to imagine the implications of struggling to communicate every day in your own clinic, but the reality for these doctors is that with increased mobility of people away from their home towns or communities, this sort of challenge impacts on every aspect of their daily life such as shopping, instructing taxi drivers and other transactions. Offered a cup of tea by clinic staff on one occasion, I asked the doctor I was sitting with how to request no milk in the local language, only to find the doctor did not know and we all resorted to English. It was also of interest to me that the doctor did not consider this an issue worthy of note and we rapidly turned back to the topic at hand. Some of the doctors called attention to the implication of another distinction in language, between the register of medical or scientific language and 'everyday language'. It would seem to me that the connectedness some of these doctors aspired to might be facilitated by the use of more every-day, less formal or technical language. But the, to me, surprising comment of one doctor who felt she could not 'connect' to a patient so easily using her own mother tongue, even when that is shared with the patient, suggests two things. The first of these is that the vocabulary of how to talk about medical matters is sometimes missing in one's mother-tongue if one has learnt medicine in English and secondly that 'connectedness' here might be being viewed within the register of 'appropriate ways to talk to patients', which will be learnt alongside instruction in the scientific basis of medicine. This might shed some light on my perception of the minimal use of informal talk in the videos.

Small talk was introduced as a topic by one respondent in the focus group who was discussing the way he felt consultations were time-pressured and offered the remark that 'we don't talk about the weather.' This initiated a discussion on non-medical talk and the Indian equivalent of the English language '*how are you*' opener, such as 'have you eaten', 'what made you think of me', 'your prayers keep me going', were discussed as a way of building rapport with patients. But some of the reactions from the doctors, for example 'who even says that (laughs)?' suggest it will seem just as clumsy to some doctors trying on these unfamiliar phrases as it is to use formal medical terms with patients. Perhaps what these doctors illustrate is that sometimes, just as in their regular daily social interactions, there is an acceptance at times within the

general practice consultation in this clinic that the goal of 'interactional fluidity' of a consultation is unattainable or only partially achievable and its absence is tolerated.

The data do however also show that some of these doctors recognise the need to develop a connection with a patient to face the challenge in taking a sexual or psychiatric history for example. These topics did not come up in the video-recorded consultations, perhaps because of their taboo status, so this research can offer no insights into that. This is an area worthy of further exploration since there will be insights to be gained from observation of the features of successful consulters in these areas that might extend into other areas of medical communication.

The experience of doctors: contextual issues

Insights are also provided by the thematic analysis into contextual issues that structure practice in the clinic. Doctors stated that their consultations are very time-pressured: 'there is too much of everything here, too much of illness, too much of people, too much of stress'. Despite the assertion of some doctors in this study that small talk is rare, some of the doctors did recognise a role for small talk in helping to connect early on with a patient to enable the patient to quickly explain their symptoms and concerns. Others felt it might slow them down since they were unaccustomed to it, or that it might actually 'waste time in chit chat' and lengthen the time a doctor spends with a patient, with the knowledge that dozens more are waiting outside the clinic door to be seen; 'Always on your head you have the pressure of the volumes of patients that we have.'

Some of the things that happen in the clinic are said by some doctors to be a reflection of the broader context in society at large. Doctors are of high social status and generally held in high esteem by patients, and some of these doctors expressed the view that patients felt that by virtue of their training and status 'doctor knows best' which seems to have led to the use of language such as an expectation that patients will 'follow orders'. One respondent described how a societal sense of collectivism rather than individual autonomy could lead to a low expectation of medical confidentiality which could lead some doctors, for example, to see no conflict in breaking bad news to family members before the patient.

Some doctors expressed the view that there was a societal move to commodification of health and that healthcare was increasingly becoming a transactional process with an impact on what happened in the consulting room. 'I am here to buy salt, I give you five rupees and that's it. Same here.' Patients have access to internet and television sources of information and advertisements which is altering the doctor-patient relationship from one of advocacy to a technical service-delivery model. There were some tensions and contradictions within the

findings and the doctors differed in the extent to which they feel the change in the democratisation of knowledge was detrimental to or an enhancement of service provision. Whether, for example, greater patient knowledge about medical matters helped healthcare by improving patient involvement in decision-making and concordance, or hindered by making patients more questioning and needing more guidance through the available information, which increased workload. The doctors also varied in the way to which they thought appeal to a traditional societal hierarchy is a help or a hindrance in this process and interestingly one doctor felt that the educational hierarchy minimised the numbers of questions patients asked doctors at both ends of the spectrum – in the more educated because they could research the issues themselves and understood better and the less educated because they had an expectation that the doctor should just tell them what to do.

This chapter offers a partial insight into the features of the consultation in this setting for these doctors. It is a representation co-created between the researcher and the respondents although I have been careful to pay attention to and put in place processes that might enhance the credibility and trustworthiness of the conclusions. Such conclusions offer a different type of insight than that developed through the conversation analysis and these two types of findings will augment the utility of each other by bringing different lenses to consider the features of general practice consulting in this setting. However, the key strength of the thematic analysis is the way in which it can provide contextual data to bring a greater understanding for an observer. My own subjectivity and experience of general practice needs to be tempered with these insights if I am to avoid the trap of comparing one setting with another, using one setting as a yard-stick to consider the other.

Chapter 5: Results - A focus on talk in interaction

5.1 Introduction

This chapter reports a conversation analysis of my video data that looks closely at the particular ways that talk seems to occur in the doctor-patient interaction in this clinic.

In this first introductory section I present some examples that speak to the themes developed from the literature review in chapter two, including examples on the combination of talk, eye contact and gesture. For example, consider clip 5.1 which reflects the importance of body movement and gaze as discussed in section 2.4.1. Heath had set out to explore the connection between body movement and speech and drew attention to the fact that:

'human movement performs social action and activity...a gesture, whether a postural shift, a nod or a look, may be used to accomplish particular tasks...movement performs "locally" and gains its significance through its co-ordination within the moment-by-moment progression of action' (Heath, 1990, p86).

Here the body orientation, including eye contact, of both patient and doctor are considered.

Clip 5.1

```

8   *DOC:
9   %gaz:  to notes, writing
10  *PAT:
11  %gaz[:  Body in torque orientated away from desk, head craned to read notes
12         (4.4)
13  *DOC:  Any other questions that you havet *
14  %gaz:  to notes continues
15  *PAT:  -□°i guess that's all° *
16  %gaz:  smiles and tosses head. Gaze shifts into distance
17  *DOC:  that's all right! *
18  %gaz:  to notes
19  *PAT:  yeah *
20         (2.0)
21  *DOC:  °ok° *
22         (7.4)

```

At line 13 the female doctor invites questions perhaps in recognition of the patient's body position as he seems to be trying to read the notes, but she does not look up and thus is seen as interactionally unavailable. She has offered a token verbal display of reciprocity without any supportive display of availability (Heath 1986, p33). The patient's quiet, negative reply at line 15 is accompanied by his change of gaze and head gesture and again is responded to by the doctor as though the patient does in fact have more questions – because the doctor then repeats, 'that's all, right?'. This seems to align with the observation by Heath that patients

attempting to engage a doctor in conversation (who is otherwise focussing, for example, on the computer screen, or notes-writing) will use gestures and body movement rather than words (ibid p75). Additionally Heath states that the use of gesture in this way achieves its success by its 'invisibility'; it does not draw explicit attention to (or confer blame on) the non-attention. However, even though here such overtures from the patient seem to be noted and responded to, the doctor's comments do not lead to further contributions from the patients perhaps due to her lack of eye contact.

Clip 5.2 contains an example of repair of interactional trouble, also discussed in thesis section 2.3, that Mehan suggests tends to happen in standard ways (Mehan, in Atkinson and Heath, 1981, p107-127).

Clip 5.2

```

23 *PAT: hh you've been here for a long time isn't it or its er≈ •
24 *DOC:
25 %gaz: looks up and makes eye contact with patient
26 *DOC: ≈ah I was previously in the Indrinigar clinics≈ •
27 *PAT: ok
28 *DOC: ≈of Nationwide itself near to Whitefield •
29 *PAT: cos i just checked this today eye↑:e •
30 *DOC: |you've been here before to ust •
31 *PAT: no I've not come (.) no I •
32 *DOC: You'↑ve not noticed er uh oh↓ •
33 *PAT: |no I got no↓
34 *DOC: this has been here Δfor the past two yearsΔ in fact •
35 *PAT: um I: travel often this w↑hay its been ↑two three months ↓ •
36 *DOC: |not noticed erhehe↓
37 *PAT: just today I noticed •
38 *DOC: ri::ght ri::ght •

```

The patient hesitates at line 23 as he starts to correct his assumption ('...isn't it, or its er...?') and the doctor interrupts, showing that she has interpreted the patient's inquiry 'you've been here for a long time isn't it?' as referring to herself not the clinic building. The patient appears to accept this misunderstanding (the 'ok' at line 27) and when the doctor finishes speaking he merely states that he noticed the clinic for the first time today. This mitigates the risk of a Goffmanian 'spoiled identity' for the doctor (Goffman, 1955, cited in Sidnell, 2010, p14-15). The literature suggests that repairs, actions to resolve interactional troubles, are often withheld; particularly other-repair carried out by the recipient not the source of the trouble, to avoid the risk of argument (Schegloff, Jefferson and Sacks, 1977, cited in Sidnell, 2010, p113). Markers of interactional difficulty such as troubles repair can have the effect of magnifying or emphasising those very interactional difficulties and faced with this a speaker has three options: to ignore it to save the face of person who has misunderstood; to make an interjection of self-repair that repeats or clarifies their comment which risks drawing attention to the mistake and embarrassing or confusing the hearer; or they can re-address the misunderstood comment in a direction that might even obscure the fact that the hearer has misunderstood, such as

simply re-phrasing under the guise of a change of emphasis and thus taking responsibility for a lack of clarity. Mehan suggests there is a general preference for allowing self-repair which, like withholding repair all together, can act to maintain face for the recipient. In the medical context, either party ignoring interactional troubles might not be safe but such information we do have about CSA performance seems to suggest that troubles repair is an area of difficulty for some weaker candidates who lack the interactional competence to manage it smoothly (Atkins et al, 2014, p128) Both passing and failing candidates have been shown to have moments of misalignment but failing candidates are said to be less fluent in the way they repair them and IMGs have slightly more such instances.

Forms of talk can be considered along a spectrum proposed by Holmes that extends from 'core business work' through 'work-related' to 'social talk' and 'phatic communion', which last two she groups together as 'small talk'. (Holmes, in Coupland 2000, p38). Small talk has been referred to as 'time-out' (Maynard and Hudak 2008, p 661), and is sometimes considered 'minor, informal, unimportant and non-serious' (Coupland 2000, p1) or 'conversation for its own sake'. Holmes makes a distinction between social talk, likely to be topicalised and relational, and phatic talk which although also pro-social contains no content.

The reason for focussing on this spectrum derived from my own observation that there seemed to be very little informal talk in the videotaped consultations, and also that some of both my IFS participants and the respondents in this study declared small talk *not* to be a feature of their consultations. Small talk is one of the ways in which doctors and patients can co-create interactional fluidity, the term I propose to describe the expectation of RCGP examiners (see reference to 'fluent' in the CSA Grade descriptors, in Appendix 4) and the form of interaction found in the linguistic analysis of actual CSA consultations which was associated with success in the CSA (Roberts 2014, p 42). In addition, 'conversationalising' is said to be the way successful candidates demonstrate in the CSA that they understand the patient perspective, conforming to the patient-centred conventions of the exam by using shared words and metaphors and 'vague language' to create a casual, conversational style' (ibid pp.32 and 104-114). The use of small talk might help develop a mutual understanding, or 'connectedness' that some doctors in the thematic analysis held to be important. A recent paper found that higher scores for 'partnership' were achieved on a validated measure (the Medical Interview Satisfaction Scale, MISS) by consultations that included 'social talk' (Little, 2015, p91). I was interested to see what kinds of talk were present in the setting, and to what extent different kinds of talk might affect the fluidity of the interaction.

First introduced into the literature in 1923, the term *phatic communion*, coined by Malinowski, was used to identify talk he described as aimless, 'a mere exchange of words', the literal meaning or information conveyed by which were unimportant but which nonetheless carried out a prosocial or relational function. (Malinowski in Ogden and Richards 1923, p315). There is

limited discussion of the work done by small talk in medical consultations; a literature review revealed only nine health-related papers that draw on recordings of actual talk. Coupland, Coupland and Robinson (1992) looked at the phatic role of 'How are you?' openings by researchers in health related enquiries with people over the age of 64. They then built on that work to look at the role small talk plays in shifting from the social to the medical frame in geriatric outpatients. They state that such talk facilitates the clinician's understanding of the socio-relational aspects of the patient's life enabling 'whole-person care' (Coupland, Robinson and Coupland 1994). Ragan (1990) had incidentally noted its use by nurses in attenuating embarrassment in gynaecological exams in women's health settings and later showed how small talk can facilitate work-talk through the use of humour and reciprocal self-disclosure (Ragan 2000). Maynard and Hudak (2008) describe its role in enabling 'disattending', as a detractor from the course of the conversation, or content of the activity; and later applied a definition of 'topicalised small talk' to their work with patients and orthopaedic surgeons which enabled them to note the distribution and possible asymmetry of such talk between protagonists of different ethnicities (Hudak and Maynard 2011). In the only instances of small talk being examined in the medical training sphere Posner and Hamstra suggested that for medical students small talk might get in the way of technical competence in vaginal examination, perhaps related to the degree of 'fit' with expected or allowable medical talk that it appears to represent (Posner and Hamstra 2013). In 2015 Little claimed, in the only GP based study, that using a validated measure of patient satisfaction, higher scores for 'partnership' were achieved by GP consultations that included social conversation (Little 2015 p91). This study however was not specifically set up to look at small talk and does not state how they defined social talk, or identified instances so defined, in videotaped consultations.

In the only work of its type, Bagheri et al (2012) looked specifically at small talk in audio-recorded clinical consultations in Malaysia where both doctor and patient were non-native English speakers but using English as their language in common. They found that in the openings of 13 out of 15 consultations there was no small talk at all and concluded, among other reasons, that small talk is felt in such multi-lingual settings to be too culture-sensitive and prone to 'miscommunication'. Whilst medical talk might be misunderstood, these authors felt that that was amenable to correction, whilst 'trying on' unfamiliar small talk might lead to offence, or even claims of discrimination, and hence was avoided altogether.

Thus the medical literature, though not extensive, suggests several roles for small talk in medical consultations: enabling transitions (between stages of the consultation or types of activity); enabling knowledge of the whole-patient; facilitating the work-talk of the consultation; enabling disattending and creating partnership between doctor and patient. There is also a suggestion however that small talk is rare in multi-lingual settings, might lead to misunderstandings between doctors and patients or 'de-doctor' the professional in some

situations. However the literature does not report any work on video-recorded general practice consultations looking specifically for examples of the use of small talk.

5.2. Identifying the form and functions of talk

It is not possible to say, based on some intrinsic quality, whether an episode of talk is carrying out a phatic role. It is not necessarily a function that arises from the intention of the speaker, from the words used or topics discussed, nor is it necessarily – despite how it is sometimes discussed in the literature – distinct or easily distinguished from work-related talk. Speech act theory predicts that a perlocutionary act can bring about predictable or unpredictable effects in terms of the feelings, thoughts, or actions of the hearer and it may be done intentionally or unintentionally (Austin 1962). In a conversation analytic approach it is thus to a combined analysis of *'what happens next'* plus *'why this now'* incorporating those projected actions and meanings that might be hearable in the utterance, that we must look for meaning (Schegloff and Sacks, 1973, p76)²². This was described in Sacks' original lectures, as 'feeding back and feeding forward'. Crucially, for example, talk that at first appears irrelevant to the 'business at hand' might preface or introduce the 'business at hand' and thus, judged by what happened next, be seen to be work-related.

Initial analysis confirmed that there were indeed very few instances of talk that might at first sight be small talk in my corpus, identified using the methodology of 'common-sense judgment' to select instances 'concerning non-task orientated, pro-social topics' (Hudak and Maynard 2011, p5). The episodes of talk that follow show the productivity of different types of talk when analysed interactionally and provide further insights into some of the themes in the thematic analysis. I have organised the clips according to the categorisation of Homes: 'core business work', 'work-related', 'social talk' and then 'phatic communion'.

5.2.1 Core business work talk.

One theme in the thematic analysis was the view that patients expect doctors to 'know the answers' which is understood as a necessary pre-requisite for the doctor to do his work effectively. Talk that is considered by both doctors and patients to be appropriate in conversation with a doctor might be a part of what perpetuates this epistemic position so that its absence, using a less obviously work-related form of language, might be seen to diminish the doctor in the role of 'knower'. In clip 5.3 we see a display of medical knowledge using work talk.

²² This page number comes from the version of 'Opening up Closings' reproduced in *Language in Social Interaction*, available at <http://web.stanford.edu/~eckert/PDF/schegloffOpeningUpClosings.pdf> 'Why that now' is discussed in section III.

Clip 5.3 Hypothyroidism

8 *DOC: awrright (.2) fine with you⁷
 9 *PAT: yeah::ah sure (.2) one more question⁷
 10 *DOC: yes tell me (.3) Δplease pleaseΔ
 11 *PAT: uh I would like to have (.2) yeah I was jus seeing (.1) like this so like
 12 ∇tee-three and tee-four are nor⁷mal stage⁷ but still tee-ess-aitch is high⁷
 13 *DOC: Yes
 14 *PAT: (.6)so its a kind of hyperthyroidism^s
 15 *DOC: its hyp^{oo}thyroidism
 16 *PAT: hyp^{oo}thyroidism⁷
 17 *DOC: like when your thyroid malfunctions it is inversely proportional if I may say^x
 18 that is the tee-three tee-four goes up⁷ the tee-ess-aitch goes down
 19 if the tee-ess-aitch goes up tee-three tee-four goes down we say its hypo that is
 20 through the less range (.2)underactive metabolism (.2) so yours is elevated your
 21 tee-ess-aitch which means these things are happening we'll work on that
 22 (.3) nothing to worry much about it
 23 *PAT: yeah
 24 *DOC: awright[↓]
 25 @End
 26

After a hesitant start in the pre-sequence at line nine, perhaps in recognition that he is about to encroach into the specialist knowledge realm of the doctor, the patient signals he has one more question about the blood tests he has brought with him. The doctor agrees to take the question and, after the patient still pauses, encourages the patient with a rapid 'please, please'. On lines 11 and 12 the patient states his query with hesitancies ('uh') and hedges ('I was just seeing') and in time (line 17-21) receives a jargon-laden response of 'inversely-proportional' 'underactive metabolism'. By using the technical terms 'T3 and T4 are normal but TSH is high... so it's a kind of hyperthyroidism?' the way the question is phrased seems to have occasioned this answer in the same terms – much as Sacks highlighted that in paired utterances the second part pair re-produces the categories of the first. It is possible that the doctor orientates to the use by the patient of medical jargon and replies using similar language as a rapport-building strategy.

The doctor's comment on line 22 seems to be responded to by the patient as indicating that the topic is now closed. Although the doctor closes the discussion with 'we'll work on that' which projects a future set of actions, the 'nothing to worry about' turns the query into something that does not require any further discussion or concern on the part of the patient; the doctor is in charge.

We can see that, having first encouraged the patient's contribution, the doctor uses first technical language between lines 17 to 21 and then a comment on line 22, which has the effect

of closing down the conversation. In contrast with the alright on line 8 which has a rising inflection which acts as a question, the final alright on line 24 has a downward inflection which acts to sound like a closing. This does not leave room for further question or comment from the patient. The doctor appears to have (re)asserted a hierarchical relationship by the use of jargon and (re-)established himself in the role of knower that some of the doctors in the thematic analysis suggested was expected by patients.

5.2.2 Work-related talk

Despite the declaration that ‘we don’t talk about the weather’, there is an instance of just that in clip 5.4. However the analysis of what happens next shows that this is not small talk. A pro-social role is said to be more likely to be developed by certain topics but even so the work done by such topics cannot be assumed from the content. Hudak and Maynard applied a definition of ‘topicalised small talk’ to their work with patients and orthopaedic surgeons which they define thus:

...a line of talk that is referentially independent from their institutional identities as patients or surgeons, oriented instead to an aspect of the personal biography of one (or both), or to some neutral topic available to interactants in any setting (e.g. weather)...an achievement of both patient and surgeon in that generation and pursuit of topic is mutually accomplished

(Hudak and Maynard, 2011, p634).

This is a helpful definition because it provides a way of starting to specify the availability of certain topics as potentially small and enables us to locate them in the data for further analysis of function.

In clip 5.4 the consultation has been about fatigue. At line nine, perhaps to fend off further silence (see below in section 5.2.3) the doctor asks whether the patient is new to the area. There is an initial hesitation from the patient at line 10 perhaps signalling some unexpectedness of the inquiry. The doctor, with a smile, makes an inquiry in line 11 that the patient orientates to as social, because she replies ‘its good’ and further expands on this to make clear she means the weather is good. The weather is extreme at ‘47 or 48 degrees’ in Delhi which lends context to the patient’s observation on the ‘pleasant’ weather in Bangalore.

Clip 5.4

9 %ges: writing(20.0) So you're new to the area
 10 *PAT: ·uh : yeah·
 11 *DOC: um fhow are you finding Bangalore
 12 *PAT: >Yeahts good the weather is good<
 13 *DOC: ffthe weather is good yeah it's quite pleasant right
 14 *PAT: Compared to Delhi
 15 *DOC: Compared to Delhi
 16 *PAT: Yeah it's very ot
 17 *DOC: Yes yes hh h (2.0)Delhi uh it must be very hot now nor is it raining
 18 *PAT: No:o it's very hot now right[now
 19 *DOC: [awe
 20 (.8) so it's a relief for you [≅
 21 *PAT: [Yeah It's forty seven or [forty eight degrees there
 22 *DOC: ≅come up to Luh awright
 23 (7.0)
 24 *DOC: And work has been fi:ne [treating you w:ell [no≅
 25 *PAT: [°yeah° [yeah hhh
 26 *DOC: ≅((makes eye contact)) stresses and hhhh [tensions
 27 *PAT: [Hhhhh no hu hu
 28 (2.5)
 29 *DOC: started fresh so you kno:w now you need lot of enthusiasm and things
 30 *PAT: <you know BUT I WORKED three years in Delhi [same company [r
 31 *DOC: [Uh hu [Okay
 32 *PAT: so got transferred here
 33 *DOC: Okay
 34 *DOC: ((no eye contact))Parents are in Delhi*** as well
 35 *PAT: Yeah
 36 *DOC: Great
 37 %ges: writing
 38 (8.0)
 39 *DOC: So what I've given yo²u is one hm (.)tab (.)Montek (.)el
 40 cee (.2)It is (.)one at night only Δat bed timeΔ (.2) for seven days

*** Moment of image extraction

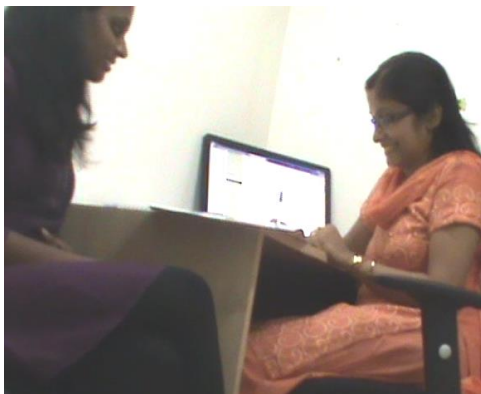


Image 5.1

This is an example of talk that is 'the relational in the service of the institutional' (Coupland 2000, p11) because it has permitted the revelation that the patient is a very long way from her

home support network, which may have a bearing on her complaint of fatigue. The effect is so close to that of institutional talk that it cannot be seen as small talk.

The doctor uses this insight in her next question. In line 24, after a seven second pause and without looking up from her notes or making eye contact, she asks the patient how work is treating her and looks up to check about 'the stresses and tensions' at work. This draws back the inquiry still further into the medical realm; in talking about it in terms of 'stresses' the doctor displays that her concern in this is not for phatic purposes. The eye contact also seems to reinforce this point too by signalling it is an important inquiry, that she has stopped writing to make.

This clip seems to clearly illustrate how initially non-medical remarks (about the weather) have uncovered other information through which the doctor has achieved a new level of understanding about her patient. Although potentially productive, she does not immediately use the information, which might suggest her uncertainty with the place of such information in the medical consultation. This suggestion of uncertainty is further reinforced by the use of the evaluative 'great' as an acknowledgement token (line 36) which feels misplaced. It seems unlikely that the doctor means to imply it is 'great' that the parents are in Delhi. Despite first appearances then, even 'talking about the weather' is not small talk and we can clearly see how it has productivity as work-related talk, Holmes' second category of talk.

5.2.3 Social talk: Fending off silence

Malinowski suggested that small talk serves a social need, by fending off silence. Taciturnity might be suspicious, mistaken for unfriendliness or even imply 'bad character' (Malinowski 1923,p314). Language here is acting not as an 'instrument of reflection' but as a 'mode of action', to create social relationships or atmospheres:

The modern English expression, 'Nice day to-day ', or the Melanesian phrase, 'Whence comest thou? 'are needed to get over the strange and unpleasant tension which men feel when facing each other in silence

(Malinowski p314).

My data set includes an example of this, in clip 5.5. Here social talk appears additionally to have shifted the way in which the actors experience subsequent silence. Image 5.2 is a still from the moment represented in the transcript at line 30 when both the patient, on the right side in the foreground and her mother, partially visible behind her and to the left, are pointing obliquely and in the general direction of a location outside of the building. The doctor is attentive, sitting forward and making eye contact.



Image 5.2

Clip 5.5

```

9    %ges: Doc walks round desk and reaches for left axilla
10   *DOC: lets keep it here
11   %ges: ((pulls neck of sweatshirt))
12   *MOT: ((? ?))
13   %ges: ((pulls at sweatshirt))
14   *PAT: e:r do you want it in my arm pit or where [do]
15   *DOC: Lhah]
16   *PAT: I'll keep it i::ts on yeah
17   %ges: ((sideways head nod))
18   Doc walks round desk and sits down, scoots chair under desk, puts
19   thermometer cap on empty container, picks up pen, rests chin on
20   hands
21   (16.0)
22   %gaz: shifts gaze to MOT
23   *DOC: where do you stay
24   *MOT: pardon
25   %gaz: DOC shifts eye contct to PAT
26   *DOC: where do you stay
27   %ges: PAT ((points with right hand obliquely))
28   *PAT: (° °)
29   *MOT: its just there
30   %ges: ((points with right hand obliquely))
31   *PAT: indrinagar
32   *MOT: it is close by
33   *DOC: indrinagar it is
34   %gaze: Looks at PAT
35   *PAT: ≈very close by≈
36   *DOC: ≈very close by
37   %gaz: Doctor and patient start into middle distance, neutral facial
38   expression and no eye contact
39   (59).
40   *DOC: °you may take it out°
41   *PAT: (5.0) one oh one point eight
42

```

The clip begins when the doctor wants to take the patient's temperature. After a 16 second pause during which the doctor fiddles with objects on her desk and shifts her posture around,

the doctor looks directly at the patient's mother and asks her where she lives (line23), using a phrasing that is not unusual in this setting ('where do you stay?'). The woman asks for the question to be repeated and the doctor then looks at the patient before repeating the question; this shift in gaze validates them both as potential respondents. The patient then says something we can't hear at line 28 and gestures up and outwards to the right. The mother speaks and makes a similar gesture and then we have five turns of talk about the location.

Why does the mother ask for the question to be repeated? The doctor first directs her repeated question to the patient, at line 26, as if she is not sure that the patient has understood. It might be that the mother has not heard since she is not expecting to be included in the conversation and not concentrating or listening to the doctor. But it might support the view expressed in the thematic analysis that 'we don't do small talk', so that the mother is momentarily wrong-footed by such a seemingly irrelevant question. We cannot hear the patient's quiet response at line 28 so we don't know whether it is a translation out of the English for her mother to understand, or is some form of permission to answer or simple repetition of the question, or some unconnected comment, but the mother follows it by offering an answer, the specificity of which is increased by the patient's subsequent remark (from the rather vague 'just there' to the name of the suburb, 'Indrinigar'). All three actors agree that it is 'very close by'.

By line 37 all attempts at conversation have ceased and all three actors are silent for nearly a whole minute until, very quietly, the doctor says that the patient can remove the thermometer and the patient then reads out the temperature.

Jaworski claims that silence is 'best avoided at all costs...to prevent communication breakdown' (Jaworski, in Coupland, 2000, p111). The length of a silence that can be tolerated seems to vary across societies and is likely to be culturally mediated (Kurzon 1995, p23). Silence however is more than an absence and can also carry a semiotic role – consider the power of ignoring or shunning conversational overtures, the angry message of 'the silent treatment' or 'sending to Coventry'. More positively silence can preserve relationships if used in preference to expressions of anger to manage conflict (Tannen 1990 cited in Oduro-Frimpong 2011, p2331, and Oduro-Frimpong 2011, p2332) and in medical interactions the positive use of silence has been looked at in antenatal clinic where it was used to minimise challenge in the interaction (O'Malley 2005, 39-54).

The doctor's question at line 23 might arise from, as Malinowski suggests, an attempt to ward off taciturnity or any ill feeling. Here the doctor fidgets through the first silence of 16 seconds starting at line 17 and she is the first to speak. The doctor is not writing at this point so she is not trying to complete a form with details of address. 'Where do you stay?' is small talk. When the next ten turns of talk are over, what happens next? Silence re-descends and this time it is

unbroken for nearly a minute. All three of the actors sit still, making no eye contact. This time there is no attempt by anyone to break the silence. The doctor at line 23 made a gesture of politeness and offered to talk or engage in 'idle gossip'. If Malinowski is right that small talk, as it fends off silence, creates a social atmosphere, then here we might say it has extended to the second episode of silence as well. There is less fidgeting from the doctor and a more prolonged period of uninterrupted silence suggesting a powerful effect of one instance of small talk exchange which has 'proofed' the actors against the silence without the talk needing to be perpetuated.

So, in this instance, we have one clear example of small talk carrying out one of the roles proposed in the literature, that of fending off silence.

5.2.4 Phatic talk: Back-channelling

Fending off silence can also be achieved however, not only through social talk, but by back-channelling including the non-lexical 'uh-huh', short phrases such as 'I see', up to longer utterances such as sentence completions. Through back channel interventions a listener signals her attention, agreement or encouragement for the speaker to proceed and rapport can develop through active, interested listening (Lambertz 2011). Using Holmes' fourth category of talk, the definition of phatic talk is that it is pro-social but lacking content. In clip 5.6 a series of such interjections can be seen. Through analysis of interaction, the work done by back-channelling can be seen here to be phatic.

The first interjection in clip 5.6 from the doctor (after her initial invitation to the patient to speak at line eight) is an acknowledgment token in the overlapping 'yeah' after the initial introduction of the matter at hand, the stomach aches. Receiving this acknowledgment, that this is an appropriate problem to present, the symptom is repeated by the patient who goes on to expand what it is like and the doctor again overlaps with an emphatic nod and 'hmm'. Nodding by the recipient, mid story-telling, is said to signal that the recipient is laying claim to be able to access the stance of the story-teller (Stivers 2008). Thus the nod at line 15 is a token of affiliation (about the burden of continuous pain) but it is also accompanied by a vocal continuer ('hmm') because the patient has hesitated. The patient stumbles and replaces 'since' with 'which' in a repair that might be needed because of the distraction of a third overlap from the doctor. There are a total of five overlaps by the doctor in this one minute 11 second clip and the doctor is also nodding in a highly involved manner.

If we ask 'what happens next' after each interjection, we see that the patient continues to tell her story and add a bit more information each time. The doctor does not ask questions. The effect of her (non) comments is to enable or allow a reveal of the patient's ideas (whether it's due to

gas or there is some kind of infection) what she has done about it (taken ajwain and water - another nod of affiliation at line 28) her health beliefs (that it is not gas since the ajwain did not help) and that it might be infection (because it is getting worse).

Clip 5.6:

8 *DOC: Yeah so (.2) video is on so er what brings you here today •
 9 *PAT: So I'm having this problem of the stomach aches ↑my≈
 10 *DOC: ↑yeah
 11 %ges: left hand to epigastrium
 12 *PAT: ≈ basic problem it's a stomach ache this is a
 13 continuous like ↑ (.2)≈
 14 *DOC: Lhmm
 15 %ges: strong downward nod
 16 %ges: cycling motion with left hand
 17 ≈↑pain since I'm which I am having the last Δthree four daysΔ now•
 18 *DOC: Lokay mm mm
 19 *PAT: So I had a C-sec four months back ↑and then so (.2)we I'm
 20 having this pain•
 21 *DOC: Lhmmm
 22 *PAT: So I'm not able t::o (.2) have find out whether it's due to g::as
 23 or is there some kind of infection •
 24 *DOC: Okay you≈
 25 *PAT: ≈Because earlier I thought that maybe gas because for four door
 26 days I've been taking ajwain and drinking water •
 27 ↑ so after doing
 28 %ges: Lnod
 29 *PAT: everything er I've seen that it's not gas Δis what I feltΔ so I
 30 thought maybe (.4) last night I thought maybe there's some
 31 kind of infection ↑(.2) because of which the stomach pain is
 32 happening •
 33 *DOC: [right
 34 *PAT: because its in::creasing day by day•
 35 *DOC: Okay
 36 *PAT: So it's not reducing after taking ajwain or (0.2) ↑taking anything•
 37 *DOC: ↑uh uh uh
 38 *DOC: Okay
 39 *PAT: So after every meal I feel like you know after having any food it's
 40 forming gas but the p::ain is not reducing it is coming more and
 41 more •
 42 *DOC: Okay
 43 *PAT: So I'm scared wha : t to eat what no : t↑ to eat=
 44 *DOC: L(Raises eyebrows, inhales
 45 grimaces and nod
 46 *PAT: I mean ((shrug))whatshould I do ♪ •
 47 %gest: waves book in her right hand out towards the right towards the
 48 doctor
 49 *DOC: Okay
 50 *PAT: So that is why(.4) the pain is increasing cons≈
 51 %gest: *moves left hand to bridge of nose and lowers head face toward
 52 the floor
 53 *PAT: ≈tinuously for me so that is what takes me to y ↑ou ha ha•
 54 %gest: waves book towards doctor
 55 *DOC: Lha ha yeah,
 56 absofflutely.** It must be difficult to have pain, right :: •
 57 You said you had a C-section four months back•
 58 @End

The 'okay' at line 42, and the lack of any other doctor interjection, comes after a story of escalating concern ('it is increasing day by day...its not reducing...its not reducing its coming more and more...') and it results in the patient explicitly expressing her fear ('So I'm scared what to eat, what not to eat) to which the doctor again does not respond in words but her facial response appears to recognise as significant (line 44). The patient then asks a direct question ('what should I do?'). The doctor does not orientate to this as a question and again says 'okay' which Heritage and Clayman claim is 'agnostic' (Heritage and Clayman 2010, p39). The patient's gesture of the hand to the face at line 51 (see image 5.3) seems to signal fatigue or despair.



Image 5.3

(Asterisks within the transcript mark the moment of image extraction at lines 51 and 56).

What happens next? There is laughter in line 53 which is mirrored by overlapping laughter from the doctor and a smile-voice in an acknowledgment token ('absolutely') which the doctor then follows with explicit acknowledgment of the implication of what she has heard (line 56).

By tracing the conversational consequences of each of the doctor's utterances we can see that without the use of any social talk it has led to the generation of a relationship which has survived the potential risk of minimisation of symptoms by the doctor posed by the non-evaluative 'okay' at line 49 and results in shared laughter and smiles despite the health worries. Since the only words from the doctor have been back-channel responses, it is through these that some alignment between the doctor and patient has been achieved.

This clip demonstrates that the smallest of non-lexical utterances by a doctor, which might go noted by a CSA examiner, can have an important interactional role in the production of medically relevant talk. It is of additional note that this is an example that goes against what is sometimes said about medical discourse, that doctors' verbal actions are said to be

predominantly questions and those of patients' are predominantly answers (Robinson 2003) and supports the conversation analysis perspective that the production of accounts is collaborative (Heritage and Clayman 2010). Focussing on back-channelling in this example has revealed how such talk, in addition to managing silence by demonstrating active listening, has an 'eliciting' function, which facilitates the production of the account which echoes other work on the development of medical relationships (Watson 2012, p23).

5.2.5 The risk of small talk

Small talk is said to enable 'disattending' (Maynard and Hudak 2008). As a detractor from the course of the conversation, or content of the activity, an off-topic comment might be offered by doctor or patient. Small talk might enable them to ignore what is happening because they consider it un-noteworthy (such as measurement of temperature), or to distance themselves from something unpleasant happening (such as a joint injection) or to close down discussion on an unwelcome topic (such as smoking cessation). Maynard and Hudak named these differences as small talk *in simultaneity* (when it enables disattending by, for example, minimising embarrassment or boredom during an examination) and small talk *in sequence* (where it acts to head-off (perhaps surreptitiously) a particular topic of discussion).

In clip 5.7 the patient is anxious, and worried about his blood pressure, as we have learnt from an earlier remark (not shown): 'also if you want to calibrate my machine I have one yeah because when I was feeling kind of breathy and I was getting weak so I bought one'. In it we find an instance of disattending for which interactional analysis seems to suggest an outcome that might give one reason why small talk is considered problematic and hence avoided in this setting.

The clip starts just as the doctor starts to calibrate the home monitor. After the second sphygmomanometer is fitted the doctor asks the patient where he lives (line 17). She has finished her writing so is not asking in order to complete the paperwork. We know that Nitesh is anxious and perhaps the doctor is trying to distract him from the process of measurement.

Clip 5.7

8 *DOC: Do you want me to put that in
 9 *PAT: °(yes) /(please)°
 10 %ges doc fits sphyg
 11 %ges holds hands up as if to help
 12 (2.8)
 13 *DOC: °(inaudible)°(3.0)
 14 %ges: picks up pen and continues to write
 15 (34.0)
 16 *DOC: °let me put that° ((second sphyg fitted))
 17 *DOC: Where are you staying Nitesh ↗
 18 *PAT: E::r Prestige≈
 19 %ges: points out to the right with right index finger
 20 *PAT: ≈Shantiniketan
 21 *DOC: £Atwe ((makes eye contact smiles and nods head sideways))
 22 (3.0)
 23 *DOC: most of do our Doctors do stay there as well
 24 *PAT: You are also ≈
 25 %ges: points out to the right with right index finger adjusts spectacles
 26 *PAT: ≈staying nearby ↗
 27 (0.8)
 28 *DOC: No ((smiles))
 29 *DOC: I stay in Yemlur †((adjusts sari))that is near Marathalli ((adjusts hair))hh h h
 30 *PAT: Lumm.
 31 %ges: Nods lifts right index finger
 32 *PAT: Okay:: I'm new to Bangalore so I don't have much ((fiddles with collar))
 33 *DOC: Rightff Right h h h h h ((picks up pen))
 34 (26.0)
 35 (beeps)
 36 %ges: doc writes
 37 (28.0)
 38 longer beep then stops
 39 (3.5)
 40 *PAT: ((cough)) =
 41 *DOC: = It's hundred twenty by eighty five eighty five is good
 42 enough it's matching with this
 43 %ges: gaze and gesture to machine on her right

The patient identifies a high-specification residential complex nearby and the doctor responds with a smile-voice and they exchange seven turns of conversation. The particular utility of video data capture is shown here since we can next see a series of gestures that we might take to be grooming gestures. The segment starts with the patient asking the doctor where she lives and seems to me to have a flirtatious quality to it. It's possible that the doctor also feels this because, although we don't know what the patient was going to say at line 32 (much social life, much local area knowledge, much to do?) the doctor interrupts, laughs, and the video shows she then straightaway picks up her pen signalling that she is now interactionally unavailable. She then returns to writing and this continues for another long silence.

In chapter two I made reference to the work of Robinson and Stivers on activity transitions achieved with the involvement of object adapters. These authors claim that object-adaptive behaviours can accomplish at least the interactive function of projecting activity transitions, and are responded to by patients as such. Picking up the pen in clip 5.7 seems to signal the end of a phase of activity when it is permissible to engage in small talk to a phase when it is not. The patient orientates to the object-adaptor behaviour as signalling the end of the phase and stops talking. In the long period of silence that follows this action the patient shifts his gaze into the middle distance and away from the doctor.

The small talk has enabled them to disattend to the blood pressure monitoring, and opened up a space for conversation, but the segment ends with silence. The silence and the reaction of the doctor (line 33), suggests that small talk can bring the risk of creating an uncomfortable 'closeness' between doctor and patient perhaps considered inappropriate in this setting. In the thematic analysis we saw the discussion that the doctor-patient relationship reflected societal norms which, in a conservative society, includes maintaining a social distance.

5.2.6 Enabling transitions

Laver suggested that small talk is found at the 'marginal phases of interaction' (Laver 1975, p218). In the opening phase, it is said to assume one of three roles: a propitiatory role (p220) - to diffuse the silence, set a comfortable scene and avoid the awkward tension alluded to by Malinowski; an exploratory role allowing participants to 'feel their way towards the working consensus of their interaction' (Laver p221) and allow us to assess the other's mood, or current state, as well as start to form judgments about the other, that might form the basis of our future interaction; and a third role as initiatory talk, to 'get the interaction underway'. Thus Laver concludes, at least within English speaking cultures, phaticity is a universal finding in openings. In my data we can find the 'how are you?' inquiry, the features of which have been investigated by Coupland et al, but also, 'please do take a seat' and 'sorry to keep you waiting'.

Laver suggests that phatic talk is likely to be found in closings for similar reasons – to preserve the relationship and mitigate against possible feelings of rejection or fend off the impending unpleasantness of silence, or to prepare the actors to re-meet at a later date. And indeed in my data we hear 'thank you for your time doctor' or 'I hope you feel better soon'. It is talk that works to protect or reinstate the interpersonal relationship and is often accompanied by tokens – gestures, eye contact, facial expressions or bodily orientation that also foreshadow (or, in the words of Laver 'adumbrate') the impending separation.

A search at such a closing transition reveals the exchange represented by clip 5.8.

Clip 5.8

8 %ges: docgaze towards notes, writing
 9 *DOC: Aahh:: and how young are you:
 10 *PAT: I'm thirty-one (0.6) i|f
 11 thirty-one years is y u(h h) [ung h h]
 12 [Um]
 13 *DOC: (0.7) ((continues to write)) h h
 14 Being young is in the mind ((looks up makes eye contact)) he heh
 15 *PAT: h h I know

Here the consultation is nearly over and the activity has moved from talking to writing. The doctor has made some remarks that might be concluding remarks (not shown): '...if things are not improving at all you will definitely have to have a reassessment and see why it is not helping. Alright? '. Then the doctor orientates to her desk and starts to write as seen in the accompanying image 5.4:



Image 5.4

Why does she open in this way at line nine? The topic is a contingent one in healthcare, an inquiry about age, so the doctor has the interactional right to ask it and it is not small talk. But she phrases it in an unusual, somewhat informal way that suggests something (perhaps sisterly?) is being implied about age over and above a request for information for the records. It may be seen as a gift or an offer of friendship, or simply be a way of mitigating against the dispreferred activity of asking someone their age. What happens next however is an apparent break in the hierarchical doctor-patient barrier as the patient orientates to the remark as playful, as shown by her reply with a rhetorical question. There is humour in the exchange and the doctor is momentarily stopped in her task, to continue with 'being young is in the mind', which is much more clearly small talk.

Thus this question about age has supported the development of the doctor-patient relationship. It is not talk that appears self-consciously to be aimed at developing a rapport it appears to arise from the interaction of two adult women, temporarily distracted from, and outside their roles as, patient and doctor. Occurring at the closing of a transaction it bridges the transition and closes the work talk. It sets the scene for the parting and is an example of what Laver called a 'consolidatory token' in the work done by small talk in perpetuating the relationship to enable it to be available again next time they meet.

5.3 Creating alignment

Using the themes from the literature as a way of trying to identify examples of types of talk, I have identified within my data set only three instances which turn out on close inspection to be truly small talk, lending weight to the impression that such talk is rare. One of these, clip 5.7, also suggests the risk of such talk and one possible explanation for why it is avoided in this setting. We saw in the thematic analysis that the doctor is of high social status and held in some esteem by patients. The register of less formal talk threatens this. The doctors however stated the need to connect with patients and we see in this section that this can be achieved in other ways by, for example, back-channelling that does not require social talk.

In the absence of small talk, the data show two alternative features of talk in this setting through which doctor and patient might come into alignment, discussed in the next two sections

5.3.1 Talk as cultural story

Clip 5.9 illustrates how any talk in interaction can both respond to and perpetuate social cohesion. At the start of the clip we are 11.04 minutes into a 23.33 minute consultation, the patient is talking about the lay understanding of what might be inferred about the unborn baby from the mother's hair loss during pregnancy:

Clip 5.9

8 *PAT: so I mean the last one month my hair started falling a lo::o.t
 9 ΔSo I don't knowΔ mayb::e I mean a lot of
 10 ff [people say other≈
 11 *DOC: [((smiles))
 12 *PAT: ≈people say a lot of things
 13 having their own stories I don't know like maybe because the kid
 14 is fighting? hhh the kid isn't doing 'like≈
 15 %gest: Doc throws head back and laughs
 16 *DOC: L Hhh h
 17 *PAT: ≈that or something mother's h hhhh hair falls
 18 *DOC: We have hhh | so many beliefs don't we≈
 19 *PAT: LI mean hhh I don't know
 20 a lot of things people say I mean °I don't know°
 21

Why does the doctor smile in line 11? She is responding to the smile-voice of the patient who speaks with some hesitancy in line nine/ten. The patient escalates to laughter in line 14 and by line 16 the doctor also laughs out loud. This is reciprocated by the patient who joins in the laughter again at line 17 and laughter bubbles through their overlapping speech.

There are hesitations in lines nine to 14 that might be taken as indicators that the patient wishes to distance herself from what 'other people' say. Perhaps she feels reluctant to proffer a lay explanation for her symptoms and wishes to preserve face in case the doctor is not sympathetic to such an explanation. However the comment from the doctor "we have so many beliefs, don't we?", contains the crucial use of the plural pronoun which has the effect of aligning the doctor and the patient with the lay public and, by virtue of this, might be seen to be the doctor metaphorically taking off the white coat of a medical professional to appear as a co-member of society. This has the effect of appearing to reverse the role of the doctor and patient. It is the doctor who is claiming a position within the group that 'has a lot of beliefs' but the patient who is, in line 19 and 20, distancing herself with repetition of 'I mean, I don't know' from 'a lot of things people say'.

In relation to my analysis, what is significant is that this comment from the doctor 'we have so many beliefs don't we' is not directly task-related talk, directed at an element of the medical decision-making. Neither can it be considered to inform the usual relationship of the doctor-patient hierarchy seeming, as it does in the first of these interpretations, to swap around the polarity of that relationship with the doctor aligning herself with the beliefs of lay society and the patient distancing herself from that view. It is informal but it is not small-talk, and it is not non-work-related. It does work that can be interpreted to locate the doctor and the patient as co-members of the same society. This shared cultural background is the same one that they will draw on to establish what counts as doing 'going to the doctor's'; a shared foundation that is

then potentially available and could be built on at any time for any other aspect of the medical conversation.

5.3.2 Creating a space

Interactional work takes diverse forms. General practice training and assessing looks for 'orderliness' in consulting (See appendix 1, especially domain 1) whereas consultation analysis can show us that, judged by outcomes, understanding can arise in quite a 'disordered' way. Consider clip 5.10, which illustrates another way in which apparently non-work-related talk is not small talk since it has a productivity in relation to the consultation. It shows that even quite unusual 'off task' talk can still be 'on task' in terms of 'being a doctor'.

Clip 5.10

8 *PAT: No (0.4) he is not taking any medication for that
 9 *DOC: Right (0.1) you want me to switch on the aycee ↗
 10 *PAT: Yeah
 11 *DOC: You're feeling hot I'll just get that (4.2) Comfortable now ↗
 12 okay↗ he he he
 13 *PAT: Yeah
 14 *DOC: Sorry about that (0.1) I could see you sweating
 15 *PAT: Yeah I generally sweat a lot : t one more thing is that I'm in obese
 16 stage but earlier like↗ I was overweight for a long time but
 17 currently I'm into obese stage so like I have put on weightΔ a lot
 18 in last fourfive years I would say
 19 *DOC: Right so you're in Bangalore for how long↗
 20 *PAT: Just 6 months I was in Pune so I just shifted to Bangalore
 21
 22 *DOC: So one more thing (.2)that I would like to do if it is okay with you
 23 maybe a (.) thyroid profile you know thyroid has a lot of tiredness
 24 setting in lot of (.)feeling hot kind of symptoms you know feeling
 25 hotter than the rest of the people staying in the same room. We
 26 will work on that nothing to worry much about it
 27 *PAT: yeahrokey ΔrightΔ

In line nine, the doctor makes an offer to turn on the air conditioning, and an inquiry after the patient's comfort is accompanied by laughter. It is followed by the word 'sorry' in line 14, which is not responded to by the patient as if it was an apology, with an anticipated second pair-part such as 'that's alright' or 'don't mention it'. The doctor listens to an account of how the patient has put on a lot of weight and then asks how long he has lived locally. She raises the possibility that some of his symptoms might be due to a medical condition (underactive thyroid) and follows this with 'nothing much to worry about'.

Why does the doctor laugh in line 12? The offer to turn on the air conditioning and subsequent inquiry after the comfort of the patient is slightly unusual within the medical consultation and she

seems to be mitigating that with 'sorry' in line 14 and offering an explanation for her inquiry. In terms of what happens next we can see that her mention of sweating leads directly onto the patient bringing up another aspect of his concern, his obesity. And after a brief detour to ask how long the patient has lived in Bangalore, a question that is likely to be related to medical history-taking and unlikely here to be small talk due to its location and abrupt insertion, the doctor expresses an interest in checking thyroid function. The comment 'nothing to worry much about it', combined with the presentation of the doctor as a considerate person who cares about the comfort of her patient, appears to have the effect of minimising the alarm the request to look for a metabolic disorder might otherwise provoke since the patient responds, initially hesitantly, but then emphatically with a quick 'right'.

So here the unusual 'you want me to switch on the a/c?' leads to a series of turns that create a space where more medical work can be done - further investigations can be offered. The turning on of the air-conditioning is not a medically task-related, but it is not small talk since it is related to another aspect of the doctor's professional role the task of 'having responsibility for maintaining an environment that is comfortable to the other people present' and in so doing, the doctor has facilitated the creation of a space then available for more medical work.

5.4 Conclusion

The analysis of the data presented in this chapter describes some of the features of the consultation in terms of patterns of talk, an analysis that was carried out to enhance the understanding of how the doctor-patient consultation is created in-the-moment between a doctor and patient in these consultations in India. I have shown examples of four categories of talk: core work business talk, work-related talk, and small talk made up of social talk and phatic talk. The data also includes an example that might tend to reinforce the view that small talk can be seen as inappropriate in some ways in this setting; there seems to be a risk associated with small talk, of de-doctoring or distracting from the medical work. This might explain why some practitioners, especially perhaps those working in a second language, less certain of their social position or unfamiliar with a shared vernacular, might avoid it. Taken with some of the themes in chapter four, that medicine reflects societal norms around the status of doctors as 'knower' and the social and educational hierarchy we can start to explain the absence of small talk.

However, competence with small talk, social talk or 'conversationalising' is important for success in the CSA and the differential success rate for different sub-groups of doctors could be one of the unintended consequences of focussing on it in assessment. I have explored how, in this setting, other talk can create the alignment sometimes attributed to small talk, in facilitating the perpetuation of shared cultural stories and supporting the creation of cultural understanding and by creating a space to carry out other tasks and build relationships. Given the reminder from Moss and Roberts of the importance of understanding 'the subtle ways patients and

doctors manage their talk', (Moss and Roberts 2005 p412) and the importance of that talk itself in enabling patients, as well as doctors, to manage their identities (Roberts et al 2005) the privileging within the CSA of particular patterns of talk is problematic.

Chapter Six: Conclusion

The aim of this project was to describe the features of general practice in one clinic in India with reference to the UK CSA. The objective was to gather data to enable an interrogation of the statement that general practice is different in India which might then help explain some of the professional difficulties doctors experience in assessment when moving from India to UK for postgraduate training. I visited the clinic for the first time in 2011 to start a process of ethnographic 'lurking and soaking' (Werner and Schoepfle 1989, cited in Snell et al 2015 p7). This period of data-gathering was to enable me to familiarise myself with the structural and procedural aspects of the setting that I had never worked in or even visited, and what became the thematic analysis draws on a data set that was initially gathered to orientate myself to the setting. It was clear to me that just as the candidates for the CSA must adjust to the NHS it was going to take time for me to be sensitised to elements of my research site and to ensure I had sufficient contextual knowledge to be able to make sense of the consultation data.

In this concluding chapter I will summarise how my analysis addresses the research questions including identifying the limitations of the study and also make recommendations arising from the findings. In addition I will reflect on the development of my identity as a 'generalist researcher' with an echo of my professional identity as a generalist clinician and how that is reflected in the re-purposed phrase 'principled eclecticism' (Mellow 2002, p109). I have applied different tools that individually seem to be useful in offering partial insights into a particular professional challenge and in combination augment the research-based understandings of professional practice.

Limitations

The literature I reviewed and the respondents in this study suggest that the understanding of what counts as a good consultation and how candidates perform 'being a good GP' is not universal. My investigation has been an attempt to explore this by looking at what doctors report, and how some consultations were conducted, in another cultural context. The study is limited in what it can say directly about the CSA itself, since I did not look at performance of candidates in the exam. Further work using conversation analysis to look at consultations in both the actual CSA, and also consultations in other countries of origin for CSA candidates would be an interesting line of further research.

In addition, the features of interaction found in one context do not necessarily provide grounds for understanding or explaining the features found in another context. The relative use of small talk and the work done by other types of talk cannot be taken to necessarily explain lack of success with the CSA but do go to a demonstration of difference.

What does the thematic analysis tell us about the context of general practice in this setting?

This thematic analysis raises the importance of language, and in particular the importance of the register of medical or scientific language as a marker of who has the greater claim to expertise in this hierarchical society. Some of the doctors recognised that the importance of connecting with patients was challenged by a potential lack of shared vocabulary or constructs to talk about medical matters and that 'connectedness' here might be being viewed within the register of 'appropriate ways to talk to patients'.

Insights are also provided by the thematic analysis into contextual issues that structure practice in the clinic and might affect how the consultation is carried out. Doctors stated that their consultations are very time-pressured: 'there is too much of everything here, too much of illness, too much of people, too much of stress'. Some doctors expressed the view that there was a societal move to commodification of health and that healthcare was increasingly becoming a transactional process with an impact on what happened in the consulting room.

The thematic analysis revealed the extent to which the respondents and I had co-created an understanding that the doctor-patient relationship was a microcosm of societal norms. This included the generally high social status of doctors, although a relative lowly status of general practice in the eyes of the profession, and also the impact of an educational and social hierarchy on the location of epistemic authority and who was expected to 'know'. Some of these doctors saw this as barrier to shared decision-making which also derived in part from a lack of the appropriate resources of doctors and patients, including linguistic confidence, to carry it out. A societal sense of collectivism being more important than individualism and autonomy came to crystallise as the origin of a varying emphasis on the importance of both confidentiality and personal decision making in this setting. The views of doctors towards language and its effect on communication were revealing and I came to the view that it was possible that interactional troubles were tolerated in this setting, despite the stated concerns of doctors to 'connect' effectively with patients, because of their experience in non-professional or social discourse where citizens might have to manage challenges arising from language barriers. Finally there is a growing and relatively affluent middle class in India with access to internet based resources and information and the ability to 'doctor-shop' and seek out multiple investigations and opinions. Some of the respondents had had more patient contact from this sector of society than others and this variation in experience gave rise to some conflicting views on the extent to which the advocacy role of the family physician was giving way to one of a technical service provider.

What does the conversation analysis tell us about the features of the consultations?

The claim of conversation analysis is that, in being a micro-level analysis, it enables us to see the 'local architecture' of the creation of inter-subjectivity of interactants which gives insight into both the effect of and the creation of the broader social order within which that interaction is taking place

I was struck even in the early stage of the initial analysis by how often issues of language seemed to come up as a feature of the interaction. There were mis-understandings, such as those caused by mis-pronunciations and possibly others of which I was unaware because of my own language deficiencies in this setting, omissions of data available for the researcher as well as the doctor, and code switching between languages. The video data were analysed through the prism of four categories of talk: core work business talk, work-related talk, and small talk made up of social talk and phatic talk. Small talk was shown to fend off silence, enable a foundation for future medical work and be used to disattend to and transition between activities. In this data set, in contradistinction to the emphasis on 'conversationalising' in successful CSA consultations, when analysed interactionally there are very few examples of small talk. Despite this, however, relationships were formed and medical work was done.

Recommendation one:

Until or unless the RCGP changes its assessment strategy, one recommendation that could reasonably be made to those preparing for the CSA is that candidates should make the most of this full range of talk available to them to demonstrate the sort of interactional fluidity that helps an examiner have confidence in the candidate. For example from the clinic in India we see in clip 5.4 in chapter five, that the doctor uses talk that is 'relational in the service of the institutional' and follows up a cue from the patient about the weather to learn that the patient is far from home and her support network, which may have a bearing on her complaint of fatigue. Similarly back-channelling in clip 5.6 allows a slow reveal of the patient's ideas and concerns without the active intervention of 'medical talk'. Candidates might also be advised to have the confidence to joke with their patients, as we see in clip 5.8, a section of talk that functions as a consolidatory token at the closing of the consultation, or in clip 5.9 that builds on, and develops, the actors' shared understanding of their cultural background.

How did the thematic analysis frame a conversation analysis of recorded video data?

When I started the conversation analysis phase I had completed the data collection for what was to become the thematic analysis and was therefore aware of the main themes that had

been discussed. So I came to the analysis of the videos with a background expectancy about 'the way things are around here', in this setting.

Conversation analysis as a process, does not look beyond or outside the interaction at hand for other influences from the broader social order, the aim of such a mode of enquiry is to look directly at talk-in-interaction. It ignores, for example, a direct look at the official discourse such as that promulgated in policy documents, government or educational strategy. However, in the focus groups and interviews, the views expressed by participants may very likely have been influenced by any of these things and they can thus be made contingent.

Without the analysis of observed consultations, the thematic analysis is vulnerable to the criticism that it reports subjective experience based on what participants say happens rather than offering illustrations that suggest that is indeed what happens. Here the conversation analysis augmented the findings of the thematic analysis. The combined approach enables a greater degree of confidence in our knowledge of the context the international medical trainees have come from and some of the specific difficulties they might have. In terms both of training for the role and preparation for the assessment this study outlines the importance of recognising the impact of differences in societal structure such as how politeness and respect are enacted and the relative position of doctor and patient in the claim to 'expertness'. There are likely to be communicative performance difficulties that contribute to the differential success rates including the risk of sounding formulaic when 'trying on' taught phrases that are not part of the way these doctors are used to talking to patients. In particular informal talk has been shown here to be only one of several ways doctors and patients come into alignment.

Importantly then, interactional outcomes, rather than inputs, should be the focus of assessment of interpersonal skills, with an emphasis on 'what happened next', rather than solely what the doctor said. Insights derived from this analysis might make a start to re-imagining how 'being a good doctor' is assessed, given that one model does not have universal applicability. In particular the training of examiners might include a recognition that they should guard against mistaking a lack of interactional fluidity for lack of medical competence.

The Practitioner Researcher

The role of practitioner-researcher brings certain considerations among which is to acknowledge the implications of 'insider' knowledge. It is hard for me to put aside the professional identity that comes from my role as a family doctor, or the assumptions embedded in my own practice. In my clinical practice, with patients I do not yet know, small talk is the way that I signal that even though I am not 'their doctor', I am another representative of the species Doctor and can be trusted to do the Right Thing for them. I judge its importance to my practice

in the way it can help build a relationship, whilst building a foundation for future work (which might after all include very difficult conversations at another stage in life). However it does not appear from my data to be a universal finding, or held by all to be the 'big talk' of a consultation that it seems to me. The work I do through small talk might very well be achieved by other means.

Such a perspective on the research findings draws explicitly on my particular perspective as a clinician and with particular experience as a trainer, and it brings a certain lens to the analysis of the video data. The insider perspective is useful to the extent that it lends an ethnomethodological 'immersive short-cut' to some contextual knowledge, but also risks the very error that this project was set up to examine: the assumption that general practice might look, or be, the same in all contexts.

Doctors entering the UK from India will bring with them an understanding of the doctor-patient relationship which has been shaped by their own experiences as citizens, patients, students and practitioners, some of which we see discussed in the thematic analysis. They will project a definition of the situation built on cues that will have been largely 'caught not taught' in the way that Bourdieu describes the unheeded acquisition of invisible capital that gives a sense of 'position' within a social setting' (Bourdieu, 1989, p19). The research question 'what are the features of general practice in one clinic in India' was formulated from a recognition that a definition of the situation, inevitably socially constituted yet superficially similar, as the doctor-patient consultation should not be assumed to be the same in all settings.

The current under-theorised role talk itself plays in successful consulting seems likely to be one of the factors that underpins the current differential success rates for international medical graduates in the RCGP assessment of consulting skills.

As Goodwin (1991) points out:

Conversing...cannot simply be seen as a problem of putting information into words or, for that matter, of using the right grammar or choosing appropriate expressions. It is a collaborative enterprise involving the coordinated efforts of speakers and listeners in the production of interactional outcomes

Goodwin (1991) quoted by Gumpertz in Drew and Heritage (1992, p305).

Overseas-trained doctors coming to the NHS are required to pass an English language test, but there is not a direct link between knowledge of a language and ability to consult effectively. The need to connect efficiently with a patient to step up to the challenge faced in taking a sexual or psychiatric history or the need to connect quickly with a patient to facilitate the patient in

explaining their symptoms and concerns in a time pressured consultation suggest a role for language that goes beyond the technical, scientific basis of medicine, but our methods for assessing competence in that are imperfect. My analysis of data suggests that it can be achieved via a wide range of interactional patterns, some of which might not be easily recognised by CSA examiners steeped in the norms of their culture.

The RCGP examinations department has commissioned several projects from linguistic ethnographers over the years. One of these authors points to the productivity, but also the interdisciplinary clashes, that have previously resulted from applying an unfamiliar research lens in a medical sphere:

Within the RCGP's regime of thought, it was generally very hard to understand the perspective of linguistic ethnography, and if the researchers weren't actually regarded as mad or bad, it was easy to see them as just sad, spending so much time on what looked irrelevant to the professionals, either all too obvious or really rather meaningless (Rampton et al 2014, p19).

The use of the term 'regime of thought' suggests a fairly rigid, collective, version of 'the way things are done around here' that mirrors the approach to the assessment of generalist medical consulting privileged by the RCGP in the CSA. A similar rigidity of view has become manifest as the results from my project are disseminated in presentations and publications. It has at times been the method of enquiry, rather than the outcomes that has provoked most debate, or a general suspicion that a focus on 'talk' is somehow not a 'proper' field of inquiry in a professional discipline; that such research accuses examiners of racism or is misunderstood to show that discussing differences in practice is the same as demonstrating a deficit model. Research in the medical field is far from always carried out with the same methods of enquiry, and qualitative methods within a constructionist approach are common, but the scientific orthodoxy of medicine has tended to be built on a positivist ontology within an objectivist epistemology. This has resulted in a community of practice that does not always have a shared language to discuss some of these outcomes.

If this research is to impact on the general practice training in a meaningful way, an informed discussion is needed about what aspects of clinical skills can reliably be assessed in the CSA. Research looking at how examiners talk about candidates points out the risks being taken when, 'inner states are read off from outward (simulated) behaviour' (Roberts et al 2014, p 93). Similarly the validity of the assessment is compromised by the finding that 'judgments of clinical management in the CSA were regularly conflated with assessment of manner and affect' (Ibid p74). Much older research has already confirmed the difficulty of trying to assess patient-centredness through analysis of video-taped consultations (Howie 2004, p460). This exam

requires candidates to project a definition of the situation that they may be unfamiliar with, whilst interacting with 'patients' who are also playing a role. As one of the respondents in my IFS concludes 'it needs acting skills this exam...and the gift of the gab' which seems to be echoed by Roberts et al who noted 'the need to rapidly imagine aspects of the case which have not been given in notes to the candidate [such that success] depends as much on managing the exam genre as simulating a comfortable encounter' (Roberts et al 2014 p124).

My research has shown that general practice cannot be assumed to be the same in all settings, making the CSA unreliable at best and lacking in construct validity at worst. It is a flawed assessment tool and judgements based in it risk being unfair and discriminatory.

Further recommendations

Any advice of the 'do it like this' variety arising from this project and aiming to support IMGs in the CSA, risks reinforcing the perception of a 'deficit' model of consulting for those trained outside the UK. In fact such advice does already exist from a variety of sources (examiners, trainers, trainees themselves), including suggestions on what to wear and to take acting classes. Given that one of the criticisms of RCGP examiners is that poorly performing candidates sound formulaic, it would seem to be counter-productive to offer candidates another model of 'good consulting' to emulate. Rather, the key message from my research is for RCGP policy makers: that the CSA cannot be held to be a reliable or valid way to assess the performance of 'being a good GP'. Feedback to candidates such as 'does not use language and/or explanations that are relevant and understandable to the patient', 'does not appear to develop rapport...' or 'poor active listening skills and use of cues; consulting may appear formulaic, and lacks fluency' seem likely to be problematic in a simulated setting, where feedback is not informed by the experience of the 'patient', which requires the 'doctor' and the 'patient' to both know, and be able to perform whilst being unaffected by, the rules of the simulation game, and where internal understandings are being 'read-off' by a third party examiner from displayed behaviours. Conversation analysis relies on an understanding that the work done by talk is displayed in how the hearer responds to it but that that meaning is co-constructed between the speaker and the hearer as they work collaboratively 'in the moment'. Close analysis of recorded talk in my investigation has suggested different ways that actual talk performs in this clinic and as a sophisticated form of human interaction it is likely to become unbalanced when one party, the simulated patient, endeavours to follow a script and the candidate endeavours to perform according to an internal 'check-list'.

Current assessment practice in high stakes medical assessment is moving towards the use of multiple data points rather than single summative assessments and the use of assessment of entrustable professional activities, EPAs, (ten Cate (2013). These are competencies assessed

during actual practice in the workplace rather than simulation and seem to offer an effective alternative that the RCGP might consider.

The opportunity must be taken to talk about these findings, using a language that examiners and others will find respectful, acceptable and understandable, a challenge not unlike that facing doctors talking to patients.

References

- Abadel, F.T., Hattab, A.S. (2014). 'Patients' assessment of professionalism and communication skills of medical graduates'. *BMC Medical Education*, 14 (28), 1-8.
- Abdel-Tawab, H., Roter. (2002). 'The relevance of client-centered communication to family planning settings in developing countries: Lessons from the Egyptian experience'. *Social Science and Medicine* 54:1357–1368.
- Al Adawi, S., Al-Busaidi, Z., Al-Adawi, S., Burke, D.T. (2012) 'Families Coping With Disability Due to Brain Injury in Oman: Attribution to Belief in Spirit Infestation and Ensorcellment'. *SAGE Open*, 2
- Al Busaidi, Z.Q. (2010a). 'A Qualitative Study on the Attitudes and Beliefs towards Help Seeking for Emotional Distress in Omani Women and Omani General Practitioners: Implications for Post-Graduate Training'. *Oman Medical Journal* 25 (3), 190-198.
- Al Busaidi, Z.Q. (2010b). 'The Concept of Somatisation, a Cross-cultural perspective'. *QU Medical Journal*, 10 (2), 80-186
- Al Eraky, M.M. Chandratilake, M. (2012). 'How medical professionalism is conceptualised in Arabian context: A validation Study'. *Medical Teacher*, 34: S90–S95
- Allen, J., Mohanna, K. (2013). 'Global' is not just 'out there' but also 'right here': Expectations and experiences in internationalised and globalised higher education'. *Educational Practice and Theory*. 35 (2), 85-103
- Antaki, C. (2003). 'Analysing Talk In Interaction'. On-line lecture series. <http://homepages.lboro.ac.uk/~ssca1/lecture01OVER.htm> . Last accessed 5.8.14
- Antaki, C., Billig, M.G., Edwards, D. and Potter, J.A., (2003) "Discourse Analysis Means Doing Analysis: A Critique of Six Analytic Shortcomings", *Discourse Analysis Online*, 1 Available from <http://www.shu.ac.uk/daol/articles/v1/n1/a1/antaki2002002-paper.html>. Last accessed 24.2.15
- Ara, N.H., Wen, L., McGrath, J., Steinbach, R., Pugh, J.A. (2005). 'Communicating about medications during primary care outpatient visits: the role of electronic medical record'. *Informatics in Primary Care*, 13, 13–21
- Ariss, S.M. (2009). 'Asymmetrical knowledge claims in general practice consultations with frequently attending patients: Limitations and opportunities for patient participation'. *Social Science & Medicine*, 69, 908–919.
- Atkinson, P., Heath, C. (eds) (1981). *Medical Work: Realities and Routines*. Farnborough: Gower.
- Atkinson, J. and Heritage, J. (1984). *Structures of Social Action, Studies in Conversation Analysis*. Cambridge: Cambridge University Press.
- Austin, J. L. (1962). 'How to do things with words'. London: Oxford University Press
- Bagheri, H., Ibrahim, N.A., Habil, H. (2012). 'Aha, ok, alright as Phatic Talk; An Analysis of Opening in Multilingual and Multicultural Clinical Consultations'. *Procedia - Social and Behavioral Sciences* 66, 8 – 16
- Balint, E. (1969). 'The possibilities of patient-centered medicine'. *J R Coll Gen Pract*, 17, 269 - 276.
- Balint, E. & Norell, J.S. (eds) (1973) *Six Minutes for the Patient*. London: Tavistock.

- Balint, M. (1955). The Doctor, his patient and the illness. *The Lancet*, 265 (6866), 683 - 688.
- Balint, M. (1957). Millennium reprint of 2nd Ed (2000) *The Doctor, His Patient and the Illness*. Edinburgh: Churchill Livingstone.
- Barbour, R. (2005). 'Making sense of focus groups'. *Med Ed*, 239, 742-750.
- Barbour, R.S., Kitzinger J (Eds) (1999) *Developing Focus Group Research: politics, theory and practice*. London: Sage Publications Ltd.
- Beck, U. 1992. *Risk Society: Towards a New Modernity*. New Delhi: Sage.
- Bergen, C., & Stivers, T. (2013). 'Patient Disclosure of Medical Misdeeds'. *Journal of Health and Social Behavior*, 54(2), 221 – 240
- Bezemer, J., Jewitt, C. (2009). 'Multimodal Analysis: key issues' in Litosseliti, L. (Ed) *Research Methods in Linguistics*. London: Continuum, 180-197
- Billig, M. (1999a) 'Whose claims? Whose ordinariness? Rhetoric and ideology in conversation analysis'. *Discourse & Society* 10(4), 543-558.
- Billig, M. (1999b) 'Conversation Analysis and the claims of naivety'. *Discourse & Society* 10(4), 572-576.
- Bourdieu, P. (1989) 'Social Space and Symbolic Power'. *Sociological Theory*, 7(1), 14-25.
Available at <http://links.jstor.org/sici?sici=0735-2751%28198921%297%3A1%3C14%3ASSASP%3E2.0.CO%3B2-T>. Last accessed 17.12.15
- Bow, C., Woodward-Kron, R., Flynn, E., Stevens, M. (2013). 'Can I ask you something about your personal life? Sensitive questioning in intercultural doctor–patient interviews'. *Focus on health professional education: a multi-disciplinary journal*, 15 (2).
- Brannen, J. (2005) *Mixed methods research: A discussion paper*. NCRM Methods Review Papers Available from <http://eprints.ncrm.ac.uk/89/1/MethodsReviewPaperNCRM-005.pdf> Last accessed 5.2.16
- Braun, V., Clarke V. (2006). 'Using thematic analysis in psychology'. *Qualitative Research in Psychology*, 3: 77- 101.
- Britten, N., Stevenson, F., Gafaranga, J., Barry, C., Bradley, C. (2004). 'The expression of aversion to medicines in general practice consultations'. *Social Science & Medicine* 59, 1495–1503
- Brown, P. and Levinson, S.C. (1987) *Politeness: Some universals in Language Usage*. Cambridge: Cambridge University Press.
- Byrne, P., Long, B.L. (1976). *Doctors Talking to Patients*. London: HMSO.
- Cahil, P., Papageorgiou, A. (2007a). 'Video analysis of communication in paediatric consultations in primary care'. *Br J Gen Pract*, 57, 866–871.
- Cahill, P. Papageorgiou, A. (2007b) 'Triadic communication in the primary care paediatric consultation: a review of the literature'. *Br J Gen Pract*; **57**: 904–911.
- Cameron, D. (2001). *Working with Spoken Discourses*, London: Sage
- Campion, P.D. (1996). *On Structures in Medical Interactions*. University of Liverpool: unpublished PhD thesis.

Campion, P. & Langdon, P. (2004). 'Achieving multiple topic shifts in primary care medical consultations: a conversation analysis study in UK general practice'. *Sociology of Health & Illness*, 26(12), 81–101

Chen, A.W Kazanjian, A., Wong, H. (2008). 'Determinants of Mental Health Consultations Among Recent Chinese Immigrants in British Columbia, Canada: Implications for Mental Health Risk and Access to Services'. *J Immigrant Minority Health*, 10:529–540

Claramita, M., Nugraheni, M.D.E., van Dalen, J., van der Vleuten, C. (2013a). 'Doctor–patient communication in Southeast Asia: a different culture?'. *Adv Health Sci Educ Theory Pract*. 18 (1), 15–31

Claramita, M., Utarini, A., Soebono, H., & van der Vleuten, C. (2011a). 'Doctor–patient communication in a Southeast Asian setting: the conflict between ideal and reality'. *Advances in Health Sciences Education*, 16, 69-80.

Claramita, M., van Dalen, J., van der Vleuten, C. (2011b). 'Doctors in a Southeast Asian setting communicate sub-optimally regardless patients' educational background'. *Patient Education and Counseling*, 85, e169–e174.

Cohen, D. J., Clark, E. C., Lawson, P. J., Casucci, B., Flocke, S. A. (2011). 'Identifying Teachable Moments for Health Behavior Counseling in Primary Care'. *Patient Education and Counseling*, 85(2), e8–15.

Collins, S. (2005). 'Explanations in consultations: the combined effectiveness of doctors' and nurses' communication with patients'. *Medical Education*, 39, 785–796

Collins, S., Drew, P., Watt, I., Entwistle, V. (2005) 'Unilateral' and 'bilateral' practitioner approaches in decision-making about treatment'. *Social Science & Medicine*, 61, 2611–2627

Coupland, J. (2000). 'Introduction: Sociolinguistic perspectives on small talk'. In Coupland J (ed.), *Small talk*, 1–25. Edinburgh Gate, UK: Pearson Education.

Coupland, J., Coupland, N., & Robinson, J.D. (1992). '“How are you?” Negotiating phatic communion'. *Language in Society* 21:207–30.

Coupland, J., Robinson, J., & Coupland, N. (1994). 'Frame negotiation in doctor-elderly patient consultations'. *Discourse and Society*, 5, 89–124.

Cushing-Leubner, J., Bigelow, M. (2014). 'Principled eclecticism and the holistic approach to language teaching and learning'. In S. Çelik (Ed.), *Approaches and principles in English as a foreign language (EFL) education* (pp. 254-263). Ankara, Turkey: Egiten.

Davidson, A.S., Fosgerau, C.F. (2014) 'General practitioners' and psychiatrists' responses to emotional disclosures in patients with depression'. *Patient Education and Counselling*, 95, 61–68

Department of Health. (2010). *The Framework for NHS Involvement in International Development*. Available from <http://www.thet.org/hps/resources/publications-old/the-framework-for-nhs-involvement-in-international-development> (accessed 13.2.15)

Department of Health. (2014). *Engaging in Global Health: The Framework for Voluntary Engagement in Global Health by the UK Health Sector*. Available from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/352928/Engaging_in_Global_Health_1_.pdf (accessed 13.2.15)

- De Wit H (2010). Globalisation and internationalisation of higher education. *Revista de Universidad y Sociedad del Conocimiento (RUSC)*, 8:241-248 Available at http://www.nvao.net/page/downloads/Internationalisation_of_Higher_Education_in_Europe_DE_F_december_2010.pdf (Accessed 14.2.15)
- Doruk, S., Sevinc, C., Sever, F., İtil, O., Akkoçlu, A. (2012). 'The trends of relevance about telling lung cancer diagnosis: social constraints, medical practice in several clinics'. *Tuberk Toraks*, 60(4): 336-343
- Drew, P. (2006). 'Misalignments in 'after-hours' calls to a British GP practice: a study in telephone medicine'. In: Heritage J, Maynard D (eds). *Communication in medical care: interactions between primary care physicians and patients*, 416–444. Cambridge: Cambridge University Press.
- Drew, P., Chatwin, J., Collins, S. (2001) 'Conversation analysis: a method for research into interactions between patients and health-care professionals'. *Health Expectations*. 4(1), 58–70.
- Drew, P. and Heritage, J. (eds) (1992) *Talk at Work: Interaction in Institutional Settings*. Cambridge: Cambridge University Press.
- Dwamena, F., Holmes-Rovner, M., Gauden, CM, Jorgenson, S., Sadigh, G., Sikorskii, A., Lewin, S., Smith, R.C., Coffey, J., Olomu, A. (2012). 'Interventions for providers to promote a patient-centred approach in clinical consultations'. *Cochrane Database of Systematic Reviews* 2012, 12, Art. No.: CD003267.
- Edwards, A., Elwyn, G. (2009). *Shared decision-making in health care: Achieving evidence-based patient choice* Oxford, Oxford University Press.
- Eraut, M. (1994). *Developing professional knowledge and competence*. London: Falmer Press.
- Fort, M.P., Alvarado-Molina, N., Peña, L., Montano, C.M., Murrillo, S., Martínez, A. (2013). 'Barriers and facilitating factors for disease self-management: a qualitative analysis of perceptions of patients receiving care for type 2 diabetes and/or hypertension in San José, Costa Rica and Tuxtla Gutiérrez, Mexico'. *BMC Family Practice*, 14:131
- Fosgerau, C. F., Davidsen, A.S. (2014) 'Patients' Perspectives on Antidepressant Treatment in Consultations with Physicians'. *Qualitative Health Research*, 1–13
- Gafaranga, J. & Britten, K. (2013). "'Fire away": the opening sequence in general practice consultations'. *Family Practice*, 20, 242–247.
- Garfinkel, H. (1967). *'Studies in Ethnomethodology'*. Englewood Cliffs, NJ: Prentice-Hall.
- Garroutte, E.M., Kunovich, R.M., Buchwald, D., Goldberg, J. (2006) 'Medical Communication in Older American Indians: Variations by Ethnic Identity'. *The Journal of Applied Gerontology*, 25 (1) 27S-43S
- Giddens, A. (1990). *The Consequences of Modernity*. Stanford, CA: Stanford University Press.
- Giddens, A. (2003). *Runaway world: How globalisation is reshaping our lives*. New York: Routledge.
- Glazer, B. Strauss, A. (1967). *The Discovery of Grounded Theory*. Chicago: Aldine
- General Medical Council (2013) *Good Medical Practice*. London: GMC. Available at http://www.gmc-uk.org/guidance/good_medical_practice.asp, accessed 18.8.15

- General Medical Council (2015) Outcomes for Graduates: Tomorrow's Doctors. London: GMC. Available at http://www.gmc-uk.org/education/undergraduate/undergrad_outcomes.asp , accessed 18.8.15
- Goffman, E. (1959). *Presentation of Self in Everyday Life*. Garden City, New York: Doubleday Anchor Books.
- Goffman, E. (1983). 'The Interaction Order'. *American Sociological Review*, 48; 1-17
- Gongal, R., Vaidya, P., Jha, R., Rajbhandary, O., Watson, M. (2006). 'Informing patients about cancer in Nepal: what do people prefer?'. *Palliative Medicine*, 20: 471-476
- Goodwin, C. (2000). 'Action and embodiment within situated human interaction'. *Journal of Pragmatics* 32, 1489-1522.
- Greatbatch, D., Heath, C., Campion, P. and Luff, P. (1995) 'How do desk-top computers affect the doctor-patient interaction?' *Family Practice*, 12, 32-36
- Hartley, L.P. (1953). *The Go-Between*. London: Penguin Books Ltd.
- Harvey, D. (1998). *The Condition of Postmodernity: an inquiry into the conditions of cultural change*. Oxford: Basil Blackwell.
- Hashim, M.J., Major, S., Mirza, D.M., Prinsloo, E.A.M., Osman, O., Amiri, L., McLean, M. (2013). Medical Students Learning Communication Skills in a Second Language: Empathy and Expectations. *Sultan Qaboos University Med Journal*, 13 (1), 100–106.
- Have, P.ten. (1990). 'Methodological issues in conversation analysis'. *Bulletin de Méthodologie Sociologique*, 27, 2-51. Available at <http://www.paultenhave.nl/mica.htm> Accessed 13.8.15
- Have, P. ten. (2005). 'Conversation Analysis versus Other Approaches to Discourse. Review Essay: Robin Wooffitt (2005). *Conversation Analysis and Discourse Analysis: A Comparative and Critical Introduction*'. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*. 7(2), Art. 3. Available at <http://www.qualitative-research.net/index.php/fqs/article/view/100/209> Accessed 4.3.15
- Healthcare Alliance (2014). *The Future of Healthcare, a Collective Vision: Talent Fast Forward, Upskill Upscale*. New Delhi: The Healthcare Alliance.
- Heath, C. (1986). *Body movement and speech in medical interaction*. Cambridge: Cambridge University Press.
- Heath, C. (1989) 'Pain Talk: The Expression of Suffering in the Medical Consultation'. *Social Psychology Quarterly*, 52, 2, 113-125
- Heath, C. (1992). 'Delivery and Reception of Diagnosis in the GP Consultation', in Drew, P. and Heritage, J. (eds) *Talk at Work: Interaction in Institutional Settings*. Cambridge: Cambridge University Press.
- Heath, C. (2002). 'Demonstrative Suffering: The Gestural (Re)-embodiment of Symptoms'. *Journal of Communication*, 597–616.
- Heath, C. (2006). 'Body Work', in Heritage, J., Maynard, W.M. (eds.) *Communication in Medical Care: Interaction between primary care physicians and patients*. Cambridge, Cambridge University Press.

- Heath C., Hindmarsh J. (2001). 'Analysing Interaction: Video, ethnography and situated conduct', in May T. (ed) *Qualitative Research in Practice*, London: Sage.
- Heath, C., Hindmarsh, J., and Luff, P. (2010) *Video in qualitative research: Analysing social interaction in everyday life*. London: Sage.
- Henbest R.J. (1998). 'Patient-centredness in a black township: a prospective study amongst the private practitioners in Ga-Rankuwa, South Africa'. *SA Fam. Prac.* 19(3):75–9.
- Henbest, R.J. and Fehrsen, G.S. (1992). 'Patient-centredness: is it applicable outside the West? Its measurement and effect on outcomes'. *Family Practice.* 9: 311-317
- Heron, J. (1976). 'A Six-Category Intervention Analysis'. *British Journal of Guidance and Counselling* 4:2, 143-155.
- Heritage, J. (1998). 'Conversation Analysis and Institutional Talk: Analyzing Distinctive Turn-Taking Systems'. In: S.Cmejrková, J.Hoffmannová, O.Müllerová and J.Svetlá (eds.) *Proceedings of the 6th International Congress of IADA (International Association for Dialog Analysis)*, Tübingen: Niemeyer, pp.3-17
- Heritage, J., Clayman, S. (2010) *Talk in Action: Interactions, Identities, and Institutions*. Chichester: Wiley-Blackwell.
- Heritage, J., Maynard, W.M. (eds) (2006). *Communication in Medical Care: Interaction between primary care physicians and patients*. Cambridge, Cambridge University Press.
- Heritage, J., Robinson, J.D. (2006). 'The Structure of Patients' Presenting Concerns: Physicians' Opening Questions'. *Health Communication*, 19(2), 89–102.
- Heritage, J., Robinson, J., Elliott, M., Beckett, M., Wilkes, M. (2007). 'Reducing Patients' Unmet Concerns in Primary Care: the Difference One Word Can Make'. *J Gen Intern Med* 22(10):1429–33
- Heritage, J., Robinson, J.D. (2011) "'Some' vs 'Any', Medical Issues: Encouraging Patients to Reveal Their Unmet Concerns.' In Charles Antaki (ed.), *Applied Conversation Analysis: Changing Institutional Practices*. Basingstoke: Palgrave Macmillan: 15-31.
- Hewitt, H., Gafaranga, J., McKinstry, B. (2010). 'Comparison of face-to-face and telephone consultations in primary care: qualitative analysis.' *Br J Gen Pract* 2010; DOI: 0.3399/bjgp10X501831
- Holmes, J. (2000). 'Doing collegiality and keeping control at work'. In Coupland, J. (ed.), *Small talk*, 32– 61. Edinburgh Gate, UK: Pearson Education.
- Holmes, J. (2003). 'Small talk at work: potential problems for workers with an intellectual disability'. *Research on Language and Social Interaction.* 36(1); 65-84
- Howie JG.R., Heaney D. and Maxwell M. (2004). Quality, and core values and the general practice consultation: issues of definition, measurement and delivery. *Family Practice.* 21(4). 458-468
- Hudak, P. L. and Maynard, D. W. (2011), 'An interactional approach to conceptualising small talk in medical interactions'. *Sociology of Health & Illness*, 33 (4): 634–653.
- Ijäs-Kallio, T., Ruusuvoori, J. & Peräkylä, A. (2010). 'Patient resistance towards diagnosis in primary care: Implications for Concordance'. *Health* 14(5), 505–522
- Indian Government Planning Commission (2013). *Twelfth, five year plan 2012-17, Vol III*. New Delhi: SAGE Publications. Available at

http://planningcommission.gov.in/plans/planrel/12thplan/pdf/12fyp_vol3.pdf (Downloaded 23.8.14)

Ishikawa, H., Hashimoto, H., Roter, D., Yamazaki, Y., Takayama, T., Yano, E. (2005a). 'Patient Contribution to the Medical Dialogue and Perceived Patient-Centeredness: An Observational Study in Japanese Geriatric Consultations'. *Gen Intern Med.* 20:906–910

Ishikawa, H., Roter, D.L., Yamazaki, Y., Takayama, T. (2005b). 'Physician-elderly patient-companion communication and roles of companions in Japanese geriatric encounters'. *Soc Sci Med.* May; 60(10):2307-20.

Ishikawa, H., Roter, D.L., Yamazaki, Y., Hashimoto, H., Yano, E. (2006) 'Patients' perceptions of visit companions' helpfulness during Japanese geriatric medical visits'. *Patient Educ Couns.* 61(1):80-6.

Ishikawa, H., Yano, E., Fujimori, S., Kinoshita, M., Yamanouchi, T., Yoshikawa, M., Yamazaki, Y. and Teramoto T. (2009). 'Patient health literacy and patient–physician information exchange during a visit'. *Family Practice*, 26: 517–523

Jayadevan, P.K. (2012). 'Bangalore among the top 10 preferred entrepreneurial locations', *Economic Times*. Available at

http://articles.economictimes.indiatimes.com/2012-04-12/news/31574639_1_startups-venture-capital-early-stage (Accessed 23.8.14)

Jewitt, C. (2012). An introduction to using video for research. National Centre for Research Methods Working Paper 03/12. London: MODE node, Institute of Education.

Joosten, A., Mazeland, H., Meyboom-de Jong, B. (1999) 'Psychosocial explanations of complaints in Dutch general practice'. *Family Practice*, 16, 245-24

Kajubi, P., Bagger, S., Katahoire, A.R., Kyaddondo, D., Whyte, S.R. (2014). 'Spaces for talking: Communication patterns of children on antiretroviral therapy in Uganda'. *Children and Youth Services Review*, 3,36

Khalil, R.B. (2012). 'Attitudes, beliefs and perceptions regarding truth disclosure of cancer-related information in the Middle East: A review'. *Palliative and Supportive Care*, 1-10

Kiguli, S., Mafigiri, D., Nakigudde, J., Van Dalen, J., & Van der Vleuten, C. (2011). 'A qualitative study of caregivers' expectations and communication desires during medical consultation for sick children in Uganda'. *Patient Education and Counselling*, 84(2), 217–222.

Kim, Y.M., Kols, A., Bonnin, C., Richardson, P., Roter, D. (2001) 'Client communication behaviors with health care providers in Indonesia'. *Patient Educ Couns*, 45(1):59-68.

Kim, Y. M., Kols, A., Mucheke, S. (1998). 'Informed choice and decision-making in family planning counselling in Kenya'. *International Family Planning Perspectives*, 30(1), 4–11a.

Kim, Y. M., Odallo, D., Thuo, M., a Kols, A. (1999). 'Client participation and provider communication in family planning counseling: Transcript analysis in Kenya'. *Health Communication*, 11(1), 1–19.

Kim, Y.M., Putjuk, F., Basuki, E., Kols, A. (2003). 'Increasing patient participation in reproductive health consultations: an evaluation of "Smart Patient" coaching in Indonesia'. *Patient Educ Couns*, 50(2):113-22.

Kitzinger J (1995) Qualitative research: introducing focus groups. *BMJ* 1995; 311:299-302

- Kress, G. (2012) Mode: multimodality methodologies. IoE London Knowledge Lab. Video available here <http://mode.ioe.ac.uk/2012/02/16/video-resource-key-concepts-in-multimodality/> Last accessed 28.2.15
- Krupat, E., Hiam, C.M., Fleming, M.Z., Freeman, P. (1999). 'Patient-centredness and its correlates among first year medical students'. *Int J Psychiatry Med*; 29 (3): 347–56
- Kurtz, S.M., Silverman, J. and Draper, J. (1997). *Teaching and Learning Communication Skills in Medicine*. Abingdon: Radcliffe Medical Press.
- Kurzon, D. (1998) *Discourse of Silence*. John Benjamin's Publishing co: Amsterdam
- Kvale S (1996) *Interviews: An introduction to Qualitative Research Interviewing*. London: Sage
- Labhardt, N.D., Schiess, K., Manga, E., Langewitz, W. (2009) 'Provider-patient interaction in rural Cameroon-How it relates to the patient's understanding of diagnosis and prescribed drugs, the patient's concept of illness, and access to therapy'. *Patient Educ Couns*. 76(2):196-201
- Labhardt, N.D., Aboa, S.M., Manga, E., Bensing, J.M., Landewitz, W. (2010). 'Bridging the gap: how traditional healers interact with their patients. A comparative study in Cameroon'. *Tropical Medicine and International Health*, 15(9), 1099–1108
- Lambertz, K. (2011). 'Back-channelling: The Use of Yeah and Mm to Portray Engaged Listenership'. *Griffith Working Papers in Pragmatics and Intercultural Communication*, 4(1/2), 11–18.
- Laver, J. (1975). 'Communicative functions of phatic communion'. In Kendon, A., Harris, R. M. & Key, M.R. (eds.), *Organization of behavior in face-to-face interaction*, 215–38. The Hague: Mouton.
- Lee, K.H., Seow, A., Luo, N., Koh, D. (2008) 'Attitudes towards the doctor-patient relationship: a prospective study in an Asian medical school'. *Medical Education*; 42(11):1092-9.
- Little, P., White, W., Kelly, J., Everitt, H., Gashi, S., Bikker, A., Mercer, S. (2015). 'Verbal and non-verbal behaviour and patient perception of communication in primary care'. *Br J Gen Pract*; 65: 290-291.
- Liu, X., Sawada, Y., Takizawa, T., Sato, H., Sato, M., Sakamoto, H., Utsugi, T., Sato, K., Sumino, H., Okamura, S., Sakamaki, T. (2007). 'Doctor-patient communication: A comparison between telemedicine consultation and face-to-face consultation'. *Internal Medicine*. 46/5, 227-232.
- Loeffler, A. (2007) 'Individual Constitutions vs Universal Physiology: Iranian Responses to Allopathic Medicine'. *Body & Soul*, 13(3): 103–123
- Mak, B.C.N., Chui, L. H. (2013). 'A cultural approach to small talk: a double-edged sword of sociocultural reality during socialization into the workplace'. *Journal of Multicultural Discourses*, 8:2, 118-133
- Malinowski, B. (1923). 'The problem of Meaning in Primitive Languages'. In Ogden, C.K. and Richards, I.A. *The Meaning of Meaning; a study of the influence of language upon thought and of the science of symbolism*. (pp 296-336) New York Harcourt, Brace & World, Inc. Retrieved from <http://s-f-walker.org.uk/pubsebooks/pdfs/ogden-richards-meaning-all.pdf>
- Margalit, R.S., Roter, D., Dunevant, M.A., Larson, S., Reis, S. (2006). 'Electronic medical record use and physician-patient communication: an observational study of Israeli primary care encounters'. *Patient Educ Couns*. 61(1):134-141.

- Maringe, F., Foskett, N., Woodfield, S. (2013). 'Emerging internationalisation models in an uneven global terrain: Findings from a global survey'. *Compare: A journal of comparative and international education* 43, 1: 9-36.
- Maynard, D.W., Heritage J. (2005). 'Conversation analysis, doctor– patient interaction and medical communication'. *Med Educ*, 39, 428–35.
- Maynard, D.W., Hudak, P. (2008). 'Small talk, high stakes: Interactional disattentiveness in the context of prosocial doctor-patient interaction'. *Language in Society* 37, 661–688
- McCormick, K. A., Cochran, N.E., Back, A.L., Merrill, J.O., Williams, E.C., Bradley, K.A.(2006). 'How Primary Care Providers Talk to Patients About Alcohol, A Qualitative Study'. *Gen Intern Med*, 21,966–972.
- McIntosh, C.D.D., Ogunbanjo, G.A., (2008). 'Why do patients choose to consult homeopaths? An exploratory study'. *SA Fam Pract*, 50(3):69
- Medical Council of India. (2012). Regulations on graduate medical education, 2012. New Delhi: Medical Council of India. Available at http://www.mciindia.org/tools/announcement/Revised_GME_2012.pdf last accessed 16.8.1215.
- Mellow, J.D.(2000). 'An Examination of Western Influences on Indigenous Language Teaching', in Reyhner,J., Martin,J.,Lockard,L.,Sakiestewa Gilbert, W. (eds) *Learn in Beauty: Indigenous Education for a New Century*, Arizona, Northern Arizona University. Available at <http://jan.ucc.nau.edu/~jar/LIB/LIB9.pdf> last accessed 5.1.15.
- Mishler, E. (1984) *The Discourse of Medicine: Dialectics of Medical Interviews*, Norwood, NJ: Ablex.
- Mo, H.N., Shin, D.W., Woo, J. H., Choi, J.Y., Kang, J., Young J.B., Huh, Y.R., Won, J.H., Myung, H.P., Cho, S.H. (2012). 'Is patient autonomy a critical determinant of quality of life in Korea? End-of-life decision making from the perspective of the patient'. *Palliat Med*. 26: 222-231.
- Mohanna, K. (2015) Exploring the self-reported factors that influence academic under-performance of ethnic minority medical students (Commentary) *Education for Primary Care* 26, (1) 16-18.
- Mohanna, K.(2016) Family Medicine in India (Editorial) *Education for Primary Care*, 27:1, 2-2
- Mohanna K., Batra B. (2016) The what, why and how of Family Medicine in India, *Education for Primary Care*, 27:1, 74-77
- Moore, M. (2008). 'What does patient-centred communication mean in Nepal?'. *Med Educ*, 42, 18–26.
- Moore, M. (2009). 'What do Nepalese medical students and doctors think about patient-centred communication?'. *Patient Education and Counselling*,76, 38–43.
- Moore, M., Bhandari, R. (2012). 'Attitudes of Nepalese Medical Students Toward Telling Patients a Diagnosis of Cancer'. *J Family Med Prim Care*.1(2), 103–108
- Moore, M., Chaudhary, R. (2013). 'Patients' attitudes towards privacy in a Nepalese public hospital: a cross-sectional survey.' *BMC Research Notes* 6:31, 1-5.
- Moss, B., Roberts,C. (2005). 'Explanations, explanations, explanations: how do patients with limited English construct narrative accounts in multi-lingual, multi-ethnic settings, and how can GPs interpret them?'. *Family Practice*, 22: 412–418

- Neal, D. R., Ali, N., Atkin, K., Allgar, V.L., Ali, S., Coleman, T. (2006). 'Communication between South Asian patients and GPs: comparative study using the Roter Interactional Analysis System'. *British Journal of General Practice*, 56: 869–875.
- Neighbour, R.H. (1987). *The Inner Consultation*. Oxford: Radcliffe Publishing.
- Nessa J., Malterud, K. (1998). 'Feeling your large intestines a bit bound': clinical interaction – talk and gaze'. *Scand J Prim Health Care*, 16, 211-215
- Newman, W., Button, G., Cairns, P. (2010) 'Pauses in doctor–patient conversation during computer use: The design significance of their durations and accompanying topic changes'. *Int. J. Human-Computer Studies*, 68, 398–409
- Nielson, S.B. (2012). 'Patient initiated presentations of additional concerns'. *Discourse Studies* 14(5) 549–565
- Odura-Frimpong, J. (2011). 'Semiotic silence in intimate relationships .Much silence makes a powerful noise – African Proverb'. *Journal of Pragmatics* 43, 2331–2336
- Office for National Statistics. (2012). 2011 Census: Key Statistics for England and Wales. <http://www.ons.gov.uk/ons/rel/census/2011-census/key-statistics-for-local-authorities-in-england-and-wales/rpt-international-migrants.html> (Last accessed 1.3.13).
- Ogden, C.K., Richards, I.A.(1923). *The Meaning of Meaning*. London: Routledge and Kegan Paul.
- Ohtaki, S., Ohtaki, T., Fetters, M.D. (2003). 'Doctor–patient communication: a comparison of the USA and Japan'. *Family Practice* 2003; 20: 276–282.
- O'Malley, M. P. (2005). Silence as a means of preserving the status quo: The case of ante-natal care in Ireland. *Multilingua* 24, 39–54
- Pan, H., Norris, J.L., Liang, Y-S., Li, J-N., Ho, M- J. (2013). 'Building a professionalism framework for healthcare providers in China: a nominal group technique study'. *Medical Teacher*, 35: e1531–e1536
- Pandey, R. (2013) Role models in family medicine lacking in India. Interview with Kumar R. *Indian Medical Times* 18.1.13.
- Park, Y. (2013). 'Negotiating last-minute concerns in closing Korean medical encounters: The use of gaze, body and talk'. *Social Science & Medicine*, 97, 176-191.
- Pendleton, D., Schofieldm T., Tate, P. Havelock, P. (1984). *The Consultation: an approach to learning and teaching*. Oxford: Oxford University Press.
- Perakyla A. (1997). 'Conversation analysis: a new model of research in doctor-patient communication'. *Journal of the Royal Society of Medicine*, 90, 205-208.
- Pilnick (2010) 'Do your best for me': The difficulties of finding a clinically effective endpoint in smoking cessation consultations in primary care'. *Health*, 14(1), 57–74.
- Pilnick, A., & Coleman, T. (2003). "I'll give up smoking when you get me better": Patients' resistance to attempts to topicalise smoking in general practice consultations'. *Social Science and Medicine*, 57(1), 135–145
- Pilnick, A., Coleman, T. (2006). 'Death, depression and 'defensive expansion': Closing down smoking as an issue for discussion in GP consultations'. *Social Science & Medicine*, 62, 2500–2512.

- Posner, D., Hamstra, S.J. (2013). 'Too much small talk? Medical students' pelvic examination skills falter with pleasant patients'. *Medical Education* 47: 1209–1214.
- Potter, J. (1996). 'Discourse analysis and constructionist approaches: Theoretical background'. In J. T. E. Richardson (Ed.), *Handbook of qualitative research methods for psychology and the social sciences*. Leicester: BPS Books.
- Potter, J, Wetherell, M. (1987) *Discourse and Social Psychology: beyond attitudes and behaviour*. London: Sage
- Power, R.J.D., Dal Martello, M.F (1986). 'Some criticisms of Sacks, Schegloff, and Jefferson on turn taking'. *Semiotica* 58-1/2, 29-40.
- Psathas, G. (1995). *Conversation analysis: the study of Talk-in-Interaction*. Thousand Oaks: Sage
- Ragan, S.L. (1990). 'Verbal play and multiple goals in the gynaecological exam interaction'. *J. Lang. Social Psychol.*, 9 (1–2): 67–84.
- Ragan, S. L., (2000). 'Sociable talk in women's healthcare contexts: two forms of non-medical talk', In Coupland J (Ed.), *Small talk*, 269-288. Edinburgh Gate, UK: Pearson Education.
- Rahman,Ur, M., Abuhasna, S., Abu-Zidan. F.M. (2013). 'Care of terminally-ill patients: an opinion survey among critical care healthcare providers in the Middle East'. *African Health Sciences*; 13(4): 893 – 898
- Rampton, B. (2010). 'Linguistic Ethnography, interactional sociolinguistics and the study of identities'. In C.Coffin, T. Lillis and K.O'Halloran (eds) *Applied Linguistics Methods: A Reader*. 234-250. London; Routledge/Open University.
- Rampton, B. (2013). *Linguistic ethnography: what and why?* (Lecture notes, Ethnography, language and communication course). King's College London, 1-5 July 2013.
- Rampton, B., Maybin, J., Roberts, C. (2014) 'Methodological foundations in linguistic ethnography'. *Working Papers in Urban Language and Literacies* 125, 1-25, Basingstoke: Palgrave Macmillan.
- Rhodes, P., Small, N.,Rowley,E., Langdon,M., Ariss S.& Wright, J. (2008) 'Electronic Medical Records in Diabetes Consultations: Participants' Gaze as an Interactional Resource'. *Qual Health Res*, 18: 1247-1263.
- Roberts, C. (2004). 'Only connect: the centrality of doctor-patient relationships in primary care'. *Fam Pract*, 21,232–3.
- Roberts, C. (2010). 'Language, migration and the gatekeepers'. *Language Issues*, 2 (21), 4-18.
- Roberts, C. (2011). 'Performing the institutional self. Language, Identity, and Intercultural Communication'. A joint conference of the BAAL Intercultural Communication Special Interest Group and The Annual Bloomsbury Round Table. 9 -10 June, 2011. Birkbeck College, London
- Roberts,C., Atkins, S., Hawthorne, K. (2014) *Performance features in clinical skills assessment*. London: Centre for Language, Discourse and Communication, Kings College London.
- Roberts, C., Moss, B., Sarangi, S., Wass, V., Jones, R. (2005). *Misunderstandings in multilingual consultations*. *Medical Education*, 39: 465–475.

- Roberts, C., Sarangi, S. (2002). 'Mapping and assessing medical students' interactional involvement styles with patients. In: Spellman- Miller K, Thompson P, editors. *Unity and diversity in language use: British studies in Applied Linguistics 17*. London: Continuum.
- Roberts, C., Sarangi, S. (2003). 'Uptake of discourse research in interprofessional settings: Reporting from medical consultancy'. *Applied Linguistics*, 24 (3), 338-359
- Roberts, C., Sarangi, S. (2005). 'A theme-oriented approach to Discourse Analysis' *Medical Education*, 39 (6), 632-646.
- Roberts, C., Sarangi, S., Southgate, L., Wakeford, R., Wass, V. (2000). 'Oral examinations-equal opportunities, ethnicity, and fairness in the MRCGP British Medical Journal'. (*Clinical Research Ed.*), 320 (7231), 370-374.
- Roberts, C., Wass, V., Jones, R., Sarangi, S., Gillett, A. (2003) 'A discourse analysis study of 'good' and 'poor' communication in an OSCE: a proposed new framework for teaching students'. *Medical Education*, 37 (3), 192-201.
- Robinson, J.D. (1998). 'Getting Down to Business: Talk, Gaze and Body Orientation During Openings of Doctor-Patient Consultations'. *Human Communication Research*, 25(1), 97–123.
- Robinson, J.D. (2001). 'Closing medical encounters: two physician practices and their implications for the expression of patients' unstated concerns'. *Social Science and Medicine*, 53, 639–656.
- Robinson, J.D. (2003). 'An interactional structure of medical activities during acute visits and its implications for patients' participation'. *Health Communication*, 15(1), 27–59.
- Robinson, J.D. (2006). *Soliciting patients' presenting concerns*. In: Heritage J.D, Maynard D.W, editors. *Communication in medical care: interactions between primary care physicians and patients*. Cambridge: Cambridge University Press; 22–47.
- Robinson, J.D, Heritage, J. (2005) *The structure of patients' presenting concerns: the completion relevance of current symptoms*. *Soc Sci Med*, 61(2): 481–493.
- Robinson, J.D. & Stivers, T. (2001). 'Achieving Activity Transitions in Physician-Patient Encounters: From History Taking to Physical Examination'. *Human Communication Research*, 27(2), 253–298.
- Roter, D. (2004). *The Roter Interactional Analysis (RIAS) Coding Manual*. Baltimore, MD: Johns Hopkins University. <http://www.riasworks.com/background.html>
- Royal College of General Practitioners. (1972). *The Future General Practitioner: Learning and Teaching*. London: RCGP.
- Royal College of GPs.(2011) *Transforming our approach to international affairs - a 10-year strategy*, Available at <http://www.rcgp.org.uk/rcgp-near-you/rcgp-international/~media/Files/RCGP-Faculties/International/MRCGP-International-Strategy-June2011.ashx> (Accessed 13.2.15)
- Royal College of General Practitioners. (2012). *MRCGP Statistics 2011-12: Annual Report on the AKT and CSA Assessments*. Available <http://www.rcgp.org.uk/training-exams/mrcgp-exams-overview/mrcgp-annual-reports/mrcgp-annual-reports-2011-2012.aspx> (last accessed 29.2.13).
- Royal College of General Practitioners. (2013) *MRCGP Statistics 2012-13: Annual Report on the AKT and CSA Assessments*. Available <http://www.rcgp.org.uk/training-exams/mrcgp->

[exams-overview/mrcgp-annual-reports/mrcgp-annual-reports-2012-2013.aspx](http://www.rcgp.org.uk/training-exams/mrcgp-exams-overview/mrcgp-annual-reports/mrcgp-annual-reports-2012-2013.aspx) (last accessed 12.3.15)

Royal College of GPs (2014). MRCGP Statistics 2013-14. Available at <http://www.rcgp.org.uk/training-exams/mrcgp-exams-overview/mrcgp-annual-reports/mrcgp-annual-reports-2013-2014.aspx> (Last accessed 4.3.15)

Royal Courts of Justice. (2014). Judicial Review Judgment Neutral Citation Number: [2014] EWHC 1416 (Admin). CO/5157/2013. Available at <http://www.rcgp.org.uk/news/2014/may/~/-/media/Files/News/Judicial-Review-Judgment-14-April-2014.ashx> (Accessed 21.8.14)

Ruusuvuori, J.(2005). "'Empathy" and "Sympathy" in Action: Attending to Patients' Troubles in Finnish Homeopathic and General Practice'. *Psychology Quarterly*, 68(3), 204–222

Sacks, H., Schegloff, E.A., Jefferson, G. (1974). 'A simplest systematics for the organisation of turn taking for conversation'. *Language* 50(4), 696-735.

Schegloff, E. A. (1997) 'Whose Text? Whose Context?'. *Discourse and Society*, 8: 165-187.

Schegloff, E.A. (1998) 'Reply to Wetherell'. *Discourse and Society* 9:457-460

Schegloff, E.A. (1999) 'Schegloff's texts as Billig's data'. *Discourse & Society* 10(4) 558-572

Schegloff, E.A, Jefferson, G., Sacks, H. (1977). 'The preference for self-correction in the organisation of repair in conversation'. *Language*, 53:361-82

Schegloff, E.A., Sacks H. (1973). 'Opening up Closings'. *Semiotica*. 8:289-327

Schouten, B.C., Meeuwesen, L., Harmsen, H.A.M. (2009) 'GPs' Interactional Styles in Consultations with Dutch and Ethnic Minority Patients'. *J Immigrant Minority Health*, 11, 468–475

Sethlare, V., Couper, I., Wright, A. (2014). 'Patient-centredness: meaning and propriety in the Botswana, African and non-Western contexts'. *African J Primary Health Care Fam Med*, 6(1).

Siddiqui, H. (2014). 'GPs' exams disadvantage ethnic minority students'. *The Guardian*, 10.4.14 <http://www.theguardian.com/society/2014/apr/10/gps-exams-disadvantage-ethnic-minorities-high-court> (last accessed 23.8.14)

Sidhu, K. (2012). 'The CSA is failing international trainees'. *Pulse*, 23.1.12 <http://www.pulsetoday.co.uk/comment/opinion/the-csa-is-failing-international-trainees/13326299.article#.UTSY8al4Fc0> (last accessed 4.3.13)

Sidnell, J. (2010). *Conversation Analysis*, Chichester: Wiley-Blackwell

Sim, J (1998). 'Collecting and analysing qualitative data: issues raised by the focus group'. *J Adv Nurs* 28(2): 345-352

Siu, J. Y. (2014). "'Seeing a doctor is just like having a date": a qualitative study on doctor shopping among overactive bladder patients in Hong Kong'. *BMC, Family Practice*, 15:27.

Skelton, J., Kai, J., Laidon, R. (2001). 'Cross-cultural communication in medicine: questions for educators'. *Medical Education*; 35:257- 261

Slingsby, B.T., Yamada, S., Akabayashi, A. (2006). 'Four Physician Communication Styles in Routine Japanese Outpatient Medical Encounters'. *J Gen Internal Medicine*; 21:1057–1062

- Snell, J., Shaw, S., Copland, F (Eds) (2015) *Linguistic Ethnography: Interdisciplinary Explorations*. London: Palgrave Macmillan UK.
- Spencer-Oatey, H. (2008) 'Face, (im)politeness and rapport'. *Culturally speaking: culture, communication and politeness theory*, 11- 47
- Starfield, B., Shi, L., Macinko, J. (2005). 'Contribution of primary care to health systems and health'. *Milbank Quarterly*; 83(3):457-502
- Stivers, T.(2008). 'Stance, Alignment, and Affiliation During Storytelling: When Nodding Is a Token of Affiliation'. *Research on Language & Social Interaction*, 41:1, 31 - 57
- Stott, N.C.H., Davis, R.H. (1979). 'The exceptional potential in each primary care consultation'. *J R Coll. Gen. Pract.* 29: 201-5
- Sumathipala, A. (2014). 'Development of metaphors to explain cognitive behavioural principles for patients with medically unexplained symptoms'. *Int J Soc Psychiatry*. 60: 117
- Swinglehurst, D, Greenhalgh, T, Roberts, C. (2012) 'Computer templates in chronic disease management: ethnographic case study in General practice'. *BMJ Open* 2:e001754.
- Tashakkori, A., Teddlie, C. (Eds.) (2003), 'Advanced mixed methods research designs' in *Handbook of mixed methods in social and behavioral research*. Thousand Oaks, CA: Sage
- Ten Cate, O. (2013). 'Nuts and Bolts of Entrustable Professional Activities'. *Journal of Graduate Medical Education*, 5(1): 157–158
- Teng, C.L., Jamin,Z.M., Kamaruddin, N., I., M., Idris, S.A. (2003). 'Health beliefs, concerns and expectations of patients presenting with non-acute pain: A preliminary study from a government health clinic in Malaysia'. *Asia Pacific Family Medicine*; 2: 23–26
- Ur Rahman, M., Abuhasna, S., Abu-Zidan F.M. (2013). 'Care of terminally-ill patients: an opinion survey among critical care healthcare providers in the Middle East'. *African Health Sciences*, 13(4) 893-898
- Wass, V., Roberts, C., Hoogenboom, R., Jones, R., Van der Vleuten, C.(2003). 'Effect of ethnicity on performance in a final year objective structured clinical examination: qualitative and quantitative study'. *British Medical Journal*, 326 (7393), 800-803.
- Watson, O. (2012). *The Language of Clinical Empathy: Modelling affiliation in doctor-patient communication*. University of Sydney dissertation (Unpublished)
- Weingarten, M.A., Guttman, N., Abramovitch, A., Margalit, R.S., Roter, D., Zivg, A., Yaphea, J., Borkan, J.M. (2010). 'An anatomy of conflicts in primary care encounters: a multi-method study'. *Family Practice*, 27(1), 93–100
- Wetherell, Margaret. (1998). 'Positioning and interpretative repertoires: Conversation analysis and poststructuralism in dialogue'. *Discourse and Society*, 9(3), 387–412
- Williams S., Harricharan,M., Bidyadhar, S. (2013). 'Nonverbal Communication in a Caribbean Medical School: "Touch Is a Touchy Issue"', *Teaching and Learning in Medicine: An International Journal*, 25:1, 39-46,

Appendices

Appendix A1: RCGP Generic Indicators for CSA Assessment Domains

GENERIC INDICATORS FOR TARGETED ASSESSMENT DOMAINS	
1. DATA-GATHERING, TECHNICAL & ASSESSMENT SKILLS: <i>Gathering & using data for clinical judgement, choice of examination, investigations & their interpretation. Demonstrating proficiency in performing physical examinations & using diagnostic and therapeutic instruments (Blueprint: Problem-solving skills, Technical Skills)</i>	
<p>Positive Indicators</p> <ul style="list-style-type: none"> • Clarifies the problem & nature of decision required • Uses an incremental approach, using time and accepting uncertainty • Gathers information from history taking, examination and investigation in a systematic and efficient manner. • Is appropriately selective in the choice of enquiries, examinations & investigations • Identifies abnormal findings or results & makes appropriate interpretations <ul style="list-style-type: none"> • Uses Instruments appropriately & fluently • When using instruments or conducting physical examinations, performs actions in a rational sequence 	<p>Negative Indicators</p> <ul style="list-style-type: none"> • Makes immediate assumptions about the problem • Intervenes rather than using appropriate expectant management • Is disorganised/unsystematic in gathering information • Data gathering does not appear to be guided by the probabilities of disease. • Fails to identify abnormal data or correctly interpret them <ul style="list-style-type: none"> • Appears unsure of how to operate/use instruments • Appears disorganised/unsystematic in the application of the instruments or the conduct of physical examinations
2. CLINICAL MANAGEMENT SKILLS: <i>Recognition & management of common medical conditions in primary care. Demonstrating a structured & flexible approach to decision-making. Demonstrating the ability to deal with multiple complaints and co-morbidity. Demonstrating the ability to promote a positive approach to health (Blueprint: Primary Care Management, Comprehensive approach)</i>	
<p>Positive Indicators</p> <ul style="list-style-type: none"> • Recognises presentations of common physical, psychological & social problems. • Makes plans that reflect the natural history of common problems • Offers appropriate and feasible management options • Management approaches reflect an appropriate assessment of risk • Makes appropriate prescribing decisions • Refers appropriately & co-ordinates care with other healthcare professionals <ul style="list-style-type: none"> • Manages risk effectively, safety netting appropriately • Simultaneously manages multiple health problems, both acute & chronic • Encourages improvement, rehabilitation, and, where appropriate, recovery. • Encourages the patient to participate in appropriate health promotion and disease prevention strategies 	<p>Negative Indicators</p> <ul style="list-style-type: none"> • Fails to consider common conditions in the differential diagnosis • Does not suggest how the problem might develop or resolve • Fails to make the patient aware of relative risks of different approaches • Decisions on whether/what to prescribe are inappropriate or idiosyncratic. • Decisions on whether & where to refer are inappropriate. • Follow-up arrangements are absent or disjointed <ul style="list-style-type: none"> • Fails to take account of related issues or of co-morbidity • Unable to construct a problem list and prioritise • Unable to enhance patient's health perceptions and coping strategies
3. INTERPERSONAL SKILLS <i>Demonstrating the use of recognised communication techniques to gain understanding of the patient's illness experience and develop a shared approach to managing problems. Practising ethically with respect for equality & diversity issues, in line with the accepted codes of professional conduct. (Blueprint: Person-Centred Approach, Attitudinal Aspects)</i>	
<p>Positive Indicators</p> <ul style="list-style-type: none"> • Explores patient's agenda, health beliefs & preferences. • Appears alert to verbal and non-verbal cues. • Explores the impact of the illness on the patient's life • Elicits psychological & social information to place the patient's problem in context • Works in partnership, finding common ground to develop a shared management plan • Communicates risk effectively to patients • Shows responsiveness to the patient's preferences, feelings and expectations • Enhances patient autonomy • Provides explanations that are relevant and understandable to the patient <ul style="list-style-type: none"> • Responds to needs & concerns with interest & understanding • Has a positive attitude when dealing with problems, admits mistakes & shows commitment to improvement. • Backs own judgment appropriately • Demonstrates respect for others • Does not allow own views/values to inappropriately influence dialogue • Shows commitment to equality of care for all • Acts in an open, non-judgmental manner • Is cooperative & inclusive in approach <ul style="list-style-type: none"> • Conducts examinations with sensitivity for the patient's feelings, seeking consent where appropriate 	<p>Negative Indicators</p> <ul style="list-style-type: none"> • Does not inquire sufficiently about the patient's perspective / health understanding. • Pays insufficient attention to the patient's verbal and nonverbal communication. • Fails to explore how the patient's life is affected by the problem. • Does not appreciate the impact of the patient's psychosocial context • Instructs the patient rather than seeking common ground • Uses a rigid approach to consulting that fails to be sufficiently responsive to the patient's contribution • Fails to empower the patient or encourage self-sufficiency • Uses inappropriate (e.g. technical) language <ul style="list-style-type: none"> • Shows little visible interest/understanding, lacks warmth in voice/manner • Avoids taking responsibility for errors • Does not show sufficient respect for others. • Inappropriately influences patient interaction through own views/values • Treats issues as problems rather than challenges • Displays inappropriate favour or prejudice • Is quick to judge • Appears patronising or inappropriately paternalistic <ul style="list-style-type: none"> • When conducting examinations, appears unprofessional and at risk of hurting or embarrassing the patient

Appendix A2: Looking at the general practice consultation around the world.

A.1 Introduction

As part of the background to this thesis I looked at what had already been published about general practice in contexts outside the UK, particularly focussing on the research methods that had been used, to help inform my choice of methodology. This appendix contains the outcome of this literature review, which is important, but is not core to the thesis.

In common with other settings of education and training, general practice training is affected by the twin themes of globalisation and internationalisation (see de Wit 2010 for examples from higher education). Globalisation has been defined by Giddens (1990, p64) as 'the intensification of worldwide social relations which link distant localities in such a way that local happenings are shaped by events occurring many miles away and vice versa'. In the UK National Health Service (NHS) and the RCGP this intensification is matched by an international agenda to support the development of public health and in particular primary care around the world. (DH 2010, RCGP 2011, DH 2014). In this context internationalisation has been defined by Maringe et al (2013, p11) as a 'developmental process through which institutions continuously seek the creation of more and more value in the global context'. This value will be manifest in a variety of ways including commercial or economic value.

In 2011 the RCGP International Committee published a ten year strategic plan, with the aspiration for 'a world where excellent, person-centred care in general practice is at the heart of health care' and which included the following strategic priorities: 'to increase the [worldwide] quality of education and delivery of general practice or family medicine and to increase support for international and overseas members'. The RCGP aspires both to train doctors within the NHS who will then return to their home country to practice and to support healthcare workers to stay in-country, by supporting local educational and training opportunities through 'expertise in primary healthcare education and training' (RCGP 2011 p3).

However, as trainees or trainers move between settings, it is important to take into account any possibility of context specific differences in practice to avoid tensions being built up between the twin imperatives of the globalisation of curricula and localisation of practice, between training approaches and features of settings in which either party works. The practice of twenty-first century medicine is changing in line with societal changes described in a short-hand as *post-modernism* (Harvey 1998, p39-65). In a post-modern paradigm, questions are asked about the organisation of knowledge and emphasis is placed on heterogeneity, concern for the 'other' and an acknowledgment of the dispersed, and contingent, nature of expertness. Thus in the UK we

see a rise in the emphasis on patient-centeredness. However the transition to a post-traditional society is said to occur unevenly across societies and across cultures (Beck 1992; Giddens 2003) and learners risk being caught as they move from one model to another, potentially experiencing things they could not anticipate and for which they find themselves ill-equipped.

Whilst the movement of healthcare professionals provides a potential benefit for patients it also requires medical educators and workplace supervisors to clarify assumptions and often implicit understandings about the nature of the professional role (Allen and Mohanna 2013, p85-103). Consistent with this, Setlhare et al in Botswana have issued a call for researchers to examine the:

[acceptance of the] universal appropriateness of the meaning and application of the Eurocentric model of patient centredness (PC) [which] needs to be backed by evidence from research in non-Western contexts...

Patient-centredness may mean different things in different settings. It may be applied differently in various contexts. The term PC does not exist in Setswana and some other languages.... The absence of this term may mean the absence of this construct in non-Western regions

(Setlhare 2010 p1).

The RCGP model of the doctor-patient relationship, whilst acknowledging patient difference, does not take account of the possibility of doctor - differences or fully address the issue of the co-construction of healthcare reality between patients and doctors.

Given the relative lack of established primary care in many non-western settings, the data on international models of consulting is limited. Some of the information below comes from women's and children's health clinics or general medical out-patient clinics that approximate to the type of patient contact – first contact, undifferentiated – that we might recognise as primary care in other settings.

A.2 Methodology for the literature review

This literature review was carried out using the Embase, Assia, psychINFO and pubmed databases. The search terms were doctor-patient interpersonal communication, consultation models, general pract*, "family medicine", NOT UK, North America. After I excluded those based in European or Australian general practice, 44 papers were retrieved.

On reading all of these, only 18 used observation of doctor-patient interactions either in real time or audio or video-recorded. They applied three main differences in methodological

approaches: rating or coding systems, grounded theory or intervention studies. The 26 remaining papers gathered data through focus groups, interviews and questionnaires and are not considered further here ²³.

A.3 Using a rating or coding approach to analysis

Henbest and Fehrsen (1992, p311-317) combined an analysis of audio-recorded consultations between doctors and patients in South Africa with exit interviews with patients. Their concern was very similar to some of the concerns of the international doctors interviewed for this thesis and was specifically to address the question:

‘Is [patient-centredness] just a luxury for the first world, the educated, the affluent, the West, or is it an important component of all patient care, including that of the third world, the uneducated, the poor, those outside the West? Is a patient-centred approach practical when doctors are faced with a heavy workload, a high proportion of organic pathology, and cross-cultural situations, especially those involving interpreters?’

(Henbest and Fehrsen 1992, p311).

Consultations in three state family medicine clinics in two black townships with patients over the age of 16 were audio-recorded. Over one-third of patients had not completed primary level education and only 2% had gone on to higher education. Seven doctors and three nurse practitioners timed the consultations, and then gave each a global assessment considering the extent to which they felt the extent it demonstrated, on a 0-3 scale, that the ‘expression of the patient's thoughts, feelings, or expectations was specifically facilitated’. The mean score was 1.95, with an approximately normal distribution. Mean length of consultation was 11.6 minutes. Each patient was interviewed following a semi-structured questionnaire format immediately after the consultation. Overall patients reported feeling understood by the practitioner in 75% of cases and 90% of them agreed with the diagnosis proffered. There was a linear association

²³ These excluded papers include opinion pieces - the meaning and propriety of patient-centredness in Botswana (Selthare 2010), allopathic medicine in Iran (Loeffler 2007); homeopathy in South Africa (McIntosh 2008); a trial of a new consultation model based on use of metaphor in Sri Lanka (Sumathipala 2014); three papers from Oman - the experience of brain injury (Al Adawi 2012), exploration of health seeking behaviours (Al Busaidi 2010a) and a literature review on somatization (Al Busaidi 2010a); work on professionalism in China (Pan 2013), Saudi Arabia (al Eraky 2012) and Yemen (Abadel 2014); four papers focusing on the experience of minorities in a Western setting - Native Americans (Garrouette 2006), South Asians in Yorkshire (Neal 2006), Minorities in Holland (Schouten 2006), Chinese in Canada (Chen 2008); issues around diagnosis disclosure or decision making in cancer and end of life care in United Arab Emirates (ur Rahman 2013), Korea (Mo 2012), Nepal (Gongal 2006, Moore 2012), Turkey (Doruk 2012), Lebanon (Khalil 2012); exploration of health beliefs in Malaysia (Teng 2003), with medical students in the West Indies (Williams 2013); doctor shopping in Hong Kong (Siu 2014); on privacy in Nepal (Moore 2013), Self care in Mexico (Fort 2013); interviews with children living with HIV in Uganda (Kajubi 2014).

between the extent of 'patient-centredness' assessed using the study scoring method and the expressed patient outcomes. On the surface this appears to be a well-designed study and it is thoroughly described with detail that gives confidence in their methodology. However it is of note that 100% of the 101 patients approached all agreed to be audio-taped. In South African black townships at this time, the differential demographic of the practitioner and patient groups raises a question about the degree to which any unintended coercion of participants might have been at play as a result of the power or status differential. This might have affected entry into the study, and also expressed satisfaction and perceived ability to disagree with the practitioner-diagnosis.

One year after publication of this work another, confirmatory, study was planned, completion and publication of which was interrupted by the immense political and social upheaval in South Africa between 1993-94. After five years a paper was published reporting on a similarly designed study this time in private clinics where patients paid out-of-pocket for service (Henbest 1998 p75-79). Compared to the first study the average educational achievement of the study sample was much higher, only 11% had not completed primary education and 20% had completed higher education. In this study the mean consultation time was considerably shorter, at three minutes six seconds with some as short as one minute. As a summary statistic about the consultation, the mean duration does not tell us much about the quality of the interaction but it does give us one way to make comparisons about the interaction as a starting point and I also adopted this approach as a first step in my own analysis. A similarly high participation rate was achieved of 94% of those invited to take part but a very low 'patient centered score', as defined by the authors using their 0-3 scale, was found. Only 4 consultations achieved their definition of 'patient-centeredness' (a score of two or more out of three). Nevertheless 100% of patients said they felt understood by the doctor, 95% felt they understood what the doctor had said to them and 95% were satisfied with the consultation.

In the face of such short consultation times (which we might speculate are driven in part by the financial imperative to see large numbers of patients in a private clinic), it does not seem at all surprising that by any measure that purports to look at the ability of the practitioner to 'fully enter the life-world of the patient' (which is the claimed meaning of a score of three out of three on Henbest's patient-centeredness tool), scores will be low. Nonetheless these patients claimed very high satisfaction levels. Either these patients do not need to be seen in patient-centered consultations to feel they have had good care, or this tool cannot measure patient-centredness, or excellence in practice in this setting derives from some other aspect.

Another study in Africa used a checklist approach to coding aspects of the consultation, in the context of family planning providers in Kenya. Two papers appear to draw on the same data set; one looking at elements of informed consent (Kim 1998, p4-11) and one at the balance of

'client/provider' participation (Kim 1999 p1-19). In the first of these studies, analysis of audiotaped consultations with 176 women was considerably hampered by the need for the consultations to be translated out of local languages into English. The talk was analysed by comparison to a checklist of information to be covered, drawn up specifically for the first paper, and in the second was coded using a modification of the Roter Interaction Analysis System (RIAS) (Roter 2004) and labelled by coders who had had one day of training in the methodology.

The RIAS system was developed in the late 1970s and is a software programme that helps summarise talk in a consultation. Usually video or audio data is directly uploaded into RIAS, each utterance is coded by trained coders (the software is only available to those attending training courses) according to a 41 category checklist. This contains items such as 'laughs, tells jokes', 'shows approval', 'shows concern or worry' and 'unintelligible utterances'. The system displays summary statistics such as proportion of time each interactant speaks for and duration of the consultation. In this study (Kim 1998, 1999) providers spoke on average 66% of the total number of sentences in a session, and clients 34%; patient interjections tended to be much shorter, and often one word, answers to direct questioning. The authors state that 'the relationship between doctor and patient is highly unequal, based on differences in knowledge and social background, and patients are accustomed to being "recipients" of medical care rather than "participants"' (Kim 1998 p 15). However neither concordance with medical advice nor satisfaction with the encounter was looked at in either paper which combined with the potential unreliability of the transcribed data weakens the findings.

Four years later a paper, based on data that had been collected at the same time and by some of the same investigators as the Kenyan work, looked at 'feasibility, acceptability, and effectiveness of client-centered models of communication in 31 family planning clinics in Egypt'. (Abdul Taweb 2002 p1357-1368). In this project 112 audiotaped consultations were coded using an adaptation of the RIAS system. From the original 41 RIAS codes, these authors derived what they considered to be seven 'mutually exclusive and exhaustive categories of talk' namely: showing solidarity with the client, facilitating client participation, giving information, (which three codes were considered to be patient centred); asking questions, instructing the client, giving directions and negative talk or showing disagreement (considered to be doctor centred). An 'index of patient centredness' was calculated based on the ratio of the number of utterances in the first category to those in the second category. The findings were that doctors tended to speak for twice as long as patients and used twice as many category two utterances as category one. Exit interviews were used to look for the degree of patient satisfaction. Labelling talk in this way, without looking to see the response of the hearer, has significant limitations, as has all the work using the RIAS system depending, as it does, on volume of talk (number of utterances) and an interpretation of meaning by the observer. However it does have

some productivity which here was enhanced by the combination with exit interviews. A direct relationship was found between the study-defined index of patient-centredness and markers of patient satisfaction in the interviews and concordance with chosen family planning methodologies over the seven months of follow up.

In a RIAS-based study in Israel, Weingarten also carried out a multi-method study to analyse video-taped consultations looking at areas of conflict that challenged the doctor-patient relationship (Weingarten et al 2010 p93-100). This extended the use of RIAS, to a combination approach with a focus group exploration with 56 GPs. Coders found a very high number of doctor-patient conflicts (40% of consultations). Faced with this data, discussions revealed the GPs' belief that this reflected a changing position of the doctor within this society and a change in the way patients see doctors. Without the quantitative data available from the RIAS, it would be much less easy to make visible, and then discuss, what was happening in the consultation.

A.4 A grounded theory approach

Slingsby et al also combined interview data with direct observation of practice in Japan, using modified grounded theory. The study was informed by their understanding that:

Contextual factors such as culture, language, gender relations, and health care systems influence physician communication styles. Researchers have developed models of physician communication styles, but how well [they] apply to the clinical milieu of non-English-speaking countries is unknown'

(Slingsby 2006 p1057).

Through speaking to doctors, patients and nurses about the consultations they observed, the authors present data from an exploratory, theory generating study and derived four communication styles along a spectrum from 'defined' to 'collaborative'. The most 'defined style' left no room at all for relationship building, derived from those physicians' understanding "that clinical medicine is technical (e.g., defined by test results) and not humanistic (i.e., dependent upon physician- patient communication)" (p 1059). The authors state that these doctors "*intentionally left out small talk*" (Slingsby 2006, p1059, emphasis added). This suggests that some of the doctors interviewed find small talk inappropriate in the consultation and seems to have relevance to my own study where an observation about the use of small talk became the focus of interest. Notwithstanding the risks involved in drawing conclusions from what doctors say they do, rather than what they can be observed to do, the authors conclude from the outcomes of their interviews with patients that this form of lack of patient involvement, in this society, could still be associated with high levels of patient satisfaction:

“patients felt comfortable with physicians with [defined-style] communications skills as long as their nurses were effective mediators. This suggests that indirect forms of communication, in which physician and patient communicate with each other through their nurse, can be just as effective as direct forms as long as the physician works collaboratively with his or her nurse”

(Ibid p1061).

The authors describe four different styles, including much more collaborative approaches, so it cannot be concluded however that all patients (and society) have just come to accept, or actually privilege this mediated style of communication or that patients would not rather have access to physicians directly through more informal conversation. The use of a theory-generating approach was useful in this study, and has enabled a variety of styles to be identified in Japanese medical practice and link this to the patient view.

A.5 Including accompanying persons

Japan is a setting where societal organisation is said to exhibit a clear hierarchy and code of behaviour which is likely to influence what happens in the clinic. Researchers there are producing a growing number of papers on physician communication styles including Ishikawa’s work in general geriatric clinics (Ishikawa 2005a, 2005b, 2006). Here, patients are commonly accompanied by a family member or companion and the team explored issues of patient-involvement and patient-centred talk, in the presence of a third party, through recordings of consultations and questionnaires completed by both parties. It seems likely that accompanied patients would share the ‘talk-time’ with their companion, and might have issues of cognitive decline that necessitated a companion to come, so it is unsurprising that patients with a companion present found the consultations less focussed on them even when they lasted longer. But these patients also expressed less satisfaction. The authors draw attention to the lack of published information about triadic consultations. In just over half of my 18 videos the patient was accompanied, by up to three other people at times, although I did not look directly at this.

A.6 Consultations incorporating technology

As primary care has developed around the world so has the prevalence of electronic medical records (EMR). A 2006 study from Israel set out to look at the degree to which the use of a computer affected patient centredness by timing the number of seconds doctors gazed at their screens and noted that the computer significantly decreased the amount of time the doctor was interactionally available for the patient. This group of observed doctors, who were experienced in the use of the EMR and had had several years to get used to using it, likened the computer

to 'an intruding third party in the medical dialogue' (Margalit 2006 p134-141). By labelling the utterances in the consultation and noting direction of gaze they noticed that it was in particular the psychosocial and emotional domains of the consultation that were diminished by viewing the computer, which overall lead to a lower degree of patient centredness. The authors go on to speculate that 'collaborative reading' of the EMR could contribute to improved quality of care since such collaborative reading would enhance the decision-making process, and empower patients to participate in their own care. This study shows the importance of being able to take account of gaze and gesture to describe what happens between a doctor and a patient. This was over 20 years after the first work of this type in the UK from Greatbatch in 1995 and illustrates the spreading adoption of methodologies, such as analyses of gaze and gesture, borrowed from conversation analysis.

There is one videoed consultation in my dataset which is marked by heavy use of the computer. This consultation lasted over 19 minutes and, other than some talk directly determined by the computer itself, such as comments on which key to press or how easy or otherwise it was to use, has no instances of non-medical talk. It does however have episodes of silence lasting over two minutes at a time when the doctor was pre-occupied with scrolling through data on the laptop, which seems to accord with the findings of Margalit et al. Analysis of gaze and gesture in the consultation can be productive in terms of understanding the barriers to doctors exhibiting interest in the patient's life-world.

A Japanese study looked at the effect of telemedicine - of consulting on-line using a camcorder - and compared this with the same doctors face to face with patients (Liu et al 2007 p227-232). They found that telemedicine consultations were generally shorter than face to face and contained fewer utterances they describe as 'empathy utterances', 'praise-utterances', and 'facilitation-utterances' from the doctors than in face to face consultations carried out by the same doctors. Patients tended not to feel telemedicine had affected the quality of the consultation, whereas doctors were dissatisfied with the experience and did not feel they could so easily get to the bottom of a patient's concerns; it is possible this is related to a fear of missing something through being unable to examine the patient. This work makes a useful contribution since it is likely such on-line consulting is set to be a much more common experience in a resource constrained era.

A.7 Research with patient sub groups

In their work, Ishikawa and colleagues reviewed 134 video recorded consultations and interviewed patients in Tokyo clinics who had been asked to self-rate their degree of health literacy (Ishikawa 2009). By coding all the doctor remarks they claim that physicians exhibited flexibility and were able to effectively alter their communicative strategy in response to the

varying health literacy needs of patients. This is a key finding as in Japan, the authors feel, there is societal pressure against asking questions of healthcare providers and those with low health literacy, who are also known to be less likely to consult other sources of information such as the internet, might otherwise receive incomplete advice. This work contrasts with work from Indonesia which analysed audio-taped consultations with patients, categorized into a group with a high and a group with a low educational level (Clarimita 2011b). They claimed to find that doctors used a 'paternalistic style' irrespective of patients' educational background. In this study (2011b) the doctors were still in training which might have affected their ability to be flexible in practice, were consulting at a rate of one patient every 5 minutes or so and were largely unsupported by senior staff who were said to 'spend most of their time in private practice elsewhere' (p170). The methodology of these studies is very similar and utterances were judged by observers as to whether they were, for example, open or closed questions, instruction giving, eliciting understanding. Of relevance to my study, the authors found that, for their respondents, irrespective of patients' educational background, communication was characterized by mostly medical content (asking or giving medical information) rather than socio-emotional conversation. The coding of utterances highlighted a very low level of what they called 'personal' talk.

Clarimita (2011b) and Moore (2009) suggest that in hierarchical societies such as Indonesia or Nepal patients are inclined to place greater value on 'caring' than on 'sharing' as a measure of patient centeredness. (Although in the fast-paced and junior-led service that Clarimita observed, they concluded neither was practiced). These terms are derived from the Patient-Practitioner Orientation Scale (Krupat 1999) and Lee et al used this scale to show that this view was also expressed by Indonesian medical students (Lee 2008). Sharing attitudes are those such as the degree to which a doctor feels information and control should be shared between doctor and patient; and caring, the degree of importance attached to the warmth and support contained in the doctor-patient relationship. Thus the centrality of the patient to the healthcare exchange is signalled within a hierarchical structure by the care the doctor shows to the patient rather than the extent to which they are consulted or asked for their opinion. That is an assumption that remains to be tested in the practice of experienced doctors and in particular by matching observed practice to a reliable indicator of patient satisfaction.

There is an interesting incidental finding in the pilot stage of Clarimita's work. In addition to the more junior interns and residents whose practice was recorded for the main study, the authors had observed two experienced doctors at work. Although not recorded in a systematic way, they report an observation that when they looked at the content of talk these seniors used more 'personal' utterances; talk, for example, included 'last night's movie on television' (2011b p173). The trainees moving to the UK for higher specialty training and assessment are generally juniors (although on average more senior than the UK candidates measured by time since

primary medical qualification ²⁴) and hence perhaps it is a feature of increasing confidence in practice that enables doctors to include small talk in the consultation and use it as a way of 'entering the life-world of the patient' (Mishler 1984, p 162).

A.8 Intervention studies

Kim et al also looked at decision-making in Indonesia during 1203 audio-taped family planning consultations (Kim 2001 p59-68). They found that several factors increased the chance of patients participating in medical decision making including information giving and higher patient educational level. The authors felt this suggested patient participation could be increased with training and two year later they tested this out. Educators set up a coaching system to teach patients strategies for asking questions, expressing concerns, and seeking clarification. An analysis of audiotaped consultations found that it did help patients ask more questions and the rate of discontinuation of treatment was (marginally) lower in the intervention group (Kim 2003 p113-122).

In a further intervention study, Larbhardt and colleagues working in Camaroon, applied the RIAS coding system. In stage one (2009 p196-201) they interviewed patients and looked at how much they could recall of the consultation. They concluded from the interviews that doctors should aim to enhance understanding and recall by including more medical explanations plus exploring, then incorporating, patients' health beliefs in a non-judgemental manner. A year later they then compared visits to traditional healers and western doctors (2010 p1099-1108) looking for some of these previously recommended actions. Video-recorded consultations with 74 patients, roughly half with a traditional healer and half with a western style local physician, were analysed. Those visiting traditional healers paid more, sometimes a lot more (up to 12 times) than others and travelled further to seek help. So, the authors conclude, patients are not visiting local healers because they are more convenient, or available or cheaper, and they are prepared to pay vast sums to seek their help, suggesting they found the consultations useful. By coding all the doctors' talk they concluded that traditional healers focussed more on psychosocial topics and on issues of daily life than on purely medical questions and, in particular, they more often asked for the patient's opinion and frequently discussed their concept of illness. Despite this, the time spent talking was less for patients in consultation with traditional healers although patients were encouraged to ask more questions themselves. The findings seem to support Selthare's view that it is the locally-sensitive enactment of patient centredness that is key to patient satisfaction.

²⁴ In 2014, 51% of UKGs sitting the exam had graduated in 2009 (the shortest possible time since primary medical qualification for those eligible for this diet) compared to 2.6% of IMGs; only 0.9% of UKGs had graduated in or before 1999 whereas 33% of IMGs had graduated in or before 1999)

A.9 Conclusion

This review of the published work looking at doctor-patient consulting around the world has shown that there is not one universal picture of what patients expect, or what effective consulting looks like. Some common themes were noted including the contrast between an expressed intention to aim for patient-centredness and the degree of patient involvement in decision making and the need of some patients, including those with lower health literacy, to depend on their physicians as the sole source of information. It is of note that, by careful analysis of naturally occurring consultation data, it was possible to show that patients consulting traditional, 'non-western', or homeopathic healers might not get more time – which has often been postulated as the reason for their increasing popularity - but do seem to be invited into the discussion more. In Japan the work of Ishikawa suggests that there appears to be a range of interactional flexibility of doctors combined with elements of societal hierarchy that has emphasised reliance on nurses or companions as channels for information. In some settings the speed with which doctors consult and the pace and volume of work seems to be a barrier to full information-giving or patient involvement.

Thus the view of Slingsby 2006 (quoted above) seems to be borne out by this limited evidence: 'Contextual factors such as culture, language, gender relations, and health care systems influence physician communication styles' (p1057).

However a key finding about most of this work is that much use has been made a pre-formed coding system to look at the conversational exchanges. This does not take into account the extent to which doctors and patients work interactionally to determine what happens. As a respondent in Slingsby's work stated:

It's important to pay attention not so much to what a patient says but to **how** she says it - to tone, speed and volume of her voice and to changes in facial expressions...obviously if a patient says, 'I am worried', her words are important. But it is more common for patients not to say this sort of things. It is more important to pay attention to **how** a patient expresses herself than what she says. Physicians have to understand their patients by sensing what they feel. (Physician 9)

(Slingsby 2006, p1059).

Appendix A3.Ethics approval and consent forms

Consent to participate in video recording of your consultation

Thank you very much for considering taking part in this research project.

You have been selected because the doctors in your clinic have agreed to use this clinic as a site for this project and because you can speak English. I am a practicing doctor from England and a researcher at the Institute of Education in London.

This is part of a bigger project which aims to find out more about what makes a safe and effective consultation. We are particularly interested in whether there are any differences in communication styles in different countries.

The project has been approved by the research ethics committee at the University of London.

If you agree to take part, your doctor will talk to you today in English. Your consultation with your doctor will be video recorded and then written up. Your name and any identifying details will be removed.

My aim is to publish findings from this project to improve training for junior doctors and I may use images from this video in teaching and in my thesis report.

You do not have to agree to take part and your decision will not affect your care in any way. If you say no to taking part, your consultation today will be carried out in the usual way and WILL NOT be video-recorded.

If you say yes, but then change your mind at any stage, it will be perfectly alright just to stop and I will erase any recordings that have already been made.

Consent:

I agree to be video-recorded during my consultation today.

I understand you will keep the recording totally confidential and the final version of the report will not identify me by name, and taking part in the project will not influence my medical care in anyway. I understand you may use images of me in the final thesis report and for teaching.

I understand that this form and the recordings will be destroyed as soon as it has been analysed.

Name.....
 (Your name is needed, by me only, to cross reference the records. It will not be used in any identifiable way)

Signature.....Date.....

Post recording consent (In case you change your mind after seeing your doctor)

Signature.....Date.....

Signature of doctorDate.....

Consent to participate in focus group discussion

Thank you very much for considering taking part in this research project which is looking at the features of general practice in India.

You have been selected because you are an experienced consultant in family medicine. I am a practicing doctor from England and a researcher at the Institute of Education in London.

The project has been approved by the research ethics committee at the University of London.

If you agree to take part, our conversation will be audio recorded and then written up. My aim is to publish findings from this project and your words may be quoted. There will be no way to identify you.

You do not have to agree to take part of course, but I very much hope you will because currently there are some issues with the assessment process for the MRCGP and I am trying to gather some insights about why some doctors from outside the UK are struggling.

If you say yes, but then change your mind at any stage, it will be perfectly alright just to stop and I will erase any recordings that have already been made.

Many thanks for your time and your help.

Consent:

I agree to be audio-recorded in the focus group today.

I understand you will keep the recording totally confidential and the final version of the report will not identify me. I have asked and had answers to all the questions I need to understand the process.

I understand that this form and the recordings will be destroyed as soon as it has been analysed.

Name.....

(Your name is needed, by me only, to cross reference the records. It will not be used in any identifiable way)

Signature.....Date.....

Post recording consent (In case you change your mind after the group)

Signature.....Date.....

Consent to be interviewed

Thank you very much for considering taking part in this research project which is looking at the features of general practice in India.

You have been selected because of your role in Nationwide Clinic. I am a practicing doctor from England and a researcher at the Institute of Education in London.

The project has been approved by the research ethics committee at the University of London.

If you agree to take part, our conversation will be audio recorded and then written up. My aim is to publish findings from this project and your words may be quoted. There will be no way to identify you.

You do not have to agree to take part of course, but I very much hope you will because currently there are some issues with the assessment process for the MRCGP and I am trying to gather some insights about why some doctors from outside the UK are struggling.

If you say yes, but then change your mind at any stage, it will be perfectly alright just to stop and I will erase any recordings that have already been made.

Many thanks for your time and your help.

Consent:

I agree to be interviewed and audio-recorded today.

I understand you will keep the recording totally confidential and the final version of the report will not identify me. I have asked and had answers to all the questions I need to understand the process.

I understand that this form and the recordings will be destroyed as soon as it has been analysed.

Name.....

(Your name is needed, by me only, to cross reference the records. It will not be used in any identifiable way)

Signature.....Date.....

Post recording consent (In case you change your mind after the interview)

Signature.....Date.....



To whom it may concern

This is to confirm that we are pleased to welcome Dr Kay Mohanna to our Institution in June 2012 for the purpose of research and teaching exchange.

Whilst she is with us she will be co-facilitating teaching sessions with our faculty and also carrying out research as part of her doctoral project. We have read an outline of the project and look forward to supporting that research.

Yours sincerely

Dr Santanu Chattopadhyay

Chief Executive Officer

NationWide Primary Healthcare Services Pvt.Ltd

No: 2036, 16th Main, 1st Cross, HAL 2nd Stage,

Indiranagar, Bangalore – 560038, Karnataka, India

Phone: 080-4317 1000, Fax: 080-2521 2577

E-mail: ceo@nationwidedocs.org

Ms Hazel Croft
Faculty of Children & Learning
Dean of Faculty: Professor Judith Ireson

Tel +44 (0)20 7612 6511
Fax +44 (0)20 7612 6177
Email h.croft@ioe.ac.uk



**Leading education
and social research**
Institute of Education
University of London

20 Bedford Way
London WC1H 0AL
Tel +44 (0)20 7612 6000
Fax +44 (0)20 7612 6126
Email info@ioe.ac.uk
www.ioe.ac.uk

Dr Kay Mohanna, FRCGP
Knowle Hurst
Knowle Lane
Lichfield
Staffordshire
WS14 9RB

13 June 2012

Dear Dr Mohanna

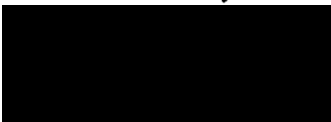
Ethics approval

Project title: Assessing the family medicine consultation: an internationally transferable concept?

I am pleased to formally confirm that ethics approval has been granted by the Institute of Education for the above research project. This approval is effective from 1 June 2012.

I wish you every success with this project.

Yours sincerely



+++++++
Hazel Croft
Research Student Administrator
On behalf of the Faculty of Children & Learning Research Ethics Committee

cc: Claudia Lapping
Research Ethics Office

Appendix A4: RCGP CSA Grade Descriptors



MRCGP Clinical Skills Assessment CSA Grade descriptors

Key: Clear pass – Pass – Fail – Clear fail	
CP	<p>The candidate demonstrates a high level of competence, with a justifiable clinical approach that is fluent, appropriately focussed and technically proficient.</p> <p><i>The candidate shows sensitivity, actively shares ideas and may empower the patient</i></p>
P	<p>The candidate demonstrates an adequate level of competence, displaying a clinical approach that may not be fluent but is justifiable and technically proficient.</p> <p><i>The candidate shows sensitivity and tries to involve the patient.</i></p>
F	<p>The candidate fails to demonstrate adequate competence, with a clinical approach that is at times unsystematic or inconsistent with accepted practice. Technical proficiency may be of concern.</p> <p><i>The patient is treated with sensitivity and respect but the doctor does not sufficiently facilitate or respond to the patient's contribution.</i></p>
CF	<p>The candidate clearly fails to demonstrate competence, with clinical management that is incompatible with accepted practice or a problem-solving approach that is arbitrary or technically incompetent.</p> <p><i>The patient is not treated with adequate attention, sensitivity or respect for their contribution.</i></p>

Note: All three CSA domains must be assessed in order to make the final global judgement. The descriptors in italics address interpersonal skills. The rest of the text addresses the other two domains.

The standard for "competence" is at the level required for the doctor to be licensed for general practice.

Serious professional concerns:

The candidate's performance demonstrates serious deficiencies in professional behaviour and/or attitude that could, in the opinion of the examiner, place patients at risk of significant harm from decisions and actions that the doctor takes, or fails to take.

Note: if you tick this box it does not simply mean that you have serious concerns about the doctor's fitness to be licensed, but that you have serious concerns about their fitness to practise at all. If this is the case, your evidence will be considered, the matter investigated at local level and the appropriate action taken including if ultimately necessary, GMC referral.

Grade Descriptors ARSRKH v.11 010612 JAC amended