The impact of familiarity on doctor-patient interaction during primary care consultations pertaining to Medically Unexplained Symptoms (MUS)

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By

Sara Louise Wheeler
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Abstract

It is common in all areas of medicine for patients to present with symptoms which cannot be adequately explained by the Western biomedical criteria of recognisable organic pathology. In this situation the social and clinical predicament of the patient is characterised by uncertainty and can lead to unnecessary emotional, social and legal difficulties. Since primary care is the forefront of diagnosis and management in the UK, General Practitioners deal regularly with uncertain and contested illness. Patients presenting Medically Unexplained Symptoms (MUS) represent a challenge to GPs in terms of their professional abilities and GPs may feel, rightly or wrongly, a *'pressure to prescribe'* from patients, whilst also experiencing a pressure not to prescribe from their colleagues in secondary care specialisms.

The widely held view of primary care is that a familiarity between doctor and patient is the most auspicious milieu, particularly in terms of managing chronic illness. However the concept lacks precision, whilst a growing body of research suggests a more complex picture.

Drawing on the concept of researcher as *'Bricoleuse[1]'*, an innovative methodological approach was adopted for exploring the nature of familiarity and non-familiarity within the primary care setting and its impact on doctor–patient interaction in terms of the management of MUS. Consecutive patients attending primary care physicians were recruited and their consultations recorded. GPs identified consultations containing MUS. Semi-structured, tape-assisted recall interviews were conducted with participating GPs and, where possible, with the patients. Transcripts were analysed thematically, triangulating between the three data sources. Data collection was conducted at five primary care surgeries across Merseyside: three large practices which had several GPs and other available services, and two single GP practices. The total number of cases collected was 23, 12 of which were 'full', consisting of three data sources: consultation, post-consultation interviews with GPs and post-consultation interviews with patients. A further 11 cases consisted of two data sources: consultations and post-consultation GP interviews.

Interpretation of the data revealed that the familiarity or non-familiarity a patient had with the health care setting generally, and more specifically a particular surgery and/ or GP, often did conspicuously influence the nature and course of the interaction during the consultation. This was confirmed by GPs reflecting on their familiarity or non-familiarity with particular patients and specific communities. Interestingly examples emerged of positive and negative aspects of familiarity and of non-familiarity.

The findings of this research provide an original contribution to the understanding of Medically Unexplained Symptoms within the wider context of contested illness and uncertainty in the primary health care setting. The complex social and clinical nature of this cohort of patients warrants an equally complex approach in terms of meeting their needs, including recognition that whilst in some cases familiarity may be conducive to management, in other cases non-familiarity may be just as useful and desirable. These findings have further resonance for the field of primary care more generally since they highlight the complexity of GP work and promote the value of *'choice'*.

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[1] In most of the literature where reference is made to the person performing the act of 'bricolage', the term 'bricoleur' is used; however this is the masculine form of the noun, and since the researcher is female, the feminine form 'bricoleuse' is used (WordReference.com accessed 7th December 2011).

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Part 1: Locating the field

Introduction

This thesis explores the primary care consultation in relation to patients experiencing *'Medically Unexplained Symptoms'* (MUS). This is a broad term which is applied to patients who present in the health care milieu with symptoms for which no satisfactory explanation within the current Western biomedical model has been assigned; that is to say, they remain unexplained, medically, since no underlying organic pathology (physical disease) has been identified (Dowrick, 2005page 15).

An important point to note from the outset, when considering this field of research, is that this cohort of patients is not a distinct, homogenous group. These patients do not share a specific disorder, but rather a social and clinical predicament of living without a medical diagnosis and thus the nature and very existence of their distress is contestable, and hence often contested (Kirmayer et al., 2004)

Furthermore the field of research is fragmented and distorted by a plethora of competing terminology regarding: perceivable underlying causes and explanations; diagnostic criteria and labels, and therefore, inevitably, the balance of blame and responsibility between doctor and patient (Barsky & Borus, 1999; Peveler, 1998; Peveler et al., 1997; Swanson et al., 2010). Explanations regarding causes range from undiscovered organic pathology, through to physical manifestations of psychological distress (Allen et al., 2002; Watson et al., 2011). Diagnostic criteria and labels follow suit and the social and political ramifications of contested illness lead to inevitable conflict and disparity between patients and health care professionals, as well as those writing the research, regarding legitimacy and blame (Barsky & Borus, 1999).

However despite the overlap and disagreement there remains at the heart of the research domain a serious issue worthy of study: patients experiencing this kind of *'diagnostic limbo'* (Corbin & Strauss, 1985) have symptoms which cause them to suffer but for which they have no tangible explanation (Dowrick, 2005). This can result in concerns regarding legitimacy and existential uncertainty (Adamson, 1997) and, depending on personal circumstances, can have personal, financial implications linked to societal expectations and sanctions over the right to be *'ill'* (Nettleton, 2006). Equally, the health practitioners involved in the care of patients in the predicament are also placed in somewhat of a quandary: they are faced with patients whom they are unable to help through medical intervention and thus their professional expertise is challenged (Dowrick, 2005) as well as their personal sense of fulfilment and job satisfaction (Wileman et al., 2002).

Whilst many of the other labels and categories in this field align themselves to a belief in organic pathology or else to psychosocial issues, and thus assign blame to one side or the other, *'Medically Unexplained Symptoms'* retains a degree of neutrality and recognises that both GP and patient have a problem (Dowrick, 2005); this is why Medically Unexplained Symptoms was selected as the most appropriate term for this thesis.

At the beginning of the research the title of the thesis was anticipated to be: *"The impact of doctors' misperceptions and emotional responses to patients who present medically unexplained symptoms in primary care".* This question had been formulated based on the findings of previous research conducted by the supervisors which suggested that persistent MUS should be regarded as a product, at least in part, of interaction with health professionals rather than purely as a result of the somatising of psychological problems by the patient (Dowrick et al., 2004; Ring et al., 2005).

However from the very beginning of data collection the researcher noted that the consultation seemed to be more of a *co-constructed* event, rather than being primarily shaped by the doctor, and this resonated with current literature regarding the deconstruction of the medical encounter (Heritage & Maynard, 2006), p119). The focus of the research was thus amended to reflect this early observation and the title was changed to: *Factors influencing doctor-patient interaction during primary care consultations with patients presenting with Medically Unexplained Symptoms in Primary Care.*

This general approach to the primary care of patients with Medically Unexplained Symptoms retained a focus on the role of the consultation in shaping the patients' health trajectory without concentrating solely on the role of the doctor; it was, however, a question with quite a wide scope and thus would need to be refined in order to produce findings which would be meaningful and useful.

Early in the data collection and simultaneous analysis process it became clear that the prior contact between participants, and thus the knowledge they had of each other, had an impact on the interaction which took place during the consultation. Interestingly, the observable effect ran contrary to the dominant view in the literature regarding the positive effects of *'sustained relationships'* and *'continuity of care'*, and reflected the idea regarding the possible negative effects of prior contact and knowledge which had begun to emerge within the literature, including an emerging concept of *'familiarity'* (Broom, 2003).

Upon returning to this literature the researcher began to explore this idea of prior knowledge and contact as *'familiarity'*, a concept distinct from *'sustained relationships'* and *'continuity of care'*, which are significantly drawn upon and written about but with notable imprecision in terms of definition; this emergent concept is distinct in that it refers to a particular component which exists within both of these fields of study, but which can exist independently and is not associated with the wider connotations of either.

As data collection and analysis continued in tandem it became clear that there were positive and negative effects of *'familiarity'* and this was also true of situations where *'familiarity'* was not present and thus *'non-familiarity'* was the defining feature of the encounter. The researcher explored this concept of *'non-familiarity'* and found it to be a largely under considered phenomenon and thus this mirroring concept was developed for the purposes of the research. Hence the positive and negative effects of these two concepts became the final focus of the research and the title of the thesis was finalised as: *The impact of familiarity on doctor-patient interaction during primary care consultations pertaining to Medically Unexplained Symptoms.*

To summarise then, the illness cohort is indistinct due to a lack of agreement in terms of diagnostic and definitional criteria. Despite this, patients who reside within this social and clinical predicament continue to suffer and the health professionals engaged in their care experience associated difficulties. Furthermore it seems the problems of this cohort can, to a certain extent, be seen to be shaped by their encounters with the health care milieu and in particular that of primary care.

Chapter outlines

Part 1 of the thesis, as presented in the thesis schematic overleaf (figure 1) comprises two chapters and is concerned with locating the field of enquiry and setting the research context within which to situate the study.

Chapter 1 is a contextual scoping exercise rather than a focussed literature review, beginning with an exploration of the origins and emerging nature of the term 'Medically Unexplained Symptoms' (MUS) within the literature. Following this exploration of the illness category and related terminology connected to it, the associated difficulties presented by MUS, for both practitioners and patients, will be presented and discussed critically; thus the rationale for the research will be set forth. The role of the primary care encounter in shaping MUS will then be explored and the scope of the research will be narrowed to the co-construction of the consultation and factors influencing doctor-patient interaction within the primary care encounter, particularly the prior contact and thus knowledge of each other which exists between physician and patient.

The concept of Medically Unexplained Symptoms as an illness category will then be considered within the wider context of the Western biomedical model and the subsequent notions of contested illness and uncertainty. The concept of prior contact and knowledge between physician and patient, and its impact on the primary care encounter will then be considered, including: Balint's *'mutual investment company'*, the widely referred to concept of *'continuity of care'*, and the emergent concept of *'familiarity'*, or lack thereof, in its various guises. This will form the foundation for Chapter 2, the structured, critical review of the relevant literature in relation to prior contact in the primary care setting.

In Chapter 2 the term *'familiarity'* will be used as a heuristic to explore the notion of prior contact in its various guises, and subsequently this and the mirroring notion of *'non-familiarity'* will be drawn from the literature and conceptualised as a robust and nuanced defining framework within which to set the research enquiry (figure 3). This chapter is a structured review which systematically evaluates the use of the term 'familiarity' within the literature relating to the primary health care milieu (illustrated in figure 2). The chapter will conclude with the aims and objectives of the research.

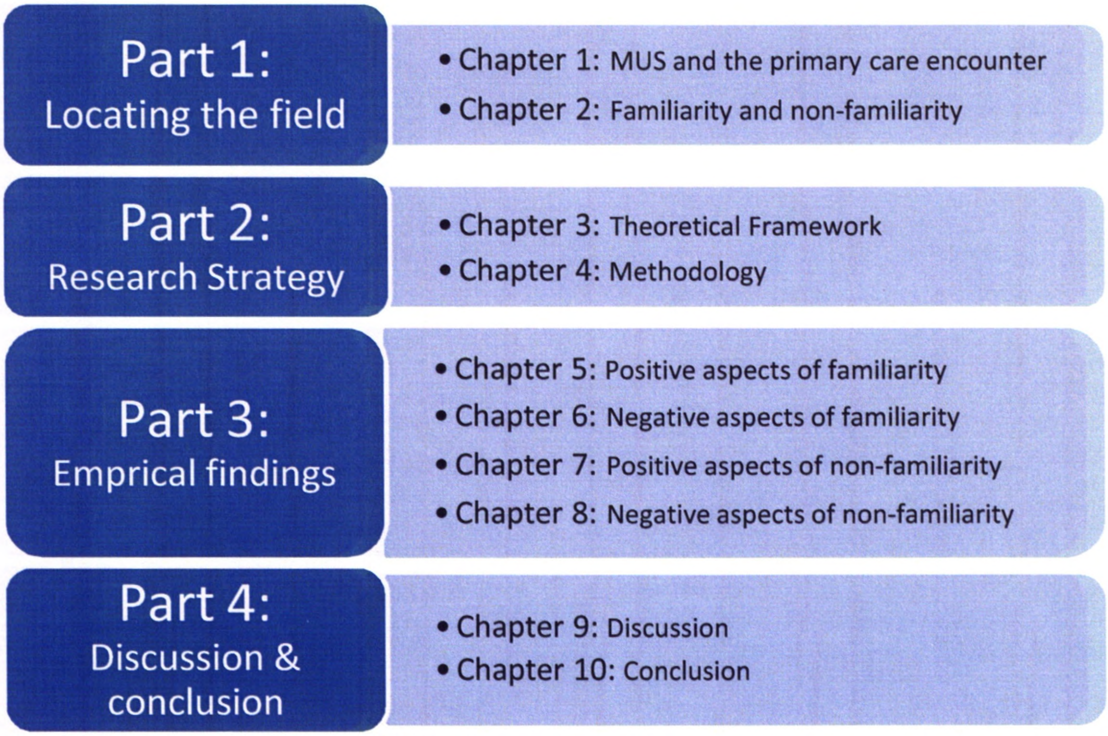
Part 2 of the thesis comprises 2 chapters and is concerned with setting forth the research strategy for addressing the aims and objectives identified in part 1. Thus chapter 3 will explore relevant theoretical considerations and present the theoretical framework for the study, drawing on the concepts of *'researcher-as-bricoleuse'* and *'maker-of-quilts'*. This will be followed by chapter 4 which will set forth the innovative research methodology for the empirical research of the study.

Part 3 of the thesis comprises chapters 5, 6, 7 and 8 which present the empirical findings of the research, presented in four parts to represent the main finding that there are positive and negative effects of familiarity and non-familiarity in the primary care encounter.

Part 4 of the thesis comprises the remaining 2 chapters and further explores the empirical findings in terms of implications. Chapter 9 presents a discussion of the findings, whilst chapter 10 presents conclusions drawn from the research.

The layout of the thesis is set forth in the following schematic:

Figure 1: Schematic of thesis:



Adapted from Nugus 2007(Nugus, 2007)

Chapter 1: Medically Unexplained Symptoms

1.1 Origins and nature of *'Medically Unexplained Symptoms'* as an illness category

The term Medically Unexplained Symptoms (MUS) has its origins in the discipline of psychiatry and the modern perception of this phenomenon emanated from the historical concept of 'hysteria', essentially defined as "repressed emotions being expressed as physical symptoms" (Semple et al., 2005), p738). Whilst it has become a widely used term throughout the medical literature, there is a lack of agreement regarding its definition and applicability, including in the sphere of primary care research with which we are concerned here (Ring et al., 2005). This review will therefore begin by tracing the history of the term 'Medically Unexplained Symptoms' to explore how it has been linked explicitly to different concepts.

In searching the Web of Knowledge database, the term *'Medically Unexplained Symptoms'* is first evident in the literature as having been used in an article published in 1980 which reported on a case of *'Briquet Syndrome'* in a man with *'chronic intractable pain'*. The article discussed the usefulness of detecting *'Briquet Syndrome'* in patients with such health complaints and observes that the patient had additionally experienced numerous *'Medically Unexplained Symptoms'* (De Figueiredo et al., 1980). Thus *'Medically Unexplained Symptoms'* was simply a literal description of one aspect of the patient's health.

An article published a year later, also presenting a case study of *'Briquet's Syndrome'*, gives an interesting account of how the traditional diagnosis of *'hysteria'* became fragmented into several categories within the most current version (at the time) of the Diagnostic and Statistical Manual of Mental Disorders (DSM-111). It seems that *'Briquet's disorder'* was a term which had previously been used to describe the new category of *'Somatisation disorder'*[2] and that all categories of the DSM-111 relating to this issue incorporated "the central components of a dramatic, vague, or complicated medical history, onset prior to or during early adulthood, many medically unexplained multisystem complaints, and a chronic, fluctuating course" (Pitman & Moffett, 1981).

Four years later an article by Slavney and Teitelbaum entitled: "Patients with Medically Unexplained Symptoms" reported on the "DSM-111 diagnosis and demographic characteristics of 100 patients consecutively referred to a university hospital consultation-liaison service for evaluation of medically unexplained symptoms suggesting physical disorders". The article begins by explaining that Medically Unexplained Symptoms are a common reason for the referral of patients to a psychiatric consultation service (Slavney & Teitelbaum, 1985). Here, the term Medically Unexplained Symptoms, rather than being used to describe a feature of patients diagnosed with a psychiatric condition, appears prominently in the identification and subsequent diagnosis of such conditions.

Over the coming years the term *'Medically Unexplained Symptoms'* continued to be applied in this manner in relation to a variety of psychiatric conditions and associated syndromes and attempts were made early on to promote a more coherent understanding and classification of 'Medically Unexplained Symptoms' (Melville, 1987).

In an article published the same year Melville argues that it is of central importance to differentiate between physical symptoms which can be *'explained'* in a medical way and those which cannot and are thus *'unexplained'*. In describing this distinction, Melville makes clear that in his view *'explained'* symptoms are defined as those which can be attributed with confidence to a valid 'disease

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[2] Currently defined as: A chronic disorder of multiple medically unexplained symptoms, affecting multiple organ systems, associated with significant psychological distress, functional impairment, and repeated presentations to medical services Semple et al., 2005, p742)

entity', and for which the "pathological mechanisms producing the symptoms are known". Interestingly he makes the point that "this definition should account for symptoms caused by organic pathology and for the physical symptoms produced by certain psychiatric illnesses" including "anxiety states, depressive illness, conversion disorder, and adjustment disorder". Melville explains this by stating that these psychiatric illnesses are "generally regarded as valid disease entities in which the pathological mechanisms producing the physical complaints can usually be identified"(Melville, 1987).

This is an interesting perspective and sets Melville's article apart from the dominant view within the field, particularly at the time of writing, since it does not see Medically Unexplained Symptoms necessarily as an indicator for manifestations of psychological distress. Instead, Melville recommends that the term *'Unexplained'* refers to physical symptoms which are not associated with the presence of valid disease, organic or psychiatric, as well as symptoms for which no pathological mechanism can be established with confidence. This approach, says Melville, "avoids the need to classify physical symptoms in the traditional way into 'organic' and 'psychogenic'" which he feels has "not always been helpful" in terms of scientific progress in this field. Melville goes on to discuss how the *'unexplained'* category of symptoms have proven difficult to understand and classify, even within the DSM-111 framework since there is an inconsistency in the classifications used in the section on Somatoform disorders, which includes some of the disorders associated with *'explained'* symptoms as well as those which are *'unexplained'* (Melville, 1987).

Melville's observations about 'Medically Unexplained Symptoms' being a difficult category to classify and understand, the problem of overlapping definitions being used interchangeably, and particularly the underlying assumptions regarding 'organic' or 'psychogenic' origins, are topics which are frequently discussed throughout the literature and persist to this day. Also notable is Melville's use of the term 'Medically Unexplained Physical Symptoms' in the title; this kind of amendment and alteration of the terminology is widespread in the literature with the variants: 'Unexplained Symptoms', 'Unexplained Physical Symptoms', Medically Unexplained Physical Symptoms (MUPS), Multiple Unexplained Physical Symptoms, Persistently Unexplained Symptoms, and Persistent Unexplained Physical Symptoms (PUPS) being used interchangeably or often without much explanation regarding distinction, adding to the imprecision of the field of enquiry (Allen et al., 2002; Burton, 2003; Dowrick, 2005; Dowrick et al., 2005,b; Escobar et al., 2002; Ring et al., 2005; Salmon et al., 2004; Stanley et al., 2002).

Additionally the field of Medically Unexplained Symptoms is intertwined with that of psychiatric taxonomies relating to *'Somatoform disorders'*, which has been complicated by the differences in the way the 'International Classification of Disease and Health Related Problems, tenth revision (ICD-10)' and the 'Diagnostic and Statistical manual of mental Disorders, fourth edition (DSM IV)' classifies this group of disorders, with each classification containing a number of disputed and unsatisfactory categories (Semple, 2005, p736).

The literature surrounding these classifications draws on the concept of *'Somatisation'* as being the main cause of the symptoms, understood as the process of psychosocial distress manifesting as physical symptoms (Escobar et al., 2002). This literature is also plagued by competing and overlapping definitions as well as closely related but differently named derivations, including: Persistent Somatisation Disorder; Somatic Fixation; Abridged Somatisation Disorder; and the Functional Somatic Syndromes, an umbrella term applied to several related syndromes, including Fibromyalgia, Irritable Bowel Syndrome, Chronic Fatigue Syndrome (also known as Myalgic Encephalomyelitis – ME or Post-viral fatigue syndrome) and war-related syndromes such as Gulf War Syndrome (Biderman et al., 2003; Creed & Barsky, 2004; De Bruyn, 1989). The named syndromes in particular lean towards a belief in undiscovered, organic pathology and are the subject of much legal, political and emotive debate (Barsky & Borus, 1999).

The aforementioned *'Abridged Somatisation Disorder'* was formulated in the late 1980s by Escobar and colleagues who were dissatisfied with the full *'Somatisation Disorder'* diagnosis, as defined in DSM-111 since, in their view, it often failed to capture the majority of patients presenting with high levels of unexplained physical symptoms in primary care. Therefore, in an effort to facilitate systematic research on somatisation in clinical and community populations, they proposed a less stringent or "abridged" construct for identifying cases (Escobar et al., 1998). This abridged construct was derived from lists of somatic symptoms included in the Diagnostic Interview Schedule (DIS) or the Composite International Diagnostic Interview (CIDI) which are standard instruments in psychiatric epidemiology (Escobar, personal communication, January 2007).

Whilst the DSM-111 cut-off required 12 unexplained physical symptoms both for men and women, the abridged construct required lower thresholds, with separate thresholds set for the sexes: four symptoms for males (from a list of 37) and six symptoms for females (from a list of 41). This difference between the genders was explained by the fact that four of the female reproductive items were not applicable to male patients, and so were removed These lower thresholds inevitably increased prevalence rates for somatisation and Escobar's research led to a new series of abridged somatisation sub-categories (Escobar et al., 2002; Escobar et al., 1998).

However whilst this abridged construct has been widely adopted, many researchers have been critical, for example Dowrick 2005 notes the unusual measure of making diagnosis gender specific (Dowrick, 2005). This focus on gender is, however, consistent with the early ideas regarding '*Somatisation disorder*' which was thought to be "rare in males" and can be traced back to 'hysteria' which was thought to be an entirely female disorder relating to disorders of the womb (Pitman & Moffett, 1981). Similarly, the study by Slavney and Teitelbaum did show higher rates of referral for Medically Unexplained Symptoms in females than males; however this strength of association (between being female and experiencing MUS) was weakened when patients were separated according to having been given a diagnosis or not (Slavney & Teitelbaum, 1985).

In contrast to these studies, Kirmayer 2004 found similar reporting rates for somatic symptoms between the sexes. Furthermore, when results were grouped by ethnocultural background and migratory history, and then stratified by sex, Vietnamese men were found to be significantly more likely to report unexplained symptoms than were Vietnamese women and this was thought to reflect the high rates of exposure to trauma in this sample, which included many refugees (Kirmayer et al., 2004). This is interesting since, as well as negating the idea that there is necessarily a link between being female and experiencing psychological distress, it also raises the idea that significant trauma, such as war, can be a potentially legitimating factor, socially, for the experiencing of psychological distress manifested as physical symptoms. This is an interesting consideration in terms of the current acceptability and normalisation of the war-related syndromes within the wider context of uncertain and contested illness.

1.2 Attempts to provide an agreed diagnostic criteria and terminology

Frequent attempts have been made to provide a satisfactory taxonomy which would facilitate research in this area and a variety of definitions and diagnostic tools have been developed and are used throughout the literature, including the aforementioned 'abridged somatisation' construct, and the 'multisomatoform' criteria which was developed specifically for use in primary care (Creed & Barsky, 2004). In considering the problem of terminological confusion Peveler et al 1997 noted that "much British research has been restricted to patients in whom a definite psychiatric disorder could be identified in addition to physical symptoms, however many patients with Medically Unexplained Symptoms do not fulfil this criterion, and improved reliability is obtained at a cost of diminished clinical validity" (Peveler et al., 1997). They therefore explored the feasibility of using a simpler method of screening to those proposed by Kirmayer and Robbins 1991 (whose study was conducted in Canada) and also to that of Escobar's 'abridged somatisation disorder' (conducted in the USA) which Peveler et al felt was a very similar construct to that of Kirmayer and Robbins and which also had a seemingly "arbitrary cut off", of which they were critical (Peveler et al., 1997).

Their study, conducted in the UK primary care milieu, sought to assess somatic symptoms using three screening instruments to see if the current constructs of: 'abridged somatisation disorder', 'high health anxiety', and 'mood disorder with physical symptoms' could be separated in a clinically meaningful way. However they also used a 3-part checklist with the participating GPs to compare the findings of the screening instruments with clinical opinion. In their findings Peveler et al stress the overlapping nature of these categories and the fact that patients could be assigned to more than one category. Whilst this study obviously focussed primarily therefore on the concept of 'somatisation' it did also take note of the importance of the clinical opinion of physicians, and concluded that it was feasible to garner this information from GPs using the checklist (Peveler et al., 1997).

There are currently no agreed research diagnostic criteria for primary care patients with unexplained symptoms (Ring et al., 2004) and the psychiatric classification systems of DSM and ICD-10 have been criticised by researchers for numerous reasons, including that they are based on relatively narrow, dualistic perspectives (Dowrick, 2005). As a key feature of many of the psychiatric classifications and the named syndromes, as well as having, to some extent, become an illness category in its own right, the presence and applicability of Medically Unexplained Symptoms as a term of reference, both distinct and in its variant guises, is widespread throughout the literatures.

To put this into perspective, a current search of the Web of Knowledge database using the search term *Medically Unexplained Symptoms* yields 928 articles. Even when the search is limited to the discrete term "Medically Unexplained Symptoms" (using speech commas to limit the search to this specific phrase using all three words) the search still yields 598 articles (accessed 30th April 2011). Both searches present articles using a plethora of overlapping terminology, diagnostic criteria and differences of interpretation.

This chapter therefore was conducted as a contextual scoping exercise to get a sense of the overall field of enquiry. Initially articles were gained from key informants in this field, including the supervisors. These articles were read and the references used to obtain more papers. Other papers were obtained over time through colleagues within and outside the specific field of enquiry during the course of the research, for example through attendance of conferences, training courses and postgraduate data analysis sessions at the University of Liverpool which drew together researchers from a variety of disciplinary backgrounds for scholarly discussions relating to their projects of study. Additionally, where definitions were unclear or papers were hard to come by the researcher contacted the authors to request further information. Clarification was also sought from a variety of key texts including medical and psychiatry manuals.

Thus this contextual scoping exercise, which as stated at the beginning of the chapter, sought to trace the history of the term 'medically unexplained symptoms' and its association to different concepts, was in some senses conducted on the principle of 'snowballing' (Biernacki & Waldorf, 1981) which enabled the knowledge base to evolve and develop over the course of the research, resulting in a grounded understanding of the concepts and parameters of the field.

1.3 Sociological conceptualisation of Medically Unexplained Symptoms

Nettleton 2006 notes that the 'named syndromes', such as Myalgic Encephalomyelitis (ME), Chronic Fatigue Syndrome (CFS) and Irritable Bowel Syndrome (IBS), have received some attention within the sociological sphere, as have the cohort of patients experiencing the specific 'unexplained' symptoms relating to chronic lower back pain. These patients however, notes Nettleton, "do at least have a label or categorisation which may help them to communicate with others about their sickness, gain support from other patients, and seek out information or specialist treatment from an appropriate clinic (e.g. a pain clinic)". This differs from the cohort of patients involved in Nettleton's empirical enquiry who are experiencing "an unclassified or unnamed set of symptoms". Thus Nettleton adopts *'Medically Unexplained Symptoms'* as the term with which to describe her cohort and proposes a move towards a "Sociology of Medically Unexplained Symptoms", setting this within the wider conceptualisations of uncertain illness and contested conditions (Nettleton, 2006). This is an interesting perspective and will be explored later on in this chapter.

A recent article by Jutel (2010) explored the "discursive construction of Medically Unexplained Symptoms in the medical literature in order to appreciate the context in which medicine understands and manages non-diagnosed complaints". Jutel's critical review of articles drawn from a search of the database 'pubmed' revealed a growing concern with the "burden that medically unexplained symptoms presents for patients, doctors and the health care system" and also the fact that medically unexplained symptoms was used in many of the articles as a "catch-all diagnostic category in which it can place the unexplained" (Jutel, 2010).

The first finding is indeed accurate but ought not to be surprising given that the rationale for much of the research in medicine will relate to issues of funding, time allocation, burden on the doctor and patient engaged in lengthy investigations and thus ultimately searches for better ways to manage the illness presented by the patient. The second observation, Jutel feels, is "paradoxical", in that MUS has become "a kind of diagnosis of the undiagnosable" (Jutel, 2010). However this is considered by many to be one of the strengths of medically unexplained symptoms as a term; rather than fragmenting the field of enquiry by enforcing the concept of a 'diagnosis' rooted in biomedical explanation, it encompasses the social and clinical predicament of living without diagnosis (Kirmayer et al., 2004), acknowledges the limitations of the biomedical model in explaining all illness medically, whilst also leaving room to recognise that unexplained illness poses a problem for both doctor and patient, without necessarily placing blame solely with either of them (Dowrick, 2005).

Taking into account all of these conflicting definitions, there are still some clear, observable problems associated with the social and clinical predicament of having medically unexplained symptoms, with or without a label, and these will be discussed under the next heading and will set forth the rationale for this study.

1.4 Problems: Why the study of Medically Unexplained Symptoms is important

1.4.1 Prevalence and frequent attending

Given the fractured nature of the field of enquiry in terms of competing, overlapping and, to a certain extent, subjective definitions and diagnostic criteria, the concept of prevalence rates should be approached with a certain degree of caution. However it is generally accepted by researchers and clinicians in this field, that Medically Unexplained Symptoms are a common phenomenon in all areas of health care, including the primary care milieu (Fink et al., 1999; Peveler et al., 1997; Ring et al., 2004; Ring et al., 2005)

A commonly assumed feature of Medically Unexplained Symptoms is that of 'frequent attendance' to the health care setting, particularly primary care (Smits et al., 2009) and also referral to secondary and specialist care, with a recent study reporting that one third of referrals from five UK primary health care centres to secondary care were for medically unexplained symptoms (Burton et al., 2011). Again it is important to carefully consider definitions and context here; Smits et al defined 'frequent attending' in the following terms: "Frequent attenders were patients whose attendance rate ranked in the (age and sex adjusted) top 10 percent during 1 year (1-year frequent attenders) or 3 years (persistent frequent attenders). All other patients on the register over the 3-year period were referred to as non-frequent attenders". Data was extracted from the medical records by the researchers and analysed statistically (Smits et al., 2009).

Thus 'frequent attending' according to the study by Smits, was defined in comparative terms between patients attending this primary care surgery within the same time frame; it is therefore possibly that actual frequency within this definition would vary year to year, depending on the relative health of the community population at the time. Similarly, the rates of referral to secondary care noted by Burton will have depended upon the definition of 'Medically Unexplained Symptoms' drawn upon and the subjective application of this definition by physicians within the clinical reality of the primary care encounter.

Published prevalence rates for MUS in primary care vary widely, with one Denmark-based study reporting 60.6% of patients as having presented at least one medically unexplained symptom (Fink et al., 1999). Generally in this field of research though, prevalence rates are estimated to be between 20%-30% (Swanson et al., 2010), with Peveler et al's UK-based study, using validated self-report questionnaires with GPs, identifying unexplained physical symptoms as the main clinical problem for 19% of attending patients (Peveler et al., 1997). A more recent UK-based study, utilising a three part checklist for garnering GP clinical opinion (as proposed by Peveler et al 1997) reported a slightly lower proportion of patients with unexplained symptoms recruited to the study: 16% (Ring et al., 2005).

Patients presenting with medically unexplained symptoms then are generally associated with high utilisation of primary health care and high levels of referral to secondary and specialist care.

1.4.2 Disproportionate levels of investigation, treatment and referral, and the potential for *'Iatrogenic harm'*[3]

In addition to frequent attending and high rates of referral to secondary and specialist care, and despite the absence of identified, organic pathology, patients in this cohort also appear to receive "disproportionate levels of symptomatic investigation and treatment, which is largely ineffective and sometimes iatrogenic" (Ring et al., 2004). Of course this overlaps with the referral to secondary and specialist care, however once there, patients with medically unexplained symptoms seem to continue to have a complex and involved health trajectory.

For example, Kouyanou et al 1997 conducted a cross-sectional study of patients attending specialist pain clinics in South London (UK) and identified high prevalence of the following examples of 'Iatrogenic harm': over-investigation, inappropriate referrals to a psychiatrist or a psychologist, over-treatment, inappropriate prescribing, inappropriate advice or information given, misdiagnosis and management (Kouyanou et al., 1997).

In a subsequent study Kouyanou et al explored the above mentioned examples of Iatrogenic harm, this time in a case control study, comparing two subpopulations within a pain clinic, where for one group it seemed that biomedical factors played a predominant part in the aetiology of pain (thus the symptoms were medically explained) and the other group's symptoms were considered to be 'unexplained'. From this study they deduced that iatrogenesis was "more likely in those without medical explanation". Furthermore, in relation to additional questions regarding patient experiences of doctors regarding their pain as 'imagined' or 'all in the mind', they observed that "this group of patients reported a significantly higher frequency of direct disconfirmation of their pain by the doctors" and suggest that "patients with medically unexplained symptoms are often exposed to attitudes that may paradoxically reinforce their determination to maintain the sick role, since to do otherwise would confirm the doctor's own view – that it was 'all in the mind after all" (Kouyanou et al., 1998).

Furthermore, reporting on a UK-based study of audio-recorded gynaecological consultations of patients presenting menstrual symptoms without pathology, Salmon and Marchant-Haycox revealed

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[3] An illness or injury introduced as a result of medical intervention that was intended to be therapeutic , Bradbury, H. (2009) *Medical Sociology: An introduction*: Sage. p6.

that "consultations were more likely to lead to hysterectomy if patients deployed specific strategies, including reporting social effects of symptoms, catastrophization, requesting surgery and citing clinical or lay authority in support." The study demonstrated that "each strategy could account statistically for gynaecologists' perceptions that decisions for hysterectomy reflected patients' rather than gynaecologists' influence". Thus the findings of the study were consistent with the theory that, in the absence of physical pathology, patients deploy specific strategies that influence gynaecologists to offer surgery. These findings were also consistent with reported accounts in the literature regarding the idea of 'patients' pressure' for prescription or referral, which had previously only been defined by doctors' subjective feelings (Salmon & Marchant-Haycox, 2000).

A UK-based study of the primary care setting, which drew on 420 audio-recorded consultations coded using a specially developed coding scheme, found that 81% of patients whose presentation was deemed to correspond to the Peveler checklist of Medically Unexplained Symptoms, received symptomatic drug prescription, investigation or referral (Ring et al., 2005).

1.4.3 Medical perspective: somatisation, 'pressure' and the 'heartsink' patient

The point raised by Salmon and Marchant-Haycox regarding 'patients' pressure' in the aforementioned study is an important one and helps to begin deconstructing the trajectory of the patient with Medically Unexplained Symptoms and reconceptualise it as being, at least in part, shaped by doctor-patient interaction within the clinical encounter, including the influence of the GPs' perceptions and emotional responses.

The disproportionate level of somatic intervention thought to be administered to patients with Medically Unexplained Symptoms has been widely attributed, by GPs and researchers, to patients' beliefs that symptoms are caused by physical disease and that they therefore insist upon somatic intervention and reject attempts from the GP to engage them in psychosocial discussions (Goldberg & Bridges, 1988; Morriss et al., 1999; Wileman et al., 2002).

A number of studies have suggested that the prescribing behaviour of doctors is influenced by their perceptions of patients as having somatisation as some aspect of their illness, for example: a UK-based study of focussed, semi-structured interviews with GPs which asked about factors causing 'discomfort' when prescribing reported that 'frequent attenders', 'heartsink patients' and 'thick notes' patients were all mentioned as causing levels of discomfort in relation to prescribing (Bradley, 1992) and these descriptions are associated with the cohort of patients with Medically Unexplained Symptoms. Another UK-based study found that the decision to prescribe was influenced by the doctor's perception of the patient's expectations (Britten & Ukoumunne, 1997).

More specifically, studies have shown that many GPs and other doctors report feeling 'pressured' by patients with Medically Unexplained Symptoms (Chew-Graham & May, 1999). These patients are also identifiable within studies reporting on 'heartsink patients', for example in a UK-based study of urban general practitioners, definitions of heartsink patients included: patients with multiple symptoms, patients with psychiatric problems, frequent attenders, and patients who were considered to be 'hyperchondriacs' (Mathers et al., 1995), all of which can be associated with the general definition of Medically Unexplained Symptoms.

However it has previously been commented upon that these studies primarily focussed on the subjective accounts of GPs relating the difficulties they perceived in relation to these patients and as such this does not provide evidence of how patients do in fact present (Salmon et al., 2005). Moreover, in a UK-based study which interviewed 68 patients with Medically Unexplained Symptoms, Peters et al found that patients did not necessarily seek treatments from their consultation with the doctor, but rather "to secure naming of, and collaboration against, the disorder" (Peters et al., 1998). Thus patients primarily consulted to have their symptoms explained and to have their suffering acknowledged as real.

Following on from this, Salmon et al set out to directly measure what patients experiencing Medically Unexplained Symptoms seek from their encounter with the doctor (Salmon et al., 2005) and to directly observe what these patients ask for (Dowrick et al., 2004; Ring et al., 2004; Ring et al., 2005; Salmon et al., 2004). The findings converged to indicate two main goals which will be explored below.

1.4.4 Patient perspective:

1.4.4.1 Legitimating and convincing explanation

In observing consultations between GPs and patients presenting with MUS, Dowrick et al revealed that patients had several ways of prompting GPs to provide explanations for their symptoms (Dowrick et al., 2004) and further quantitative analysis of the data confirmed that in most cases (91%) patients utilised these devices (Ring et al., 2005).

In accordance with the widely held belief that patients experiencing MUS reject GP responses that do not fit their own beliefs and that do not legitimate their symptoms (Borkan et al., 1995) Dowrick et al found that patients commonly escalated their presentations following GP responses which they found unconvincing or else cast doubt on the legitimacy of their symptoms (Dowrick et al., 2004). Furthermore, patients appeared to introduce new symptoms into the consultation in response to GPs' disposals of previous symptoms until the GP offered further investigations; it was unclear if these symptoms were introduced in reaction to the GPs' responses or else would have been introduced anyway (Dowrick et al., 2004).

1.4.4.2 Emotional support

As mentioned above, Peters et al found, upon interviewing patients with MUS, that they generally sought an alliance with the GP in relation to their problems rather than somatic intervention. Thus in contrast to the idea that patients with MUS believe their symptoms to emanate from organic pathology, it appeared that many patients suspected emotional or social causes for their symptoms (Peters et al., 1998).

In a subsequent study, Salmon et al used patient request forms to ask patients directly what they sought from the GP. This study revealed that a consecutive sample of patients consulting their GPs with MUS (N=420) sought more emotional support from their GPs than did patients who consulted the same GPs on the same days, but whose symptoms were, in clinical opinion, 'explained' (Salmon et al., 2005).

1.4.5 Co-constructed and co-somatised?

There is a growing view within the literature that unexplained syndromes are shaped by patients' interactions with medical care (Barsky & Borus, 1999; Page & Wessely, 2003; Stanley et al., 2002). Ring et al demonstrated that GPs were significantly more likely to propose symptomatic responses (drugs, investigation and specialist referral) than were patients (Ring et al., 2005). Receiving unrequested somatic intervention is likely to shape illness beliefs and increase dependency on medical intervention. Meanwhile, studies have shown that where GPs fail to provide legitimating explanations this paradoxically appears to promote patient disability in that they feel the need to assert their illness and their authority regarding their symptoms (Hadler, 1996; May et al., 2000).

Dowrick et al observed that GPs commonly drew on normal test results or clinical assessment to assert that serious illness was absent or that symptoms could be treated easily by prescription or non-prescription remedies. However this 'normalisation' of symptoms appeared to elicit elaborated and extended accounts from the patients regarding their somatic presentation (Dowrick et al., 2004).

Ring et al proposed that, in primary care at least, MUS should be regarded as a product of interaction with doctors rather than a result of the somatisation of psychological problems within the patient. In particular, in their view, focus should change from the patient to explore the GPs' role in shaping the problem of MUS through medical consultation (Ring et al., 2005).Drawing on the findings of Ring et al, it was therefore proposed that the following phenomena be explored:

"The impact of doctors' misperceptions and emotional responses during consultations with patients who present medically unexplained symptoms in primary care"

However Ring et al assume that, unlike the observations published in the literature regarding the pressures on surgeons to offer surgery (Salmon & Marchant-Haycox, 2000), the management of Medically Unexplained Symptoms in primary care is "addressed in the context of a continuing doctor-patient relationship rather than one or two consultations" (Ring et al., 2005). This is not necessarily the case since patients may attend a primary care surgery where there are several GPs practicing simultaneously and they may be allocated to whoever is free rather than to the same GP each time.

Furthermore, Ring et al assert that, since problems are addressed in primary care within a continuing doctor-patient relationship, this means that "a greater range of management options is available to GPs" (Ring et al., 2005). Thus, Ring et al support the idea that the context of a continuing doctor-patient relationship is conducive to more effective communication and management which, whilst consistent with the dominant views in the field regarding sustained relationships and the *'mutual investment company'* (Balint, 2000) and *'continuity of care'* (Baker et al., 2007) has recently come to be questioned (Chew-Graham et al., 2004).

Additionally, upon undertaking fieldwork, the researcher noted that the consultation appeared to be more of a co-constructed event and thus the observable effects would be of 'co-somatisation'. Finally, the effects of prior knowledge, or lack thereof, appeared to be both positive and negative.

Thus there appeared to be sufficient rationale for taking a closer look at the relational element of the clinical encounter, particularly in terms of prior contact and knowledge, and how this might impinge upon the primary care encounter, particularly in relation to consultations pertaining to medically unexplained symptoms.

1.5 Re-focussing the research endeavour

Patients with medically unexplained symptoms reportedly engage in high utilisation of primary and secondary health care, with disproportionate rates for referral to secondary and specialist care, despite the absence of identified organic pathology. This not only represents a significant and potentially inappropriate burden on health care resources but is also unhelpful for the patient who may spend large amounts of their time attending health care appointments and engaging in considerable 'information work' to try and ascertain what may be wrong with them (Rhodes et al., 1999).

Previous studies by the supervisors have identified the potentially *'somatising effect'* of the primary care encounter and set forth a proposal for examining the impact of the misperceptions and emotional responses of GPs. However once the research began, using a data collection method which triangulated between the recorded consultation and associated tape-assisted recall interviews with both participants, it became clear that it was more helpful to view the primary care encounter as a 'co-constructed' event. It also quickly became clear that the interaction between doctor and patient was affected by the degrees of prior contact and knowledge, or not, that participants had of each other. Thus the focus of this study was amended to include a detailed exploration of the nature and impact of this prior contact and knowledge.

The scoping exercise will now briefly move to a consideration of the historical backdrop of the primary care milieu, with its underpinning paradigm of the biomedical model and emphasis on the need for a diagnosis in recognising illness, and this will then be set in context of the fields of uncertain illness and contested conditions. Following on from this the highly influential theories of the 'mutual investment company' and 'continuity of care' will be considered. The chapter will conclude by highlighting the need to conceptualise a specific feature of these above mentioned concepts – that of prior contact and knowledge, or lack thereof, that doctors and patients had of each other, and each other's context, with a specific focus on where this is thought to impinge upon the primary care encounter; the need for precise, well defined terminology will also be outlined.

1.6 The primary care encounter

Throughout human history we have sought to explain illness and to promote health and well-being. The ways in which we have sought to do this have varied considerably through time and have depended upon the best, currently available *'knowledge'* and resources, and also upon the dominant perspective, paradigm or what Foucault termed *'episteme'*[4] of each particular era or *'epoch'*; the latter being pertinent since the values and beliefs of the society in question will have influenced how *'knowledge'* was constructed, organised and interpreted (Cregan, 2006 , p46).

Early Hippocratic medicine is credited with having been holistic in approach, based as it was upon observing changes in the patient's condition and through observation of the four humours. This Humoral framework was central to the medical theory advanced by Galen (AD 129-c.210) and largely dominated the landscape of Western medical thinking until the late 18th century. However the 17th century reflections of Thomas Sydenham (1624 – 1689) are noteworthy as they can be seen as somewhat of a turning point in clinical thinking - encouraging the belief that diseases *could* and *should* be classified. Whilst Sydenham believed himself to be a Hippocratic, his thinking established the modern medical dilemma: how to retain a belief in the unique individuality of the patient, and still apply the more general findings of a scientifically grounded diagnosis and therapy (Bynum, 2008 , p5-38).

The classification of disease became the subject of much interest within the enlightenment medicine of the following century, with several nosologies proposed, all of which were primarily based on what modern medicine would now deem *symptoms*, rather than *signs* or *causes*. This reveals a prominent aspect of enlightenment medicine in that it was patient-orientated and doctors relied upon patients' accounts of their own feelings and symptoms to make their diagnoses. Thus before the diagnostic methods of modern times, patients and doctors shared a language and conceptual framework regarding disease and its causes. Furthermore, the prognosis they received, whether grave or favourable, was directly related to the *symptoms* that led them to seek medical advice in the first place (Bynum, 2008 , p38-42).

The emergence of *'modern medicine'* is situated historically as having been in the latter part of the 18th century with the advent of what has come to be termed 'hospital medicine'. It is widely agreed that the period between the two French revolutions of 1789 and 1848 saw France, and more specifically Paris, at the forefront of medical education and practice throughout the Western World. This phenomenon arose largely due to the establishment of three medical schools whose primary purpose was initially to produce a healthy military for the new republic. The medical education at these schools was designed to be intensely practical and based within the hospital and came to be based on

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[4] A body of knowledge or a system of meaning that encompasses a world-view that is fundamentally associated with a socially recognised institution (Cregan, K 2006, p54)

three pillars: physical diagnosis, pathologico-clinical correlation, and the use of large numbers of cases to elucidate diagnostic categories and to evaluate therapy. With many modifications, these pillars have remained fundamental to Western medicine, as has the centrality of the hospital (Bynum, 2008 , p43-46).

1.6.1 The rise of the biomedical model and its need for a clear cause/ effect

The incorporation of science into medicine in this way, together with rapid changes in biomedical theories of health and illness, had wide reaching consequences for the conceptualisation and treatment of illness (Shorter, 1996 , p103-135). There was a shift in the diagnostic process from the focus being on symptoms or external evidence and verbal inquiry to locating disease within the anatomical frame (Cregan, 2006, p53). This altered the nature of the doctor's expertise, from recognising the significance of symptoms for the individual patient, to developing a detailed knowledge of the manifestation of the disease. "This focus on objectively measureable disease, independent of the bodily or social context in which it occurs" remains a distinctive feature of modern medicine (Bradbury, 2009, p39).

1.7 The wider field of uncertain illness and contested conditions

Nettleton 2006 situated Medically Unexplained Symptoms within the context of uncertain and contested illness and the wider sphere of uncertainty as experienced within society. Citing Bauman (1991), Fox (1980) and Turner (1996), Nettleton explores the idea that uncertain illness and contested conditions are constructs which have paradoxically been shaped by the increasingly scientific pursuit of gaining control within the medical sphere, including the classification, naming, and categorisation of diseases; this pursuit it seems has led to increasing intolerance of clinical uncertainty. Furthermore, '*Embodied doubt*' is a feature of contemporary life. Thus in many ways, the relatively marginalised and neglected set of people who live with MUS comprise an extreme example of the lives of the majority of people in the *'risk society'* (Nettleton, 2006).

This is an interesting perspective and is useful in terms of shifting the focus within the study of medically unexplained symptoms, away from the pursuit and lack of a diagnosable, organic pathology to a wider consideration of the social and clinical predicament as it exists within the broader framework of understanding health and illness. An illness trajectory is influenced as much by societal pressures, cultural ideas and contact with the healthcare system as it is by organic pathology or suffering experienced (Barsky & Borus, 1999).

A lack of classification according to the dominant medical model means that many of the usual, stabilising criteria are not applicable; ideas regarding underlying cause may be focussed on organic pathology or else manifestations of psychosocial distress, and these ideas may be entrenched or else unconsidered, and may be labelled or unlabelled. To understand the degrees of separation to which the plethora of 'conditions' which fall within the remit of Medically Unexplained Symptoms are subject to, it may be helpful to envisage the field as a continuum, with belief in organic pathology at one end and belief in 'somatisation' at the other. Conditions reside at various point in the continuum depending on beliefs in terms of cause, label and management and their positioning is subject to change depending on the best, currently available, medical knowledge – thus new discoveries in the sphere of medical knowledge solve the mystery regarding the underlying causes of a particular condition, patients may pass through the continuum and enter the realm of explained illness. Similarly, interaction with certain health care professionals might also lead to this occurring, particularly in cases where somatisation is identified as the underlying cause and appropriate psychosocial interventions are administered and found to be successful.

An increasingly scientific approach to medicine, coupled with an increasing inability in society to deal with uncertainty (Nettleton, 2006), inevitably makes the social and clinical predicament of being without a medical diagnosis (Kirmayer et al., 2004) and thus being beyond the explanation of the Western Biomedical Model, a difficult and uncomfortable position to occupy. Status as legitimately 'ill' is contested and thus permission to be 'ill' is difficult to obtain (Nettleton, 2006). An influential aspect of the health trajectory for patients in this predicament is their interaction with health care and, specifically, the primary care milieu. The prior contact they have with practitioners in this setting will be crucial in terms of their own perceptions and the management of their ill health, whether transient or chronic. An important aspect of this interaction is the prior contact and thus knowledge that exists between patient and practitioner. The literature on this topic will now be explored.

1.8 Balint's construct of a 'Mutual Investment Company' and sustained relationships in the primary care milieu

One of the most notable differences between primary care and the other health care milieu's is the potential for sustained involvement between doctor and patient, and possibly their families too, over a long period of time. Whilst other health care milieus do not necessarily preclude sustained contact and there are circumstances where this may occur – for example specialist clinics within hospitals for chronic conditions such as diabetes, it is, or has been, more common in the primary care milieu where patients have attended appointments with the same GP at the same practice throughout their lifecourse, along with other multi-generational members of their family and community.

When such sustained relationships do occur between doctor and patient in the primary care setting, Balint (1957) explains that this can be the "basis of mutual satisfaction and mutual frustration" within which a "unique relationship establishes itself". Describing this ensuing relationship Balint comments that "It is very difficult to describe this relationship in psychological terms. It is not love, or mutual respect, or mutual identification, or friendship, though elements of all these enter into it. We termed it – for want of a better term – a 'mutual investment company'. By this we mean that the general practitioner gradually acquires a very valuable capital invested in his patient, and, vice versa, the patient acquires a very valuable capital bestowed in his general practitioner". Balint goes on to describe the acquaintanceship which is built between doctor and patient over a number of years during which time "the general practitioner gradually learns a vast amount of important details" relating to the family and community context of the patient (Balint, 2000 , p249-250).

It was in observing the provision of this 'continuity of care' to patients and their complex needs that Balint become one of the first authors to observe the stress which this placed on GPs; this subsequently led to the original groups which provided GPs with the opportunity to discuss the nature of the relationships which they sustained with their patients (Dicker, 2006).

The ideas of Balint and his followers were very influential, particularly on the newly established Royal College of General Practitioners[5], and the doctor-patient relationship came to be seen as an integral part of British general practice and as being in some way therapeutic. A central tenet of Balint's concept was that knowing a patient, in the context of a continuing relationship, empowered the doctor to make appropriate clinical decisions. Over the years much effort has therefore been expended upon achieving a satisfactory doctor-patient relationship, with some authors noting that the doctor-patient relationship has been elevated to be an outcome or goal of every consultation (Chew-Graham et al., 2004).

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[5] Founded in 1952 (www.rcgp.org.uk)

However, as Dowrick 1997 notes "the relationship between doctors and patients does not occur simply in the isolation of the consultation room, but is determined to a considerable extent by the context within which the participants find themselves", and this context has changed significantly in Britain since the time of Balint's initial path-breaking work (Dowrick, 1997). Amongst the changes Dowrick notes the "major shift in the organisation of general practice from smaller to larger units" and that "despite the opportunities for greater personal knowledge afforded by smaller list sizes and more frequent contact, continuity of care has decreased" (Dowrick, 1997).

These two points are linked of course and have been the subject of much heated debate in recent years, particularly in light of the proposals of Lord Darzi in his report: *Healthcare for London: A Framework for Action* (published on 11 July 2007) which set forth the case for a new kind of community-based care at a level that falls between the current GP practice and the traditional district general hospital (www.bma.org.uk) namely that of the polyclinic (Darzi, 2007). Whilst these proposals caused huge controversy they do in fact reflect the reality that there has been a general shift from the single-handed GP practice to the multiple-GP practice, which also incorporate numerous other health professionals and services onsite, even in suburban locations; some single-handed and smaller practices do however continue to operate in a more traditional way.

Consequently the parameters within which Balint's 'Mutual Investment Company' (Balint, 2000) can exist have changed and are set to change further, with fewer people accessing care in this way. Additional priorities such as rapid access and patient choice share priority, and the possible ways in which the associated concept of *'continuity of care'* may be manifested have expanded and changed and are possibly set to change even further over the coming years. In addition, however, there has been much controversy over the definition of *'continuity of care'*, particularly within the published literature and thus it seems that this field of enquiry is fragmented and debatable.

1.9 Defining 'Continuity of care' as applied to primary care

The concept of *'Continuity of care'* elicits heated and emotive debate whenever it is raised, for example an article published in the British Medical Journal 2000 entitled "Controversy in primary care: Does continuity in general practice really matter", and accompanying Commentary: "A patient's perspective of continuity" sparked 11 rapid responses, each one expressing strong opinions and asserting personal and/ or professional authority on the matter (Brampton, 2000; Guthrie et al., 2000). However the definition of *'continuity of care'* has been equally disputed and discussed for many years, rendering any clear debate regarding its legitimacy and/or therapeutic value difficult to discern.

For example in an editorial for the American Journal of Public Health in 1980, Starfield comments on a Review within that issue, written by Rogers and Curtis (Rogers & Curtis, 1980) which reviews "the variety of subjects subsumed under the rubric of 'continuity' and accurately convey the wide variety of phenomenon to which the term has been applied" (Starfield, 1980). The review it seems concludes by calling for the "establishment and agreement on the definition", "conceptualisation, operationalisation and testing of the model", "establishing actual levels of continuity in different settings, documenting the relationship between continuity and quality, and defining an optimum level of continuity" (Starfield, 1980).

Starfield goes on to comment on the fact that two of the most prominent rubrics within which 'continuity' is debated and which warranted further distinction were the concepts of 'longitudinality' and 'continuity'. Starfield explains that: "Longitudinality is intended to facilitate communication between practitioners and patients (by virtue of mutual knowledge about each other) so that the concerns of patient and practitioner are more readily and more easily explored" (Starfield, 1980). Thus the concept of 'longitudinality' within 'Continuity of care' at this time was akin to Balint's ideas regarding the 'Mutual Investment Company'. Meanwhile the notion of 'continuity' was defined as "an uninterrupted succession of events" or "the existence of a mechanism to bridge the parts of an event" (Starfield, 1980).

However Starfield points out that "despite the conceptual distinction between these two phenomena of care, the literature on continuity contains articles which address both". Thus, even at this time, there existed "confusion about the lack of standardization of terms" and this was considered to be a "major problem". Starfield sums up the problem of terminological confusion by noting that "if continuity is used in different ways by different researchers, it is inevitable that some will show that continuity is a valuable feature of medical care and some will conclude the opposite" and concludes by suggesting ways in which standardisation within the field may be promoted, including the standardisation of terms or else the formulation of new ones (Starfield, 1980). Starfield's final comments here are the most salient since they polarise the need for agreed points of reference and the difficulties which can occur without them, for example: in attempts to draw inferences regarding the positive and negative effects of the phenomenon being discussed.

Over twenty years later Saultz published a review entitled "Defining and Measuring Interpersonal Continuity of care" (Saultz, 2003b). Writing from an American perspective Saultz states at the beginning of the review that "for family physicians, continuity implies a longitudinal relationship between patients and those who care for them that transcends multiple illness episodes and includes responsibility for preventative care coordination. In the ideal case, this longitudinal relationship evolves into a strong bond between physician and patient characterized by trust, loyalty, and a sense of responsibility" (Saultz, 2003b). However he also notes that the possibilities for such 'continuity' have changed in the past two decades due to a number of changes in the American Health Care system (Saultz, 2003b).

Saultz states that the intention of the review was to "examine continuity as a characteristic of the relationship between physician and patient, a concept that may be called *interpersonal continuity*". However he notes that "there is little uniformity in how continuity of care has been defined by different authors" and that "several authors defined multiple dimensions of continuity". Furthermore he explains that: "a common methodologic problem in continuity research is confusion about the difference between knowledge of the patient and a relationship with the patient" (Saultz, 2003b).

Saultz thus sets forth a "new conceptual definition of continuity" based on the review. Saultz proposed that "continuity can best be defined as a hierarchical concept ranging from the basic availability of information about the patient's past to a complex interpersonal relationship between physician and patient characterized by trust and a sense of responsibility". The table below shows how Saultz placed these concepts in "a hierarchy of increasing complexity" representing "a synthesis of these concepts" (Saultz, 2003b):

Hierarchical Definition of Continuity of Care (Adapted from Saultz, 2003)

1. **Informational:** An organized collection of medical and social information about each patient is readily available to any health care professional caring for the patient. A systemic process also allows accessing and communicating about this information among those involved in their care.
2. **Longitudinal:** In addition to informational continuity, each patient has a "medical home" where the patient receives most health care, which allows the care to occur in an accessible and familiar environment from an organised team of providers. This team assumes responsibility for coordinating the quality of care, including preventive services.
3. **Interpersonal:** In addition to longitudinal continuity, an ongoing relationship exists between each patient and a personal physician. The patient knows the physician by name and has come to trust the physician on a personal basis. The patient uses this physician for basic health services and depends on the physician to assume personal responsibility for the patient's overall health care. When the personal physician is not available, a coverage arrangement assures the longitudinal continuity occurs.

Publication of the review provoked debate on the journal's "electronic letters" section (http://www.annfammed.org/cgi/eletters/1/3/134) with one physician welcoming the "formulation of continuity into a three-component hierarchy" commenting that it "seems useful and stimulating, providing more than just the appearance of clarity" (Green, 2003). However a New York-based Family Physician was critical of the findings stating that "after more than a quarter of a century of full service family practice, I understand continuity in a way that is untouched by the literature" (Bagley, 2003). This seemed like an interesting point about the published literature not reflecting clinical reality, however he goes on to describe an idealised scenario of the family doctor "caring for friends" and "diagnosing pregnancy, delivering the baby and watching that wonderful creation of God grow into a fine human being with family, friends, dreams and hopes of her own" (Bagley, 2003). Whilst this all sounds wonderful and is no doubt a very satisfying aspect of GP work it does not reflect the common experience of general practice, particularly as patients' lives within modern society become increasingly transient; it also does not take into account the fact that not all doctor-patient relationships are necessarily harmonious and that when discord does occur, ongoing contact over time, whatever term is used to describe it, only serves to exacerbate this problematic 'relationship'.

Bagley also goes on to comment that "Continuity is such an inadequate word to describe helping a friend (patient)..." and that "The literature fails to describe what family physicians provide for their patients every day. It is about trust. It is about connecting" (Bagley, 2003). This is an interesting point except it is difficult to discern how this description differs from the third category presented by Saultz describing 'Interpersonal continuity'.

Concurring with the points made by Bagley, Lucy Candib (also a USA-based family physician) emphasises the "complex mutigenerational families" cared for in the primary care milieu, emphatically stating that: "despite our nomenclature, no one is looking at the fact that in the course of this kind of continuity we have generational connections with multiple levels of family" and furthermore that "continuity is not just 1:1 between doctor and patient, but rather to a whole family" (Candib, 2003). This point about the relationship between the doctor and the patient within their wider family context is interesting and does perhaps offer considerations for revision or amendment to point 3 in Saultz's proposed hierarchy, although again the relevance of this kind of model could be questioned with regards to the increasing transient nature of relationships and patient lives more generally, with greater geographic mobility due to opportunities in work and study. It also assumes that this kind of close-knit, multigenerational contact is always a welcome and positive aspect of healthcare, which isn't always necessarily the case.

The final word in terms of these comments is by Saultz himself, who begins by commenting that he was surprised when he embarked upon the research at "how little research has been reported regarding long term doctor-patient relationship" before going on to propose a list of provocative questions resulting from the review, including: "while doctors and patients may like long term relationships, do such relationships actually improve care in any measurable way?" and "Can we learn something about long term relationships by studying how doctor-patient relationships end? Perhaps a long term relationship is one that hasn't had a reason to end!" (Saultz, 2003a). That these ideas emanated from a considered review of the published literature is very interesting. Detached from the emotional entanglement of clinical reality and the focus on satisfying aspects of the job, Saultz questions the legitimacy of the idea that long-term relationships are necessarily a positive model within which to conduct the primary care encounter. Whilst the first question states that doctors and patients do value these long-term relationships, the second question alludes to the possibility that both parties may not be enthusiastically attached to the idea. This is a very interesting thought to bear in mind when exploring the primary care encounter from the perspective of both doctor and patient.

Three years after the publication of Saultz's review, Jee and Cabana published an article entitled: Indices for Continuity of care: A systematic review of the literature. Using the acronym "COC" to describe Continuity of care, the authors state that the purpose of their review is: "to evaluate COC indices and to introduce a conceptual framework for their categorization". Early on in the article they make the case that theirs is a robust review, pointing to the fact that they drew on "several databases and sources of experts, with two investigators independently reviewing and applying rigorous and clearly defined inclusion and exclusion criteria". The review is USA-based and the authors state that they have characterized "COC indices used in outpatient settings, which principally reflect the relationship in primary care between the physician and the patient". Furthermore they state that "By critically appraising the current body of literature that has measured COC in outpatient settings, we can assess the strengths and weaknesses of applying these indices to measure physician-patient relationships" (Jee & Cabana, 2006).

Explaining the search criteria for the study Jee and Cabana explain that they found that the term continuity of care had multiple meanings within the medical literature; they quote Starfield and emphasise that: "*Continuity* (follow up from one visit to the next) differs from *longitudinality* (the long-term provider-patient relationship), although most of the literature uses these interchangeably"; thus for the purposes of their review, they decided to accept indices or measures for continuity that described either of the above mentioned concepts and present them within their conceptual framework. They state that their goal was ultimately to "capture the nature of an ongoing relationship, or the lack thereof, between a provider and patient in an outpatient setting" (Jee & Cabana, 2006).

It is interesting to note that, of the forty-four articles identified for review, these included 32 different indices used to measure COC, revealing a distinct lack of precision in the application of the term. These were analysed for similarities and differences and organized into five major categories by characteristics of:

1. Duration
2. Density
3. Dispersion
4. Sequence
5. Subjective/ miscellaneous measures

Discussing their findings Jee and Cabana state that: "this analysis demonstrates that a variety of COC indices with differing considerations of what is important to measure have been applied across a spectrum of outpatient populations. They comment on Saultz's review of interpersonal COC in the physician-patient relationship and his three dimensional hierarchy: informational, longitudinal, and interpersonal. They note that he examined 21 indices of COC on the basis of whether they do or do not require an assigned provider and also identified several family continuity measures; they then comment that their own review complements that of Saultz by looking at particular COC indices and providing "a conceptual framework that assesses the types of COC indices by grouping similar indices together by five primary categories" (see above). They state that their analysis of COC indices: "illustrates that there has been no consensus among the published literature about what should comprise COC indices and that no index is wholly inclusive of all facets of continuity" (Jee & Cabana, 2006). This is an interesting point as it highlights the need for a more nuanced understanding, perhaps using terminology which is not associated with the arguments regarding 'continuity of care' so as to focus on each aspect separately, without it being associated with the wider connotations of 'continuity of care'.

The remainder of the article breaks down the different indices and demonstrates their weaknesses and reductionist nature, for example: "duration measures are insensitive proxy measures for the relationship between provider and patient because there is no consideration of how often, or how seldom, a patient may see his or her provider, although these are the only measures to take time into consideration". Furthermore they reflect that "density measures are widely used because they are easy to calculate" and that whilst they do take into account the frequency with which care is sought, this frequency is calculated only with respect to a particular provider (Jee & Cabana, 2006).

Based on their comprehensive systematic review, Jee and Cabana state that: "there are many different types of COC indices that can be categorized as emphasizing different aspects of the physician-patient relationship (duration, density of visit, dispersion of care, sequence of visits, or subjective perceptions of COC). The wide variety of COC indices suggests that there has been no consensus among the published literature about COC." Whilst they feel it is beyond the scope of their review to suggest that one index is superior to another, they hope that their proposal to organize the diversity of indices into 5 general categories with similar characteristics will enable health service researchers to understand that these COC indices have unique assets and limitations (Jee & Cabana, 2006).

Whilst this 5 category view of the indices is undoubtedly useful, viewing the different aspects of COC together like this risks confusing each with the wider connotations of continuity and each of the aspects which may or may not impinge upon each other. Also, both Saultz's review and that of Jee and Cabana were operating within an American perspective; meanwhile reviews were conducted from the perspectives of other countries and were in turn influential upon the debates within their own contexts. For example, in parallel with the publication of Saultz's review in 2003, another review, emanating from a Canadian-UK perspective was published in the British Medical Journal by Haggerty et al (Haggerty et al., 2003) and this was highly influential in terms of research regarding the British health care system.

The review by Haggerty et al was particularly comprehensive in approach and considered continuity of care from a multidisciplinary perspective, reviewed articles from an impressively wide range of databases and additional sources, and incorporated articles written in English, French and Spanish. An interesting feature of the review was that, amongst other things, it explored the way in which continuity of care had been framed and emphasised within the different health care domains, which are presented in the review as: primary care, mental health, nursing, and disease management.

The authors report that within the primary care literature, continuity is: "mainly viewed as the relationship between a single practitioner and a patient that extends beyond specific episodes of illness or disease"; "implies a sense of affiliation between patients and their practitioners (my doctor my patient) often expressed in terms of an implicit contract of loyalty by the patient and clinical responsibility by the provider" and that this "affiliation is sometimes referred to as longitudinality, relational, or personal continuity and it fosters improved communication trust, and a sustained sense of responsibility" (Haggerty et al., 2003).

This definition involves many of the components of Balint's 'mutual investment company' (Balint, 2000) and the authors make the specific point that "in family medicine, continuity is different from coordination of care, although better coordination follows from continuity" (Haggerty et al., 2003). Elsewhere in the review 'coordination' is referred to in the context of service provision, for example within the mental health literature, 'coordination' is referred to in the following terms: "Care provided by different professionals is coordinated through a common purpose and plan" and also that "Coordination often extends to social services such as housing and employment, and case managers are appointed to facilitate both health and social services" (Haggerty et al., 2003). This is interesting as it defines continuity in the primary care context as a long-term affiliation between doctor and patient, but appears to draw the perimeters of this affiliation as being within the primary care encounter.

Another interesting aspect of this definition is that, whilst it corresponds with the category of 'interpersonal' presented by Saultz's review, the authors offer the alternate terms of 'longitudinality', 'relational' and 'personal' continuity as interchangeable (Haggerty et al., 2003); meanwhile in Saultz's review, the category 'longitudinal' is more compatible with the concept of 'coordination of care' offered by Haggerty et al, with Saultz's definition of 'longitudinal' including the description: "This team assumes responsibility for coordinating the quality of care, including preventative services"(Saultz, 2003b). Thus despite these two reviews being published in the same year and focussing on the same topic and field of enquiry there is a definite discord in their interpretations of certain definitions and use of terminology.

As a result of their extensive reviewing and consultation process, Haggerty et al conclude that "continuity of care is distinguished from other attributes of care by two core elements: care over time and the focus on individual patients". Furthermore, they assert that "both elements must be present for continuity to exist, but their presence alone is not sufficient to constitute continuity". Asserting the importance of these attributes, the authors explain, firstly, that "care of an individual patient distinguishes continuity from attributes such as integration of services and coordination, which are often used interchangeably with continuity" (Haggerty et al., 2003). Essentially it seems that on this point the authors feel that the focus of enquiry should be on the health care experience of the individual patient, rather than on the organisation of the health care milieu and its services.

Secondly, they explain that whilst "care over time has been identified as a longitudinal or chronological dimension of continuity" it is their belief that "it is not a dimension but an intrinsic part of continuity" (Haggerty et al., 2003). Thus the authors feel that, regardless of the actual length of time involved, time is nevertheless a fundamental aspect of continuity, since it "distinguishes continuity from other attributes such as the quality of the interpersonal communication during a single clinical encounter" (Haggerty et al., 2003). This is an interesting point and presents a rational perimeter between the debates relating to continuity and those regarding other aspects of health care delivery which are similar in focus and may in fact overlap on occasion, including 'cultural competence' (Kirmayer, 2004), and 'rapport' (Dowrick, 1997).

In addition to identifying these salient features of continuity, Haggerty et al propose "three types of continuity":

Three types of continuity (Haggerty et al., 2003)

1. **Informational continuity:** The use of information on past events and personal circumstances to make current care appropriate for each individual.
2. **Management continuity:** A consistent and coherent approach to the management of the health condition that is responsive to a patient's changing needs.
3. **Relational continuity:** An ongoing therapeutic relationship between a patient and one or more providers.

Haggerty et al's Type 1, 'Informational continuity' corresponds directly to the first feature identified by Saultz's hierarchical definition of continuity of care, also termed 'Informational continuity'. Essentially, the same could be said for Haggerty et al's Type 2 'Management continuity' and Saultz's 'Longitudinality', except, of course, the terms used, with Haggerty et al in their review somewhat confusingly referring to 'longitudinal' continuity as being interchangeable with the terms 'personal' and 'relational', which would appear to be more appropriate corresponding terms for Saultz's third definition of 'interpersonal'. Haggerty et al's third type of continuity 'relational continuity' is consistent with the ideas set forth by Saultz under the heading of 'Interpersonal'. Thus, despite some variation regarding terminology, both reviews arrive at more or less the same position, effectively proposing the same key features of continuity (Haggerty et al., 2003; Saultz, 2003b).

It can be concluded from the above evaluation that 'continuity of care' as a field of research is subject to definitional and interpretational disparity, lacking in precision, as well as being a topic which has been elicited much debate and emotive exchanges. Whilst it is an important field of enquiry in terms of the wider context of this research, it is not specifically 'continuity' with which this investigation is concerned.

For the purposes of this study it was specifically prior contact and knowledge that doctors and patients had of each other, and of each other's context which was of interest, and in the qualitative, subjective sense of which Jee and Cabana were critical (Jee & Cabana, 2006). Consequently a terminology was sought which would describe this specific facet and which would not risk engaging the wider, emotive debates regarding 'continuity of care'.

1.9.1 Familiarity in primary care – an emerging concept

Whilst considering the medical literature around the aforementioned topics, an article was identified which appeared to allude to prior contact and knowledge affecting the doctor-patient interaction, without being part of the wider debate regarding continuity; the term used was: 'Familiarity' within an article entitled: "Familiarity breeds neglect? Unanticipated benefits of discontinuous primary care" (Broom, 2003). This was a qualitative, Australian-based study which, contrary to the idea that continuity of medical care is generally considered to be beneficial to patients, set out to "investigate the possibility that familiarity with patients may sometimes discourage case findings" – with case findings being new diagnoses of type-2 diabetes. The study concluded that: "the same circumstances that enhance management of chronic disease can at the same times hinder its diagnosis. Primary care service providers may need to instigate more active methods of case finding in order to avoid this paradoxical effect of familiarity with the patient" (Broom, 2003).

Focussing specifically on the way in which 'Familiarity' had been defined, the researcher noted that 'Familiarity' appeared to be defined against the opposing concept of discontinuity, specifically: "discontinuity in diagnostic care was defined as occurring when the diagnosis was made by someone other than the respondents' usual GP, or when someone else (not the GP) took the initiative that led to the diagnosis [This definition is roughly congruent with relational continuity (an ongoing relationship between patient and provider), but it contains elements of other definitions. This is a wide definition that may exaggerate the detection of discontinuity; however, since the aim is to identify a potential dynamic rather than to estimate population prevalence, the possibility is of limited concern.] (Broom, 2003).

In order to seek further clarification on how *'Familiarity'* had been defined the researcher contacted the author. Professor Broom explained that the study had not originally set out to study familiarity or discontinuity, however the theme appeared prominently in the patient narratives. Thus 'familiarity' had not been specifically defined, but rather 'discontinuity' was defined in terms of identified instances that were clearly cases of not seeing one's usual general practitioner. So 'familiarity' was essentially a definition by exclusion in that it was what was left over after removing the obvious 'discontinuity' (Broom, Personal communication, 2008).

This term and concept were therefore considered to be useful constructs in considering this particular aspect of the doctor-patient dynamic and its possible impact on interaction. Thus a focussed, critical review of the literature using this term was conducted; this will be presented in chapter 2.

Chapter 2: Familiarity – a critical review of the literature

2.1 Introduction

Since the focus of the research was the illness category of Medically Unexplained Symptoms, with a particular emphasis on the phenomenon as it exists within the primary care setting, the research was located in the field of healthcare, with the nature of the research being that of social science research; as such it was an interdisciplinary study, with the supervisors being drawn from the disciplines of clinical psychology and primary care, with the researcher emanating from the discipline of sociology.

This interdisciplinarity was reflected in a number of ways throughout the study, beginning with the very nature of the research question and subsequent focus of the structured literature review – that is: establishing how prior contact and knowledge participants have of each other and their individual contexts has been previously discussed within the literature, specifically under the rubric of *'familiarity'*. Thus, although the review is a structured, critical and 'systematic' review of the relevant literature, it differs from the 'systematic review' as understood by readers of the medical literature which specifically approaches research synthesis by focussing on methodological approach and criteria for audit as evidence of rigour (Jutel, 2010).

The researcher was inspired by the approach adopted by Medical Sociologist Annmarie Jutel in her "traditional literature review" (Jutel, 2010) of the "discursive construction of such symptoms in the medical literature in order to appreciate the context in which medicine understands and manages non-diagnosed complaints" (Jutel, 2010). Jutel's review uses 'Medically Unexplained Symptoms' as a heuristic[6] for understanding the role of classification in constituting medicine as a social authority. This choice, Jutel explains, "was driven by the desire to capture the discursive content of the medical articles", which would have been difficult "to capture using a system-based process" (Jutel, 2010). Instead, the approach using a 'heuristic'(Jary & Jary, 1995; Marshall, 1998) in this manner relies upon "what MacLure (2005) refers to as intellectual connectivity, critique, interest, expertise, independence, tacit knowledge, chance encounters with new ideas, and dialogic interactions between researcher, 'literature' and 'data'"(Jutel, 2010; MacLure, 2005).

Finally, Jutel explains that, "although this process requires greater levels of subjective judgement and intuition on the part of the researcher than the sciences might normally tolerate, it leads to highly informed judgements based on extensive experience. Importantly these judgements are subjected to levels of scruitiny and interrogation at least equal to, if not more demanding than, those in the methodologically driven systematic review (Jutel, 2010).

These reflections on the approach to reviewing the literature are reminiscent of another sociological endeavour seeking to conceptualise a previously under-researched phenomenon – namely Morgan's (2009) exploration of "acquaintances: the space between intimates and strangers" which also bears some similarity, in terms of subject matter, to the current research endeavour in that it seeks to explore prior contact and "a form of knowledge" (Morgan, 2009).

Morgan explains that his research is not based on systematic research since this would not be appropriate for a project which seeks to "open up a relatively novel area of social enquiry" in order to stimulate future research relating to the area and also perhaps to "provide a framework for the reinterpretation of existing data" (Morgan, 2009, page 15). Thus, Morgan draws upon existing work which was designed to explore other issues (Morgan, 2009, page 15). Thus it would seem that there is a precedent for the current research endeavour to use the term 'familiarity' as a 'heuristic'; the aim of the project will be to explore its discursive construction as a concept within the medical literature in

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[6] A general concept or artificial construct to assist in the exploration of social phenomena; a form of preliminary analysis Jary, D and Jary, J. (1995); Marshall, G. (1998)

relation to doctor-patient interaction and its effect on the primary care encounter and delivery of health care in this milieu.

2.2 Method for obtaining review articles

Articles were obtained through a straightforward search of the database 'Web of Knowledge'[7] for all years until the present day (1898 – 2011) and then the research was regularly updated to include new articles until the beginning of the month of thesis submission (May 2011). It was anticipated that the term 'familiarity' would prove problematic in terms of conducting a literature review of this kind given that it has versatility both in terms of relational application and also general use relating to familiarity with objects; indeed an initial search of the database using just the term 'familiarity' yielded 15,867 articles. However when combined with the term 'primary care' the field was significantly reduced to 369.

Abstracts were obtained and reviewed to identify articles relevant to the study. Having eliminated articles which were not in the English language and which related to non-relational familiarity, for example: clinician familiarity with guidelines for the management of back-pain, 35 articles were identified as relevant and the full text obtained and subjected to closer inspection by the researcher. Further articles were eliminated on closer inspection if they did not apply directly in some way to primary care or if the term 'familiarity' was only used in the abstract by the authors to sum up issues discussed in the article. This resulted in the articles for review being reduced to 22. This process of obtaining relevant articles for review is illustrated, along with the analysis and evaluation process and distribution into categories, in figure 2 on page 31).

2.3 Characteristics of review articles

Of the 22 articles remaining, all were empirical rather than review articles; this had not been a criteria of the review, it was simply the case that these were the relevant articles which used the term 'familiarity' in some way to describe doctor-patient interaction within the primary care setting. Dates ranged between 1976 and 2011. Just over half of the articles (n=12) were written in the USA, with an additional 2 articles being the combined output of USA and Canada, and a further 1 article emanating from the USA, Canada and Puerto Rico; 2 more articles heralded exclusively from Canada. The Netherlands and the UK contributed 2 articles apiece and 1 article was written in Australia.

2.4 Analysis and evaluation

Articles were read in-depth to get a sense of common themes and assumptions; this resulted in the articles being assessed in the following ways: whether or not they had utilised a specific, quantitative measurement or applied the term in a descriptive, qualitative way; to whom and/ or what specifically the 'familiarity' applied. This second aspect of the review resulted in the construction of a model (Figure 3) of familiarity and non-familiarity and will be explained in full later in the chapter. Considerations regarding measurement and description and classification according to the model and reflections on the positive and negative effects observed, as well as associated note-taking, assisted in the synthesis and construction of the discussion around the prominent debates, assumptions and contradictions that this body of literature presented (Jutel, 2010).

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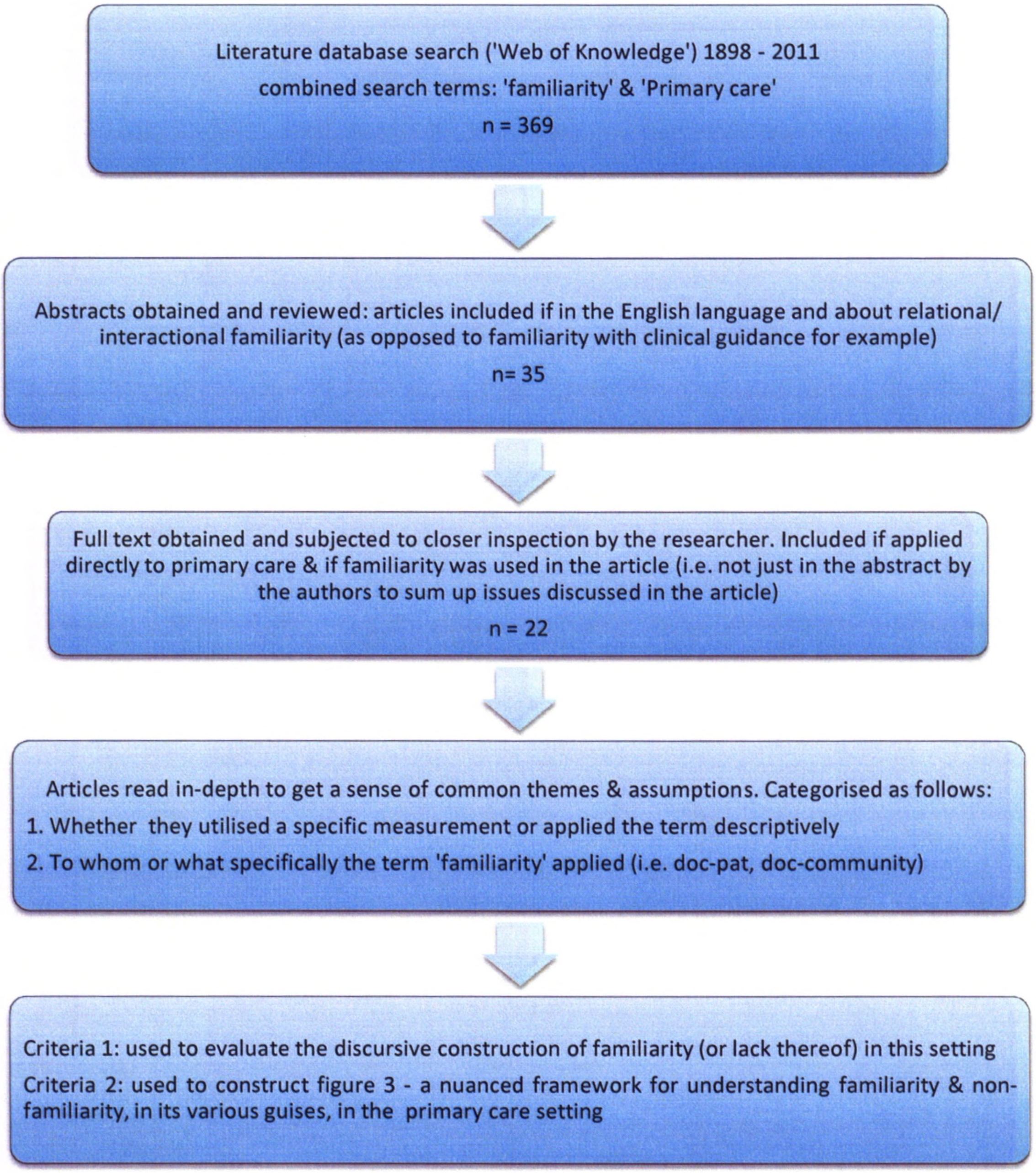
[7] Thompson Reuters Web of Knowledge: an integrated access, multidisciplinary research platform including information in the sciences, social sciences, arts and humanities.

Figure 2 Flow diagram of the literature review process, resulting in the construction of a framework model:



Literature database search ('Web of Knowledge') 1898 - 2011
combined search terms: 'familiarity' & 'Primary care'
n = 369

Abstracts obtained and reviewed: articles included if in the English language and about relational/ interactional familiarity (as opposed to familiarity with clinical guidance for example)
n= 35

Full text obtained and subjected to closer inspection by the researcher. Included if applied directly to primary care & if familiarity was used in the article (i.e. not just in the abstract by the authors to sum up issues discussed in the article)
n = 22

Articles read in-depth to get a sense of common themes & assumptions. Categorised as follows:
1. Whether they utilised a specific measurement or applied the term descriptively
2. To whom or what specifically the term 'familiarity' applied (i.e. doc-pat, doc-community)

Criteria 1: used to evaluate the discursive construction of familiarity (or lack thereof) in this setting
Criteria 2: used to construct figure 3 - a nuanced framework for understanding familiarity & non-familiarity, in its various guises, in the primary care setting

2.5 Specific measurement vs. descriptive application of the term 'familiarity'

The discussion of 'familiarity' in terms of what it represented was varied, with some articles (n=8) discussing it according to a specific measurement, whilst the remaining articles (n=14) drew on a more generalised understanding of the term or else did not address definition. Examples of specific measures also varied and will now be discussed.

In a study regarding the effect physician-patient familiarity might have on patient recall of medication changes, Rost et al classified patients according to a hierarchy based on a count of prior visits, under which patients were classified as "newer", "intermediate" or "established" (Rost et al., 1990). A later study by Kelleher et al, looking at provider familiarity with patients, was also physician-reported, this time according to the three separate categories of: "their personal patient", "their group's patient", and "not a primary care patient for the practice" (Kelleher et al., 1997). A study published the following year by Klinkman et al used a 7 point likert scale with physicians which included a question regarding the number of times they had seen a patient in the past year (Klinkman et al., 1998), whilst Bertakis et al compared "initial visits" with "return visits" to assess impact of familiarity on interaction within the consultation (Bertakis et al., 1999).

In a study looking at the identification of anxiety syndromes in primary care, Wren et al used a "clinician visit questionnaire" which required clinicians to select one of five categories from: "my patient", "in our practice", "self-referred from another practice", "referred by another provider", and "other" to describe familiarity with the patient (Wren et al., 2003). Meanwhile a Netherlands-based study looking at communication in general practice across European countries asked GPs to rate familiarity measured with a 5 point likert scale, with 1 being "bad" and 5 being "good" (van den Brink-Muinen et al., 2003) as did another Netherlands-based study a year later (Verhaak et al., 2004). In a primary care practice survey of residents of the capital district health authority, "familiarity with the clinic" was assessed by calculating years as a patient and total number of visits during the past 12 months (Sinclair et al., 2008).

Whilst measurements can be useful to help categorise and define within research, they can also be limiting and often do not reflect the complexity of the social and clinical reality they are applied to. Thus a specific measurement, whether in terms of years at a practice, number of visits a year or other measurable construct, is perhaps not necessarily the best way to conceptualise the field of enquiry; perhaps a more useful assessment might be gained through a consideration of how prior knowledge is formed and developed between the participants and their wider contexts, how this is perceived by those involved, and how this might impact upon the interaction they experience within the clinical encounter. As mentioned above the majority of the studies (n=13) did not use specific measurement criteria to define familiarity, or the lack thereof, but gave more descriptive and analytical accounts or else looser, more nuanced measurement criteria. These descriptive accounts will now be considered.

The first study in the review, which looked at the plausibility of on-the-scene, emergency care provided by the primary physician in a small, rural town location, described the physician's "professional familiarity with the patient and the person reporting the illness or injury" (in the event of an emergency). Within the article the author comments that in this rural primary care setting, patients were "encouraged to follow through with their previous physicians whenever practical". Discussing the impact of the familiarity in positive and negative terms, the author comments that: "the primary physician's familiarity with the patient's and/ or the reporter's emotional status and assessment of the patient's potential for longevity, health and productivity helps in appropriately tailoring the emergency response to the particular situation." Furthermore, in terms of the wider community context, just under half of "the reporters were patients' relatives who were themselves patients of the physician" (Morris, 1976). This is quite a detailed and considered account of the relationships under scrutiny in this study and reveals much about the context of the health care being delivered.

Another of the early articles from the review offers a somewhat descriptive account of familiarity in a study regarding recognition of depression, by primary care physicians, in patients who smoke; the author talks of familiarity with the patient in terms of "prior knowledge of the patient" and does in fact classify the familiarity according to a three point scale but the categories are "new patient", "somewhat familiar" and "very familiar" (Parchman, 1991). This kind of loose measurement of familiarity in the patient who has been seen before perhaps allows the incorporation of important, subjective feelings on the part of the clinician which, if teamed with vignettes or more detailed explanations, may be quite useful. Of course these three measurements may in some way be comparable to those used by Rost et al (1990) described above, however the words used here are very different with those used in Rost's study which implies discrete, measurable categories, whilst those used by Parchman are at least perceivably indicative of some degree of subjectivity.

Two years after Parchman's study, in an aptly titled article regarding "why do patients continue to see the same physician", Gabel et al cite "patient familiarity with the physician" as a contributing factor to the maintenance of continuous care" (defined as: at least 15 years of seeking health care from a single family physician). Drawing on ethnographic interview questionnaire data and the idea of 'semantic relationships', the authors construct a domain of "familiarity with physician" which includes: "their knowledge of the environment and knowing what to expect during their visit. They knew where the practice was located, where to park, and how to get to the office. There was comfort in knowing the physician's staff and the procedures of the office. The ongoing relationship gave the patients a feeling of freedom from the unknown and allowed them to be relaxed. Even in their discomfort they could be comfortable" (Gabel et al., 1993). This definition gives a lot of detail regarding the particular context of the study and its participants but which is also categorised in such a way as to make transferability and comparisons with other studies possible and relevant.

In an intriguing study regarding "exactly how physicians should participate in their communities" Pathman et al (1998) "propose and test an organising framework that identified four distinct categories of activities whereby physicians can interact with their communities" one of which is the "informed and appropriate use of the community's health resources" which, in the analysis, was described in the following terms: "Familiarity with the community's health resources. Among the community health resources, physicians were most familiar with local physical therapists, social workers, and nutritionists. Physicians were least familiar with the less traditional or mainstream health resources for patients: local chiropractors, women's shelters and clergy" (Pathman et al., 1998). Whilst this may initially seem like a periphery description of 'familiarity' in relation to this review, Pathman et al go on, in the discussion, to say: "The neighbourhood location of primary care physicians and the long-term therapeutic relationships they build with patients make their connections with the community particularly relevant" (Pathman et al., 1998). Thus it is clear from the description of familiarity here that, if anything, it is more than continuity and relates to a detailed understanding of community and the cultural context of patients with whom they may or may not be engaged in delivery of continuous care to, but whom they may encounter within their particular primary care surgery. Certainly the description of familiarity here is detailed and nuanced.

A study published a year later by Robinson and Roter (1999), looking at the problem of psychosocial disclosure in the primary care setting, administered a questionnaire with patients prior to seeing their physicians which, amongst other things, asked patients to rate their physician's familiarity with them; whilst this rating did include a scale: "not at all", "slight", "moderate" and "high", this was asking patients about their sense of "perceived familiarity" (Robinson & Roter, 1999) which would appear to capture more subjective feelings than the kinds of measuring criteria discussed earlier in the review, although the words are somewhat more clinical and objective in tone. Interestingly, Robinson and Roter conclude by saying: "If Primary care physicians inquire, most psychosocially distressed, somatically presenting patients will disclose psychosocial problems" and that "Inquiry is particularly productive with unfamiliar patients" (Robinson & Roter, 1999). Thus they are proposing that perhaps there are negative aspects to 'familiarity' and positives to being 'unfamiliar', although this category is not described or distinguished in its own right but is rather a definition by exclusion.

In a similar vein to Robinson and Roter, Broom 2003's intriguingly entitled article: "Familiarity breeds neglect? Unanticipated benefits of discontinuous primary care" explores the possibility that a familiarity between physician and patient may actually delay the diagnosis of new cases of type 2 diabetes and that therefore there may be benefits to non-familiarity. As discussed above, familiarity was not formally defined for the purposes of the study as it had not been the focus of the research but had emerged as a strong theme from the narratives of the participants; thus familiarity was a "definition by exclusion" being "what was left over after removing the obvious 'discontinuity' (Broom, 2008).

In a UK-based study which explored public preferences for different attributes of out-of-hours primary medical care, Morgan et al found that, whilst attributes such as the doctor's manner (whether the doctor takes time to listen), the type of consultation (whether the patient receives a home visit, telephone advice, sees an accident and emergency doctor or attends a primary care treatment centre) and waiting time for consultation best predicted the public's preferences for out-of-hours care, three other attributes which had been considered were not statistically significant; these attributes included familiarity and were listed as: ease of access, seeing a familiar doctor, and the doctor's shift arrangements. The attribute of 'familiar' doctor was defined as "doctor you know" and "doctor you don't know". This was an interesting finding in terms of assumptions regarding the positive and negative effects of familiarity, and they conclude by suggesting that "more consideration should be given to the doctor's manner and waiting times rather than familiarity of doctor" (Morgan et al., 2000).

In 2005 Hsu et al conducted a longitudinal study to evaluate the impact of introducing Health Information Technology (HIT) on physician-patient interactions during outpatient visits. Drawing on self-administered patient questionnaires which assessed patient satisfaction in three domains, within one of which was perceived primary care provider's (PCP) familiarity with patient, they found that, compared with baseline, consultations using computers improved satisfaction with physicians' familiarity with patients. Familiarity was categorised as "how familiar the PCP was with you as a person" and "how familiar the PCP was with your medical history" (Hsu et al., 2005). Thus the idea of familiarity was clearly divided into two aspects, but kept loose and open to interpretation and subjective feelings of the patients.

In a USA-based study published in 2008 Baik et al explored what comprises clinical experience in recognition of depression in the primary care setting. Drawing on analysis of in-depth interviews with clinicians, the authors proposed that clinical experience comprised of three dimensions which influenced their perceived ability to care for patients with depression: 1. Knowing one's professional role; 2. Knowing oneself; and 3. Knowing one's patients. This third dimension involved the need to have "familiarity with individuals" and it was considered that "familiarity with each patient was important not only for the clinician to recognise the symptoms of depression in the patient but also for conveying the clinician's recognition of the patient in a way that is palatable to the patient". This category of "knowing one's patients" is then described as having 2 aspects, with the first being that: "as a novice, all patients are new and unfamiliar and that it takes time to get to know them". The second is concerned with how acquiring clinical experience highlighted the fact that "familiarity with patients is a key in making the diagnosis of depression. By recognising a change in a patient's behaviour and affect as well as a patient's life context, the diagnosis of depression could be presented". Thus "both the opportunity to acquire the personal knowledge of patients and developing the good sense to use that information took time" (Baik et al., 2008). This assessment of familiarity is very detailed and theoretical in terms of conceptualising its construction and applicability; the authors return to this idea in a more recent article which is discussed below.

A Canadian-based study published the same year as the one above, set out to examine contributory factors to attrition behaviour in diabetes self-management programmes. The study drew on telephone interviews with individuals who had type 2 diabetes and attended a diabetes education centre; findings included the observation that "a common response for programme attrition was the lack of familiarity with the Diabetes Education Centre and its services (Gucciardi et al., 2008). Here the category was constructed to describe the theme which emerged from the data and is not defined in any particular manner, however it is interesting to note that the familiarity being discussed is that which exists between the patient and the particular health care milieu and also that it is actually the lack of familiarity and its effects which is being alluded to.

Another article published that year, based in the USA, involved telephone interviews with primary care clinicians who had participated in a previous study regarding Child Abuse Reporting Experience to explore issues relating to their reporting decisions. Four major themes were identified and these included the theme: Familiarity with the patient or family. In discussing this theme, the authors state that "many clinicians discussed their familiarity/ unfamiliarity with a family in describing their decision-making processes about the injuries they evaluated"; these were separated, by the authors, into four different types of familiarity: 1. Familiarity based on duration of relationship; 2. Judgement based on clinician familiarity with previous health behaviours and attention to medical care; 3. Clinician familiarity with other children in the family; 4. Clinician familiarity with family stressors and/ or family situation (Jones et al., 2008). Whilst Jones et al do offer categories which account for different aspects of familiarity, they are based on the vignettes from the interviews with clinicians and are quite loose and descriptive, allowing for categorisation without being too limiting.

Another USA-based study, also published in 2008, drew upon in-depth, ethnographic interviews with survivors of Intimate Partner Violence (IPV) to understand the risks and benefits of disclosing IPV to clinicians across specialties, including primary care. Amongst the findings the authors comment that: "Regardless of whether disclosure occurred, beneficial encounters were characterised by familiarity with the clinician". Furthermore they observe that: "Of note was the fact that in most beneficial disclosures regarding IPV participants reported familiarity with the clinician" and that "in primary care, these relationships involved getting to know the clinician through a variety of contacts both related and unrelated to IPV" (Liebschutz et al., 2008). In this article, familiarity is used by the authors to describe a theme which emerged from the data, rather than a specific concept which had been formulated prior to the research or a specific measurement applied to the data. The concept is not explored or specifically defined, maybe because this was not the focus of the research or maybe because by this point in time familiarity was being discussed with greater regularity in the literature and was considered to be an accepted term subject to universal understanding. However, a study published two years later was mindful of such assumptions.

In a study of the use of depression instruments in primary care, Baik et al (who wrote one of the other articles of the review, discussed above) found that "a clinician's familiarity with the patient consistently emerged as an important condition for the recognition and management of depression, which can mitigate the challenges of competing demands, stigma, and the absence of objective evidence for diagnosing depression". Furthermore they argue that "the clinician's familiarity with the patient assists in recognising changes in the patient that signify depression, obviates a lengthy negotiation process, breeds trust, and expediates a shared agenda" (Baik et al., 2010). Reflecting on the concept of 'familiarity' Baik et al suggest 2 salient dimensions of familiarity: "the duration and the nature of the patient-clinician relationship". Interestingly they also comment that whilst "continuity of care (seeing a patient over time) is a facilitator in a clinician's familiarity, there is, however, considerable conceptual variation in how clinicians gain familiarity with each individual patient". They conclude by proposing that "further investigation into this conceptual inquiry would be beneficial to our ability to expediate the process" (Baik et al., 2010). Thus Baik et al discuss 'familiarity' in the context of 'continuity of care', making appropriate distinctions, and conclude that the concept of familiarity in primary care, at least where it relates to the familiarity which exists between physician and patient, is in need of further examination and conceptualisation.

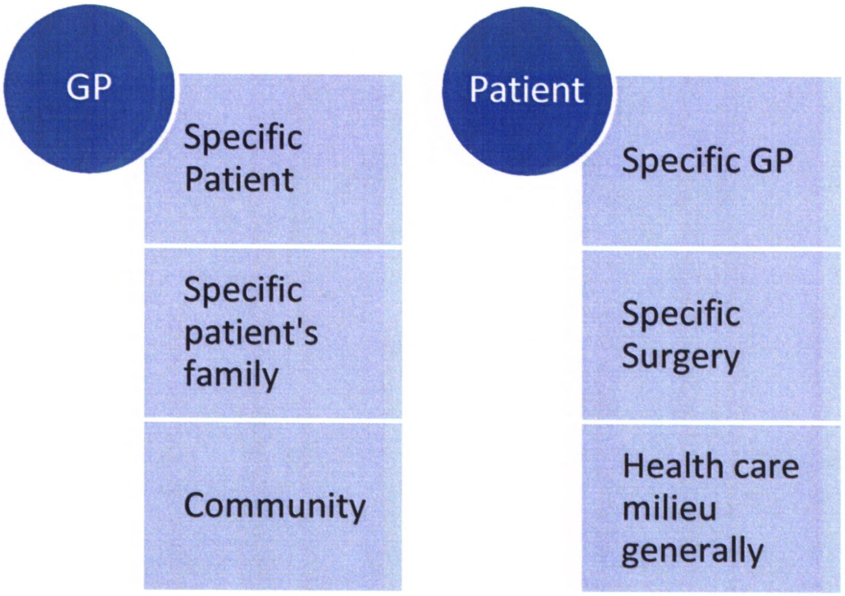
The most recent article to draw on the concept of 'familiarity' in relation to the primary care encounter, without a specific measurement, is a UK-based study which set out to explore the views and experiences of health care professionals in 16 different European countries in relation to the difficulties professionals experience when providing health care for migrant patients. For this study structured interviews with open questions and case vignettes were conducted with health care professionals working in areas with a high proportion of migrant populations; professionals were drawn from 3 health care settings including primary care practices. Of the eight types of problems identified, one of the problems was "lack of familiarity with the healthcare system amongst migrants" This lack of familiarity with the health care system was regarded as common among recent immigrants, for example accident and emergency care was often the only care access many migrants had because they didn't know how the health system worked. In turn, not fully understanding the health care system affected treatment available. Interviewees reported cases where available resources and services were underused by migrants, because they were not aware of their existence. Furthermore, respondents discussed that previous experience in other health care systems often led migrants to have different expectations of the roles of doctors and patients and that "different understandings of the patient-clinician relationship could result in uncertainty and mistrust, if experiences differ greatly from expectation". Interviewees regarded the role of doctors as given greater precedence amongst certain migrant patients, who it was felt "may have unrealistic expectations about the capacity of doctors to sort various physical and social problems within short consultations" (Priebe et al., 2011).

Thus from an overall examination of the literature it seems that, in addition to Baik et al's calls for greater clarity of the conceptual enquiry in relation to the "two salient dimensions of familiarity" namely its: "duration and the nature" within the dyadic patient-clinician relationship, there also seems to be a need for defining the concept in terms of the multi-dimensional context within which this relationship may exist and operate. Thus regardless of measurement or description, one clearly observable aspect of definition remains: between whom or what specifically does the familiarity relate to. This aspect of the articles will now be reviewed.

2.6 Familiarity and non-familiarity in the literature: building a framework of understanding

Having viewed the articles in the review together a framework of multi-dimensional context was constructed which reflected the ways in which relevant 'familiarity' was discussed with regards to the primary care consultation and a model constructed (figure 2)

(Figure 3: GP familiarity/ non-familiarity & Patient familiarity/ non-familiarity)



Whilst discussion of each aspect of this multi-dimensional context were distributed unevenly throughout the articles and some articles discussed more than one aspect, this model appeared to encapsulate all of the different ways in which familiarity was discussed in terms of its influence on the primary care encounter and the doctor-patient interaction therein. It also proved useful to consider 'non-familiarity' in the same terms.

2.6.1 GP-Specific patient and patient-specific GP

As perhaps is to be expected, the dynamic most often explored was that of the dyadic patient-clinician relationship, however more often than not studies focussed on this relationship from either the perspective of the physicians or the patients, rather than both. Thus on the model this is represented as two separate aspects, with one being attributed to the GP section of the model and the other being placed within the patient's framework, although there is a certain degree of overlap. Additionally this dyad and other aspects of the multi-dimensional context of the primary care encounter were also conceptualised, albeit less so, in terms of lack of familiarity, and thus each aspect of the model is also representative of this mirroring concept.

Beginning with the clinician to specific patient dimension, familiarity has been conceptualised in terms of a GP's ability to make informed assessments of patient's in on-the-scene emergency situations, extrapolating from their professional familiarity with them within the primary care setting (Morris, 1976). It has also been explored in terms of its impact upon patient recall of medication change, in a study which considered the co-construction and perception of this familiarity by observing the consultation and then conducting questionnaires immediately following the visit with both participants: clinicians and patients (Rost et al., 1990). It has been conceptualised in terms of a physician's "prior knowledge of the patient" (Parchman, 1991), with consideration given to extent of knowledge and its contribution to the diagnostic process with regards to depression (Klinkman et al., 1998; Parchman, 1991) and mood and anxiety disorders (Wren et al., 2003) and furthermore as a detailed, nuanced concept with degrees of familiarity and distance, as perceived by the GP, resulting in a patient being considered as their "personal patient", their "group's patient", and "not a primary care for the practice" (Kelleher et al., 1997; Wren et al., 2003).

It has been defined in terms of initial visit and return visit, with inferences drawn regarding its impact on the content and duration of the primary care consultation due to its effects on the physician's "practice style" (Bertakis et al., 1999), and physician perception of familiarity with their patients within health systems which involve registered patients, and those that do not (van den Brink-Muinen et al., 2003; Verhaak et al., 2004). It has also been considered as an aspect of clinical experience in terms GP perception of "knowing one's patients" (Baik et al., 2008) as an important aspect of the doctor-patient relationship which is assisted by continuity of care (Baik et al., 2010) and also as a potentially harmful aspect of continuity of care in terms of delayed diagnoses of new cases (Broom, 2003).

Conversely, this dyadic aspect of familiarity has been observed from the patient perspective in terms of the co-construction of the consultation and participant perception of familiarity (Rost et al., 1990). It has been observed from the patient perspective as a reason for pursuing continuous care with the same physician (Gabel et al., 1993) and, conversely, as a less important consideration with regards to planning out-of hours primary care than other factors such as "doctor's manner" and "waiting times" (Morgan et al., 2000). It has also been described as a beneficial aspect of primary care encounters from the perspective of survivors of intimate partner violence, regardless of disclosure (Liebschutz et al., 2008).

2.6.2 GP-Patient's family

Specific reference was made to the GP's prior knowledge and familiarity with a patient's family, although in far fewer cases than the main dyadic relationship of doctor-patient/ patient-doctor. Morris 1976 makes reference to it in term of its importance in the delivery of on-the-scene emergency care in a rural location, in that the perceptions regarding the reporter's emotional status are informed by the familiarity the physician has with them personally since they are often relatives of the patient and may also themselves be patients of the physician (Morris, 1976). Meanwhile a more recent study identified a clinician's familiarity or unfamiliarity with a patient's family as one of four major themes affecting decision-making regarding suspected cases of physical abuse (Jones et al., 2008).

2.6.3 GP-Community

In terms of the wider context of the patient, the study by Morris et al could be seen to be discussing the context of community in that the delivery of on-the-scene emergency care is discussed in terms of the relationships which exists within the rural context of the study and how this impacts upon the delivery of care in this setting (Morris, 1976). A specific focus on community is presented by Pathman et al who discuss the ways in which physicians can interact with the communities within which they live and work; this includes a familiarity with the healthcare resources available and thus by extension the way in which health care is conceptualised, accessed and managed within the community in question (Pathman et al., 1998). In some ways community context is also an aspect under consideration in the most recent study of the review concerned with health care delivery for migrant populations, which involves understanding the ways in which a particular community of people understand and respond to the health care system (Priebe et al., 2011).

2.6.4 Patient to specific surgery

Possibly the flip-side to the GP's familiarity with a patient's family, is the patient's familiarity with a specific surgery, although it does not necessarily follow that a patient will have a sense of familiarity with a specific GP simply because they have a familiarity with the specific surgery within which a GP operates. Within the articles of the review, it was discussed by Gabel et al as an aspect of familiarity with the physician and was described in terms of their "knowledge of the environment" and "thus their ability to know what to expect from their visit". Other important aspects included familiarity with the location of the practice and associated practical knowledge such as where to park and how to get to the office, as well as more emotional aspects such as knowing the physician's staff and the procedures of the office" (Gabel et al., 1993).

Meanwhile, non-familiarity with a specific surgery is cited as a possible contributory factor to attrition behaviour in diabetes self-management programs, with lack of familiarity with a specific diabetes education centre, including a lack of knowledge regarding the program and a lack of awareness of the need to return, being common responses regarding program attrition (Gucciardi et al., 2008).

A Canadian-based primary care practice survey study of residents of the capital district health authority cited "familiarity with the clinic" as a possibly predictor of which particular patient receive advice on diet and exercise; the patients' familiarity with a specific clinic was defined in the study according to "years as a patient" and "total number of visits in the past 12 months" (Sinclair et al., 2008).

Meanwhile, the final study in the review discusses the lack of familiarity migrants have with the health care system in their new country generally which appeared to result in the primary care milieu being bypassed with patients only accessing accident and emergency services for all of their health needs. A number of good practice strategies were also identified in this article for addressing the problems, including fostering good relationships between staff and patients, moving towards continuity of care; one way to achieve this was through the implementation of "welcoming policies" (Priebe et al., 2011) Thus in this instance, increasing patient familiarity with a specific practice was seen as a way to improve the general health care experience of migrants and to reduce difficulties faced by the health professionals involved in delivering the health care to this community.

2.6.5 Patient to health care milieu generally

In some ways this might be seen as the mirror concept to the GP-community construct, with patients coming to appreciate the cultural, professional and political context within which their primary care physicians operate and thus developing a clearer understanding of the primary care encounter. There is an inevitable degree of overlap with the category above, however it is possible for a patient to become familiar with the primary care setting, and certainly the wider health care setting, without consistently attending the same primary care surgery.

The study on attrition behaviour in diabetes self-management, discussed above, in many ways reflects the idea of patient familiarity with the health care milieu generally in that their lack of understanding of how the services of care work in respect to their chronic condition (Gucciardi et al., 2008). However the clearest example within the reviewed articles is the most recently published article regarding good practice in health care for migrants across 16 European countries. In this study "lack of familiarity with the health care system" was pinpointed as one of eight problems identified by clinicians during structured interviews on this issue. This led to inappropriate use of accident and emergency care, affected treatment available to this community and, paradoxically, the underuse of available resources and services because this group were not aware of their existence.

Additionally, previous experience in other health care systems often led migrants to have different expectations of the roles of doctors and patients. Consequently these different understandings may result in uncertainty and mistrust, particularly if experiences differ greatly from expectation (Priebe et al., 2011). This is an interesting observation as in some ways it mirrors the concept of a 'Mutual Investment Company' as proposed by Balint (Balint, 2000) and this would be logical in many ways since Balint was discussing sustained relationships between particular patients and physicians, over time, within the same surgery, within the same health care system. Conversely, the patient group discussed by Priebe et al are in the process of engaging with a new and unfamiliar health care system, and have thus often not yet accessed a particular surgery or if they have are not currently engaged in a state of continuous care with a particular physician and have thus not yet been in a position to consider or develop a mutual trust and respect necessary for the establishment of a 'mutual investment company'.

2.7 Conclusion

The predicament of those experiencing Medically Unexplained Symptoms is best understood within the wider context of contested illness and uncertainty. This conceptual framework has the potential to encompass all of the disparate diagnoses and definitions, and possibly even to be visualised as a continuum which could be useful in terms of understanding how each concept relates to others in the field, particularly with regards to things like having a label or not, belief in organic pathology or psychosocial issues, and whether or not blame is assigned to one side or another. This idea will be explored in more detail in the discussion section of the thesis in relation to the empirical findings of this study.

The patient trajectory and management of such intractable illnesses is best understood in relation to the encounter and more specifically in relation to the doctor-patient interaction within the encounter and its contribution to shaping the ongoing trajectory of the patient. Prior contact and knowledge participants have of each other is an important aspect of the doctor-patient dynamic and undoubtedly has an impact upon the interaction which takes place within the encounter. This has previously been addressed in a number of ways including the idea of the 'mutual investment company' and 'Continuity of Care', however both concepts lack precision and have become part of a fractured field embroiled in emotive debate.

'Familiarity' can exist within and outside of the definitions of the 'mutual investment company' and 'continuity of care' as a distinctive feature, it is less restrictive than most of the definitions applied to continuity of care and is currently a less emotive and thus less confused topic of study; it is also perhaps a more appropriate, relevant and proportionate measure for a more transient, flexible society and the changing nature of the healthcare system which reflects this. Familiarity thus shows potential for being a useful term, as does the mirroring concept of 'non-familiarity'. These ideas will be explored further in the context of the empirical data collected within this study.

2.8 Aims and objectives

It has previously been identified that the interaction between doctor and patient during the primary care encounter has a role to play in shaping and constructing the trajectory of patients with Medically Unexplained Symptoms, both in terms of their experience of their illness and also, to some extent, in certain cases, the severity of the symptoms themselves as well as the longevity of suffering (Salmon, 2006).

It has also been identified that, within the context of the interaction taking place during the primary care encounter, prior contact and knowledge participants have of each other, are influencing factors in terms of understanding and therefore of knowledge construction. However the current conceptualisations which address such prior contact and knowledge – including 'the mutual investment company' and 'continuity of care' – lack precision and are associated with a number of complex and emotive debates, all of which hampers their utility.

The structured, critical review of the literature above, using 'familiarity' as a heuristic to explore the concept of prior knowledge and contact, has revealed that this term has utility for exploring these concepts, within and outside of the aforementioned 'mutual investment company' and 'continuity of care', offering a new conceptual framework within which to conduct the research, including a mirroring concept of 'non-familiarity', which will be useful in defining the largely unexplored ideas of distance and lack of familiarity.

A nuanced model (figure 3) has been constructed in order to define the different aspects and manifestations of 'familiarity' as previously discussed in the literature and this shows promise for providing further clarity of the broad phenomena covered by 'he mutual investment company' and 'continuity of care'. Finally, 'Familiarity' also has the advantage of not being connected to the wider, emotive discussions surrounding the two more established constructs and therefore offers a new lens for studying previously observed phenomena.

Bearing these advancements in mind, the aims and objectives of the study are as follows:

1. Explore the positive and negative impact of 'familiarity' and 'non-familiarity' on doctor-patient interaction within the primary health care encounter, specifically in relation to patients presenting with Medically Unexplained Symptoms
2. Assess the extent that 'familiarity' and 'non-familiarity', in their various guises, as conceptualised in the model constructed from the structured review (figure 3) present within our primary care-based sample
3. Gain an understanding of how the primary care consultations in these circumstances are co-constructed events, including: How participants perceive themselves, and each other, and more specifically what they perceive and why (focussing on the interaction itself)

4. Consider how this knowledge can be applied in a useful and meaningful way, in terms of research, practice and policy

Part 2 of the thesis will set forth the 'Research Strategy' deployed to address these aims and objectives, beginning with a discussion of 'Theoretical Frameworks' and associated issues in Chapter 3, moving onto the 'Methodology' in Chapter 4.

Part 2: Research Strategy

Introduction

Having located the field of enquiry in part one of the thesis, there remain a series of questions, with the main question being: What observable impact, if any, does *'familiarity'* have on doctor-patient interaction during primary care consultations – and, more specifically, in relation to consultations with patients presenting with Medically Unexplained Symptoms? In order to form a clear perspective on the impact of the *'familiarity'* we need to understand the nature and extent of the *'familiarity'* concerned, together with the mirroring concept of *'non-familiarity'*.

Furthermore, if we are to draw inferences regarding the impact of *'familiarity'* on consultations pertaining to *'Medically Unexplained Symptoms'* it will be important to reflect on the specifics of this social and clinical predicament as it appears in the study. A clearer understanding of this cohort of patients as represented within our study will also enable us to critically reflect upon the validity of epidemiological evidence, prevalence rates and other empirical observations presented in the literature, for example: high degrees of somatic responses by GPs despite the absence of demonstrable, organic pathology (Ring et al., 2005).

It will also be important to consider how *'familiarity'* has a bearing on the GPs' perspectives of these patients and on their own role with regards to these patients; equally, attention will need to be paid to how *'familiarity'* affects patients' perspectives of the GPs, and of themselves within the consultation. Additionally, we will need to understand what both participants perceive with regards to the interaction itself, as well as how and why it is that they formed these perspectives. Thus the research methodology must be designed in such a way as to enable the focussing of discussions specifically on the interaction, rather than on the health trajectory generally (for patients) or their role as practitioners generally (for the GPs).

In summary, we need to gain an understanding of the primary care consultation as a '*co-constructed'* event, specifically in relation to patients whose suffering is currently unexplained within the western biomedical model and is thus, to varying degrees, contested. This understanding will inevitably include any perceptions constructed by the participants post-consultation, as well as the explanations and justifications offered by the participants for their ideas and actions, which may or may not reflect their true understanding or feelings regarding the encounter.

Part two of the thesis therefore is concerned with presenting the research strategy for exploring these questions, including the conceptualisation of a theoretical framework within which an understanding of the problem to be explored is formed, and then the methodological approach designed for the empirical researching of the emerging questions and subsequent analysis strategies for dealing with the data produced.

Chapter three will reflect on epistemological considerations in the context of social science research, specifically in relation to: health care and an illness category with a high degree of uncertainty; interaction and relationships in terms of degrees of prior knowledge or distance. By considering the questions we seek to answer and the range of epistemological theories available, a theoretically informed framework will be constructed which will best suit our project of enquiry.

Chapter 4 will then focus on the formulation of the methodology for the study, considering the implications of the theoretical framework, and consider the methods which would offer the best mode of enquiry for the data we hope to collect and the questions we seek to answer.

Chapter 3: Theoretical framework

3.1 Introduction

It is generally accepted that social science research should be embedded within a *'theoretical framework'* and that this will offer perspectives, methods and a *'tradition'* within which to situate the research. The reasoning behind this assertion is that social science research is inevitably framed by conceptual and theoretical considerations and thus such frameworks, properly handled, can enrich and enhance the research (Cooper, 2001 , p-13)

Furthermore, Gilbert points out that, in some senses, it is not a question of choosing whether to ignore or attend to these issues, since theory *will* be present in the research, but may be present in the form of unrecognised assumptions that shape what is done in an uncontrolled manner. Thus, the explicit use of concepts and theories is part of good research practice, in that the researcher will have more control over the direction, meaning and implications of his or her work (Gilbert, 2001). This reasoning seems plausible since researchers do inevitably bring their own ideas and perspectives to the research and this will indeed have some bearing on all aspects of the research process, including the conceptualisation of the research questions, through to the selection of methods for data collection.

Setting out a *'theoretical framework'* at the outset then would seem to be a most sensible and worthwhile endeavour; if nothing else it offers a coherent landscape of ideas and a shared language within which to debate our topic of study. However, upon closer inspection, this is actually far trickier a task than at first it may appear, since it can be quite difficult to navigate the plethora of terms which appear to be used to describe this particular component of the research process, all of which may have a slightly different meaning or else refer to a different aspect of research entirely and are used to varying degrees, interchangeably.

All of this makes for confusing reading and can feel quite detached from the starting point of wishing to explore certain questions and intriguing social phenomena. This is therefore a matter to which the researcher devoted a considerable amount of time and energy, and the fruits of this enterprise comprise the rest of this chapter, setting the scene for chapter four which will chart the development of an innovative research methodology designed specifically to address the various complexities of the subject matter under observation and to enable the exploration of the research questions set out in part one of the thesis.

3.2 What is a *'theoretical framework'*?

As mentioned above a plethora of terms has been applied to this aspect of research, seemingly with varying degrees of overlap and misinterpretation. To begin with the term *'paradigm'*, this was first coined in 1962 by Philosopher Thomas Kuhn, in *'The structure of scientific revolutions'*, to describe the underlying conceptual framework supporting a whole scientific worldview upon which scientific theories are based (Kuhn, 1970).

In 1970, Kuhn argued that science proceeds through successive scientific revolutions whereby one paradigm of scientific understanding is replaced by another, with *'paradigm'* representing a cluster of beliefs about the proper conduct of science; an important tenet of this argument by Kuhn was that multiple paradigms within a field were incompatible (Bryman, 2008). Kuhn termed the replacement of one *'paradigm'* with another *'paradigm shift'* (Kuhn, 1970)

However the term *'paradigm'* is now also widely used within the social sciences to describe underpinning theoretical ideas and perspectives upon which methodological decisions are based. Paradigms are also interchangeably referred to as: *'theoretical frameworks'*, *'theoretical perspectives'*, *'sociological perspectives'*, *'sociological theories'*, *'theoretical orientations'*, *'conceptual frameworks'*, *'approaches'*, *'stances'* and *'epistemologies'*.

Essentially, it seems, they are thought of as *'world views'* - lenses through which to organise experiences and which provide insight into the most valid and reliable methodologies (Cooper, 2001); and contrary to Kuhn's assertions regarding *'paradigms'* in the scientific world, there are numerous perspectives and schools of thought existing simultaneously, within the realm of the social sciences, with which a researcher can align themselves and *'locate'* their studies.

The emergence of the idea of a *'science of society'* is attributed to the enlightenment period and more specifically to Auguste Comte, who coined the term *'Positivism'* to describe the concept of applying natural science methodology to human society. The aim of *'positivism'* was to discover *'laws'* of society, which were thought to operate in a manner similar to the laws of nature, so that just as technology successfully manipulated the physical world, a social technology could engineer rational changes in the social world (Filmer et al., 1998).

Whilst positivism has been hugely influential it has been heavily criticised on a number of counts, primarily for its reductionism and failure to appreciate the complexity of human behaviour and the influence of factors such as context (Smith, 1998) and the way in which people may construct and reconstruct their accounts of their experiences and beliefs (Silverman, 1993).

Subsequently more reflective attempts to understand society emerged and an abundance of overlapping and competing perspectives, paradigms and approaches came into being, each with their own merits and critiques, with some popular paradigms including: phenomenology, ethnomethodology, symbolic interactionism and grounded theory - although there appears to be some ambiguity on the point of whether or not this is a methodology which resists the idea of a theoretical framework or whether it is in fact its own theoretical framework, with the argument complicated further by the fact that the two founders parted company and subsequently set about shaping their own versions of grounded theory (Charmaz, 2005).

The ensuing tensions and debates have been hailed by some as the *'paradigm wars'*, although there is also some confusion regarding what precisely this alludes to, with arguments alternating between the philosophical and technical divides that characterise qualitative and quantitative research. In epistemological and ontological terms, it seemingly refers to a perceived incompatibility of fundamental assumptions in terms of what should be regarded as acceptable knowledge and how institutions should be characterised (Bryman, 2008)

Thus lines are drawn between competing theoretical approaches, frameworks and paradigms. Each provides a *'tradition'* within which to frame research (Cooper, 2001) and thus practical guidance on: how to approach the research question; which methods or *'instruments of observation'* to apply (Sulkunen, 2008); how to analyse your data; and to some extent whose work to draw on when discussing your findings. It also provides a protective justification which can be drawn upon to explain why certain things were done in a certain way.

However the decision is less clear when working in an interdisciplinary environment, particularly where multi-method research has obvious practical value in terms of explaining epidemiological anomalies such as high levels of somatic interventions in patients lacking demonstrable organic pathology (Ring et al., 2005). Thus, if epistemological considerations are mixed up with the qualitative, quantitative divide, and different epistemological positions invite different standpoints to what data is, and indeed what can legitimately be termed *'data'*, what of multi-method approaches? (Nilsen, 2008)

Thus, in an age of interdisciplinarity and increasing methodological pluralism, how best to navigate the competing epistemological frameworks and paradigms to find a suitable intellectual space within which to conduct one's research?

3.3 The process of selecting/ conceptualising a theoretical framework

So it seems that in order to select a theoretical framework within which to frame one's research, the researcher must read about the different paradigms and decide which is the *'best fit'* for them. The task is to assess which *'world view'* most closely matches one's own. However, Pertti et al suggest that, whilst there is generally a tendency in the field of social science for researchers to define themselves and others in terms of their *'differentness'*, and whilst these differences are referred to as *'paradigms'* or *'philosophical positions'*, they often have more to do with technical decisions regarding the methods they wish to use (Pertti et al., 2008).

In any case the question remains: why then is the self-identity of social researchers caught up in the idea of incommensurable paradigms, which downplay diversity and a pragmatic use of methods? Particularly when it is evident that, despite the *'paradigm wars'*, in actual practice, social researchers have always been quite flexible in applying different methods (Pertti et al., 2008).

Salmon 2003 is quite candid in his scepticism regarding the popular assertion that qualitative investigators should explicitly state the epistemological basis of their work, particularly where this is drawn upon to justify the use of particular methods. He points to the important distinction to be made between the fact that "epistemologies describe the use to which methods can be put, not which methods can be used, for example qualitative methods can serve a researcher who believes that research *discovers* underlying reality (an assumption associated with the positivist paradigm) as easily as they serve one who believes that researchers' interaction with research participants *constructs* reality" (Salmon, 2003).

Furthermore, Salmon believes that "it is a rare researcher who thinks through an epistemological position before choosing a method", and that "such positions are more often post-hoc rationalisations of what has been done". Speculating regarding the underlying reasons for this phenomenon which he terms *'retrospective epistemologism'*, Salmon suggests that, in reality, "researchers use methods for historical, ideological or practical reasons – they use the methods they have learned to use and that they *can* use" (Salmon, 2003).

Perhaps some additional reasons could be considered alongside those proposed by Salmon, for example: a postgraduate student or a contract researcher may have come to a research project which has already been conceptualised, and the researcher employed to conduct the research and apply the methods which have already been selected and which have received ethical approval.

Whilst it is not entirely improbable that a person in such a position may gain extraordinary insights from their superiors and that this may alter their *'world view'* and thus their *'research paradigm'* (particularly in the case of postgraduates for whom the learning curve of producing a thesis is immense) it still seems quite unlikely that this is the case with each research project they take on until they themselves gain autonomy over the conceptualisation of the research proposal. Again, it is therefore more likely that the researcher will adopt the paradigm or approach selected by their supervisors or line manager, who will themselves have complex reasons for their selection.

In view of these revelatory discussions it is worth noting that there are arguments within social science against conforming too strictly to the doctrines of a particular framework or methodology, for example the criticism of *'cookbook'* style methodology (Charmaz, 2006). Additionally, certain distinctive and highly influential views of the world are derived from the work of individual thinkers who may not be located within a particular school of thought, for example Erving Goffman and Michel Foucault (Cooper, 2001).

Foucault in particular was quite resistant to the idea of specifying an *'epistemological position'*, or indeed of having a new epistemological tradition based on his work. Instead he advocated the idea that others should draw on aspects of his work which they found useful for their own projects or needs; notably he conceptualised the idea of his work as a *'toolbox'* making the following comment in an interview about his expectations for *'Discipline and Punish'*:

"I want my books to be a sort of toolbox that people can rummage through to find a tool they can use however they want in their own domain...I want the little book that I plan to write on disciplinary systems to be of use for teachers, wardens, magistrates, conscientious objectors. I don't write for an audience, I write for users, not readers" (Gutting, 2005 , p113, quoting Foucault interview 1974).

It is worth noting here that Foucault was referring to the ideas and conceptualisations within his work, rather than in the sense of the application of particular methods as neutral tools, which has also been a popular analogy, particularly in texts describing social survey work, but has been criticised for its positivistic implication that the objective investigation of social and cultural life is uncontroversial (Seale, 1998).

However, there are, it seems, some emerging conceptual frameworks which allow for flexibility of approach in terms of epistemological, ontological and paradigmatic assumptions and subsequent methodological development. Three of the most prominent are: *'complexity science'*, *'epistemological anarchism'*, and *'bricolage'*. These will now be briefly discussed in relation to each other, and the theoretical framework of this study will be outlined.

3.4 Complexity science, epistemological anarchism and Bricolage

Complexity science emerged within the natural sciences in response to the need to explain certain observable phenomena, for example: weather patterns, which did not appear to conform to the concepts of the existing scientific paradigm, based on the principles of order, reductionism, predictability and linearity, and instead produced complex and unexpected results (Cooper & Geyer, 2007).

Broadly speaking, complexity science has developed as a transdisciplinary term for describing and understanding a wide range of chaotic, dissipative, adaptive, nonlinear and complex systems and phenomena, and thus represents a challenge to the long held belief in the linear paradigm, human rationality and fundamental physical order. In this sense it can be said to represent a 20th century Kuhnian *'paradigm shift'* (Bogg & Geyer, 2007).

At its core is the critique of the idea that physical and social phenomena are primarily linear and therefore predictable, orderly and that they can reach stable endpoints, and the recognition that many phenomena are directed by non-linear interactions that cannot be understood by breaking systems down into constituent elements and applying analytical rules (Kernick, 2002). Whilst it does not disprove the linear model, it does argue that there are a range of social phenomena which cannot adequately be understood within this framework (Bogg & Geyer, 2007).

Drawing on biological theories regarding co-evolution and natural selection, a central tenet of complexity is the concept of a *'critical point'* (far-from-equilibrium) which a complex system will reach as a result of interacting variables, upon which either a new order will be created or else disorder will ensue. Being pushed far-from-equilibrium is healthy behaviour in a complex system, as it facilitates evolution and adaptation, leading to better ways of working. When a social entity is pushed far-from-equilibrium, it is forced to experiment and explore the *'space of possibilities'*, in order to discover and create new ways of working (Spencer, 2009).

The versatility of complexity science in terms of method selection in the social science includes its natural acceptance of the use of quantitative and qualitative methods, recognising the value of the former for investigating the linear aspects of social phenomena, and the latter for enabling the investigation of alinear aspects of the same social phenomena (Cooper & Geyer, 2007).

Its value in terms of healthcare research and practice has also been highlighted, given that the *'current explanatory model of medicine'* is largely speaking positivistic and increasingly found to be lacking in terms of its ability to equip health professionals working in the field in terms of the problems which confront them in their routine practice (Sweeney & Griffiths, 2002 , p xiv).

Recent research in the field of type-1 diabetes has demonstrated the usefulness of complexity science as a theoretical framework for conceptualising illness, particularly illnesses of uncertainty. Its application and critique of the current reductionist, biomedical approach to diabetes care has merit both in terms of researching and understanding the multiple, interacting variables of diabetes management and also practical application in terms of blood glucose management, particularly in adolescents (Cooper & Geyer, 2007; Spencer, 2009).

However Spencer 2009 discusses the *'epistemological problem'* of complexity science as a theoretical framework by itself, drawing on criticisms of this idea which include: the interdisciplinary background of its methods, models and metaphors (Spencer, 2009). The central tenet of Spencer's argument appears to be that conducting qualitative research grounded in epistemological tradition is essential to give validity and trustworthiness of research findings and conclusions, which will be based on demonstrably sufficient knowledge of the assumptions of this tradition, by the researcher, and by the methods used (Spencer, 2009).

Other criticisms from the field presented by Spencer include the lack of prior, empirical application, and the fact that complexity science is thus currently, largely *'metaphorical'* in nature and is therefore a set of presuppositions rather than a distinct epistemology for exploring phenomena (Luhman & Boje, 2001). Whilst Phelan 2001 takes this further to state that: "allowing metaphors to dominate a field of study holds the risk of lowering the credibility of the field in mainstream science and hinders the resources for future development" (Phelan, 2001).

In considering the above critique of complexity as a theoretical framework we can return to Salmon's discussion regarding recognising good research, in which he draws on the work of Feyerabend to highlight the fact that "the justification for the value of scientific methods, if based on the methods themselves, is inherently circular and an example of *'methodologism'*" (Salmon, 2003). Interestingly, in this same article, Salmon proceeds to describe the *'epistemological anarchism'* framework, set forth by Feyerabend (1975, 1978) as an alternative to such *'methodologism'*. According to Salmon, this epistemology "highlights the fact that all methodologies have limits" and suggests therefore that "the value of a methodology can only be tested by research that violates it. Thus scientific progress has resulted, not from allegiance to methodological rules, but from breaking them" (Salmon, 2003).

This would appear to resonate with the concept of a *'critical point'* (far-from-equilibrium) discussed within complexity science (Spencer, 2009), suggesting that both could have similar implications for research as potential theoretical frameworks and the subsequent selection of methods. Additionally these concepts resonate with the comments Foucault made regarding the interpretation and application of the work of others:

"I prefer to utilise the writers I like. The only valid tribute to a thought such as Nietzsche's is precisely to use it, to deform it, to make it groan and protest. And if commentators then say that I am being faithful or unfaithful to Nietzsche, that is of absolutely no importance" (Gutting, 2005 , quoting Foucault, p43).

Discussing Feyrabend's earlier work (lectures on *'Knowledge without Foundations'*), Couvalis 1989 highlights the fact that Feyerabend was not only sceptical about the idea that a *'traditional epistemology'* would experience any degree of success in locating "the foundations of all out knowledge", but that such a search was actually dangerous as well as useless, since it ran the risk of establishing false beliefs which would be held uncritically (Couvalis, 1989 , pvii).

Furthermore, Couvalis describes the way Feyerabend still saw merit in the pursuit of particular kinds of knowledge, but through a differently developed approach which consisted of encouraging the development of a proliferation of rival theories which would be used to show up one another's inadequacies. Thus, when looking for foundations (or theoretical frameworks) the existence of rival theories on a subject should be seen as an advantage rather than a problem (Couvalis, 1989 , pvii-viii).

The implications of complexity science and epistemological anarchism for the researcher at work constructing their methodological framework would therefore appear to be that experimentation and combining challenging methods, possibly even from diametrically opposed paradigmatic traditions, are pivotal to successfully exploring their subject matter and producing a useful analysis.

But how then does the researcher decide which particular methods to use? Salmon's view is that Feyrabend's ideas "provide an epistemological rationale" for a playful and creative approach to research rather than one which requires strict adherence to methodological rules. According to Salmon, "the anarchist scientist is not only free to select from an infinite array of methods but may also create their own methods, possibly even mid-research, learning and adapting in order to explore and describe their observations to best effect" (Salmon, 2003).

This aspect of epistemological anarchism resonates with a third theoretical framework – the multilogical *'Bricolage'*. As Kincheloe and Berry 2004 explain, *'bricolage'* refuses to follow a set course and values improvisation; it involves the process of employing methodological strategies as they are needed in the unfolding context of the research situation. The bricoleur or bricoleuse' "actively constructs research methods from the tools at hand rather than passively receiving the *'correct'*, universally applicable methodologies" (Kincheloe & Berry, 2004 , px1 - 2).

Describing what they term the *'impudent dimension'* of bricolage, Kincheloe and Berry tell us that "bricolage is cynical of the notion that monological, ordered methods get us to the 'right place' in academic research". Instead, bricoleuse believe that methods should be employed because they are considered to be the best suited to answering the question at hand (Kincheloe & Berry, 2004).

Thus bricolage perfectly encapsulates the flexibility and creativity of approach espoused by complexity science and epistemological anarchism and, given its metaphorical origins (explored below) it even captures Foucault's concept of the research *'toolbox'*. This appealed very much to the researcher, as did the recent application of the analogy with *'quilt making'* (Denzin & Lincoln, 2005a; Flannery, 2001) which holds a personal significance for the researcher as well as a particular applicability to the subject matter and the interdisciplinary nature of the research.

3.5 The researcher as *'bricoleuse'*[8] and *'quilt-maker'*

3.5.1 Origins of *'bricolage'*

The concept of *'bricolage'* was first set forth by Claude Lévi-Strauss in his 1966 text *'The Savage mind'* in which he states his intention to explore the positive side of *'totemism'*, which had been the subject of his previous text of the same title (Levi-Strauss, 1968 , pxi).

In chapter one of the *'The Savage mind'*, Lévi-Strauss sets about describing the function of myths and rites within the *'science of the concrete'* of totemistic, tribal groups, and states that, in spite of being restricted by its essence to results, this form of scientific knowledge was no less scientific than the exact natural sciences of the day and its results no less genuine (Levi-Strauss, 1968 , p16/17).

Lévi-Strauss then expands upon this theory of the relations between these two kinds of scientific knowledge by drawing an analogy with the relations between engineers and modern day *'bricoleurs'*, which was, at the time of writing (and still is today) a French term used to describe someone who works with their hands, undertaking odd jobs and is a jack of all trades or a kind of professional do-it-yourself. The crux of the comparison appears to be that whilst engineers and natural scientists require certain raw materials and particular tools in order to perform particular tasks, the *'bricoleur'* makes do with *'whatever is to hand'* and mythical thought does the same in terms of drawing on the previous

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[8] In most of the literature where reference is made to the person performing the act of 'bricolage', the term 'bricoleur' is used; however this is the masculine form of the noun, and since the researcher is female, the feminine form 'bricoleuse' is used here (WordReference.com accessed 7th December 2011). However when quoting the work of others who refer to 'bricoleurs' this term will be used for accuracy of referencing and ease of reading.

experiences, observations and reflections of the individual; thus "mythical thought is a kind of intellectual *'bricolage'*" (Levi-Strauss, 1968 , p16/17).

The concept of *'bricolage'* has subsequently been adapted and developed, with de Certeau describing it as *"the poetic making do"* (de Certeau 1984), whilst extensive mapping of its application to the field of qualitative enquiry and the conceptualisation of the researcher as *'bricoleur'* has been contributed by Denzin and Lincoln and their handbooks of qualitative research (Denzin & Lincoln, 2000; Denzin & Lincoln, 2005b) and further conceptualisation contributed by Kincheloe (Kincheloe, 2001; Kincheloe, 2005a; Kincheloe & Berry, 2004; Kincheloe, 2005b).

Another interesting development has been the further metaphorical analogy of qualitative researchers as *'bricoleurs' or* and *'quilt makers',* drawing parallels between the fact that both *'bricoleur'* and *'quilter'* work with the materials they have to hand and do so with varying degrees of adherence to overarching patterns or designs, depending on the individual purpose and circumstances under which the research is conducted and the quilt created (Flannery, 2001).

3.5.2 Current application of *'bricolage'* and the metaphor of *'quilting'*

Drawing on the metaphor provided by Lévi-Strauss the concept of *'bricolage'* has been applied to all aspects of the research process including: interpretive; theoretical, political and methodological (Denzin & Lincoln, 2005a) and Kincheloe 2005 states that: "In the first decade of the 21st century, bricolage is typically understood to involve the process of employing methodological strategies as they are needed in the unfolding context of the research situation" (Kincheloe, 2005b).

Citing Becker 1998, Denzin and Lincoln describe how the "qualitative researcher as *'bricoleur'* uses the tools of his or her craft, deploying whatever strategies, methods, and empirical materials that are to hand" (Denzin & Lincoln, 2005a , p4). Furthermore they comment that "if the researcher needs to invent, or piece together, new tools or techniques, he or she will do so" and that "choices regarding which interpretive practices to employ are not necessarily made in advance" (Denzin & Lincoln, 2005a , p4).

In theoretical terms the researcher-as-bricoleur is knowledgeable about many interpretive paradigms that can be brought to any particular problem and the "'bricoleur-theorist' works between and within competing and overlapping perspectives and paradigms". In methodological terms the bricoleur is "adept in a diverse range of research methods and related tasks and processes, including intensive self-reflection" (Denzin & Lincoln, 2005a , p6).

Thus the qualitative researcher is, it seems, engaged in the kind of *'intellectual bricolage'* observed by Levi-Strauss in mythical thinkers. They may draw upon any number of interdisciplinary paradigms as 'lenses' and apply a plethora of methodological procedures in their exploration of a particular phenomenon, including the kind of creative approach which may involve the development of new tools specifically fashioned for the job in hand, as described by Salmon 2003 in relation to epistemological anarchism (Salmon, 2003).

According to Kincheloe: "Bricolage exists out of respect for the complexity of the lived world and is grounded on an epistemology of complexity" (Kincheloe & Berry, 2004). Furthermore, "Appreciating research as a power-driven act, the researcher-as-bricoleur abandons the quest for some naïve concept of realism, focusing instead on the clarification of his or her position in the web of reality and the social locations of other researchers and the ways they shape the production and interpretation of knowledge" (Kincheloe, 2005b).

Drawing on the work of Pattie Lather (1991; 1993), and Richardson (2000) McKenzie 2005 describes the way that "this 'art of quilt making'" and "oblique collage of juxtapositions" might seek to combat the idea of reality as being something which awaits discovery, as espoused by "positivistic and postpositivistic traditions" and the "traditional regimes of truth in the social sciences" by moving towards what Lather terms "transgressive validity" and which Richardson terms "crystallization".

Both promote the idea of adopting methodological practices which capture multiple-dimension approaches to the world (McKenzie, 2005)

3.5.3 Quilting as a metaphor

In exploring the *'quilting'* metaphor, Flannery 2001 argues that current metaphors in science are "distinctly masculine in tone" for example, use of terminology such as "exploring, hunting, discovery, wresting secrets from nature, and conquering or penetrating the unknown". Drawing on Tiles 1996, Flannery explains that it is important to give consideration to the use of metaphors since "the content of scientific knowledge cannot be completely separated from the means used to acquire that knowledge" and that metaphors are a part of the means. It is Flannery's contention therefore that alternative metaphors should now be sought which have "less aggressive and alienating connotations", with one such metaphor being that of *'quilting'* (Flannery, 2001).

Highlighting the applicability of *'quilting'* as a metaphor, Flannery draws parallels between the *'quilter'* and the *'scientist'*, in that "both spend their time trying to fit pieces together to make a pleasing whole, and often, this involves playing with the pieces, rearranging them to make them fit and to allow them to be used most effectively". Furthermore, "both quilting and science are crafts that must be learned, and the best way to learn each is by doing, by being apprenticed to experts" (Flannery, 2001).

Flannery points out that, just as quilting often operates within narrow design parameters of existing quilt patterns, so too do scientists, and "a researcher may use a particular experimental design, a particular approach, over and over again to attack different problems because this plan has been successful in the past". Thus, Flannery points out, there is a tension in both worlds, "between creativity and conformity, with great value placed on creativity, but always within a framework: for quilters, a pattern or style, and for scientists, a paradigm, a way of thinking, a ruling theory that shapes the way work is done within a field" (Flannery, 2001).

These reflections resonate with those set forth by Salmon 2003 in relation to the fact that "researchers use the methods they have learned to use and that they *can* use, whilst a tension exists between strict adherence to methodological rules and the potentially more fruitful approach of permitting the researcher to draw upon their 'imagination, creativity and common sense'" (Salmon, 2003).

Emphasising the link between *'quilting'* and *"bricolage or tinkering"*, Flannery points to the fact that "historically many quilts were made out of necessity from bits and pieces of cloth from worn-out garments or scraps from other sewing projects" and thus quilters had to do the best they could with what they had. Meanwhile, "in qualitative inquiry, there is the necessity of selecting from the results those that can be stitched together to make the most compelling case and then deciding how to juxtapose elements, as in a quilt, so they are most rhetorically effective" (Flannery, 2001).

Drawing inferences from the application of the metaphor, Flannery observes: "Bricolage, in both science and quilting, implies more than just making the best of a bad situation. It implies creativity that although born out of necessity nonetheless results in a very positive outcome. Being forced to use unlikely materials or ideas, in new ways, often leads to particularly elegant results" (Flannery, 2001). This is an important point to note, that the outcomes of *'tinkering'* and *'quilting'* can often be preferable to those achieved through careful adherence to a precise framework, instructions manual or quilting pattern.

Exploring the significance of the metaphor, Flannery points out that, "unlike many others used to characterize science, it is a metaphor with many feminine connotations" and also that it is a "culturally inclusive metaphor" given the strong tradition of quilting amongst African American women (and its link to their African Heritage) and also its tradition in many other cultures worldwide (Flannery, 2001).

Indeed Hooks 1990 devotes an entire chapter to the discussion of actual quilting and its tradition within her family, exploring the art of making *'crazy quilts'* (or utility quilts) in African American households to explain the metaphor being used at the beginning of the chapter to describe the way in which she conducted the research for her book. Quoting an extract from "*Artists in Aprons: Folk Art by American Women*", Hooks states that:

"A woman made utility quilts as fast as she could so her family wouldn't freeze, and she made them as beautiful as she could so her heart wouldn't break" (Hooks, 1990 , p115-117).

These reflections on the metaphor of quilting were very appealing to the researcher, particularly the above reference to the creativity entwined with functionality, steeped in familial and cultural traditions. Being from the Welsh community, where quilting has a long and cherished heritage, the researcher felt a natural affinity with the concept of quilting as a metaphor and additionally liked the idea of her research being something which she could approach creatively as well as functionally, experimenting rather than adhering to a strict methodology.

The mix of functionality and creativity in actual Welsh quilting heritage has recently become the focus of the work of Valériane Leblond, an artist from French-Quebec who has settled in Ceredigion and has devoted considerable effort to capturing rural Welsh life in the small, white cottages of the area and the significant role of quilting in this setting: (accessed 22nd May 2011).

(http://valeriane-leblond.eu/yn_ngymraeg/Oriel/Pages/2009.html

Parallels can also be drawn between the quilting mentioned by Hooks and Flannery above, and that discussed by Marged Lloyd Jones in *"O Drelew i Dre-fach"*, as she describes how her mother-in-law created a marvellous quilt from pieces of clothing of the original community to settle in Patagonia. This quilt utilised scraps of clothing from garments with cultural and personal significance to create a unique quilt which served to celebrate the historical voyage and settlement of this particular community (Lloyd Jones, 2007).

Finally, in exploring *'quilting'* as a research metaphor, Flannery acknowledges the limits of metaphors and discusses them with particular reference to the quilting metaphor; she concludes with an interesting comment regarding the fact that "science can only benefit from the stretching of its metaphorical borders, allowing new approaches and the framing of new questions" (Flannery, 2001). Given that this message is at the heart of the science of complexity, epistemological anarchism and *'bricolage'*, it seems that the exploration of metaphors in this way has merit and was fitting in this discussion for the purposes of the project.

3.5.4 Bricolage in health and relational research

In terms of research specifically relevant to the field of study in question, *'bricolage'* has been applied in the fields of health and also in the re-conceptualisations of relationships. For example McAndrew and Warne 2009 explore the use of *'bricolage'* in the context of researching nursing practice and conclude that it "provides the opportunity to re-examine the significance of personal beliefs as these are brought into contact with the practice of nursing" (Warne & McAndrew, 2009).

Meanwhile Aagard, discussing the complexity of establishing a Western health care program in an indigenous culture (a hospice and palliative care programme in Tanzania), applies the term to the actual practice of nursing rather than researching (Aagard, 2009). This focus is also evident in Broom's exploration of how patients being treated with a combination of biomedical and complementary and alternative medicine navigate the "'piecing together' of therapeutic trajectories, drawing on intuitive, embodied knowledge, as well as formalized 'objective' scientific expertise" (Broom, 2009).

However in exploring the conceptualisation of *'acquaintanceship'* in terms of knowledge and degrees of distance, Morgan 2009 describes the research process itself as a "form of bricolage", which he says is: "rather like acquaintanceship itself" (Morgan, 2009 , p16).

The idea of the research process mirroring the field of enquiry appealed to the researcher since it seemed that *'bricolage'* was a central feature of much of the subject matter under scrutiny, for example: General practitioners (GPs) draw on a broad range of medical, psychological and social knowledge and training, as well as their own intuition and autobiographical experiences, in order to recognise, diagnose and treat or refer a whole spectrum of health difficulties which are presented to them in no particular order or manner as part of their daily routine.

Additionally, patients must present their health difficulties as best they can, working within a framework of knowledge and using language which may be a complex mix of lay perspective and specialist knowledge gleaned from any number of resources now available. The primary care encounter then is then the ultimate exercise in *'bricolage'* since the participants are engaged in the task of defining the problem and searching for solutions, drawing on anything useful that comes to hand (or mind) within reason.

3.5.5 Challenges facing the *'researcher-as-bricoleuse'* and *'maker-of-quilts'*

Kincheloe 2001 recounts the difficulties his doctoral students experienced in attending job interviews, where search committee members responded negatively to the methodological employment of *'bricolage'* which statements such as: "bricolage, oh I know what that is; that's when you really don't know anything about research but have a lot to say about it" (Kincheloe, 2001). However, as has been discussed here, contrary to this belief it is the *'bricoleur'* or 'bricoleuse' who holds a fuller, more well-rounded understanding of the research sphere, since they are engaged in a process of constantly challenging the research process and experimenting or 'tinkering' in the Levi-Strauss sense.

Furthermore, drawing on the work of Friedman 1998 and McLeod 2000, Kincheloe points out that, "given the social, cultural, epistemological, and paradigmatic upheavals and alterations of the past few decades, rigorous researchers may no longer enjoy the luxury of choosing whether or not to embrace the bricolage" (Kincheloe, 2001). Kincheloe also points out that the rationalistic articulation of method runs the risk of perpetuating 'unanalysed assumptions' embedded in such "passive methods" (Kincheloe, 2001). Elsewhere, Kincheloe also reasons that "for the bricoleur to use the means at hand, the methods that exist, demands that the researcher be aware of them" (Kincheloe, 2001).

Thus the researcher must strive to be comprehensively knowledgeable in as wide a field of epistemological perspectives and methodological strategies as possible; in terms of the Foucauldian toolbox analogy, the researcher should be constantly looking to obtain and maintain a wide range of tools which they can draw on to meet specific project aims.

On this point the researcher's academic background and diverse career can be thought of as an advantage. Having studied an undergraduate degree in Sociology and History the researcher undertook a research dissertation in Sociology on the topic of: "The drowning of the Tryweryn valley to provide water for the city of Liverpool and the rise of nationalism in Wales" (Edwards, 2001).

An assortment of methods was deployed for the purposes of this research, including archive searches in Dolgellau archive and Liverpool Records Office. Subsequently the research evolved into action research and included meetings with the city council to discuss the possibility of a public apology and a monetary donation to the fund to erect a monument on the banks of the reservoir to commemorate the drowning which was constructed as an event of social and historical significance in Wales. In addition the researcher has worked on a variety of research projects and held a diverse range of employments and voluntary positions which can also be drawn upon as part of the research process since, according to Denzin and Lincoln (citing Harper 1987) "the bricoleur's life story, or biography may be thought of as *'bricolage'*" (Denzin & Lincoln, 2005a).

Finally, Kincheloe points out that "At the core of the deployment of *'bricolage'* in the discourse of research rests the question of disciplinarity/ interdisciplinarity. *'Bricolage'*, of course, signifies interdisciplinarity – a concept that serves as a magnet for controversy in the contemporary academy" (Kincheloe, 2001). Since the research team and nature of the enquiry are intrinsically interdisciplinary in nature and thus are already subject to the criticisms and controversies which are likely to be attracted by deploying *'bricolage'* as a part of the research strategy, bricolage would seem to be an excellent choice of theoretical framework within which to conceptualise the research.

3.6 A theoretical framework drawing on Bricolage: justification for final selection

From the initial scoping exercise undertaken and presented in chapter 1 it became clear from the outset that the main phenomenon being studied, that of the illness category of 'medically unexplained symptoms', was extremely complex and problematic. Whilst all topics of study in the social sciences, particularly in the field of health care research, are likely to involve degrees of complexity and uncertainty, 'medically unexplained symptoms' is particularly complex since it is a categorisation of ill health which falls outside of the dominant criteria of definition – the Western biomedical model, and the need for a 'diagnosis'.

The field of research is fractured and complicated further by the fact that 'medically unexplained symptoms' is but one label amongst many to describe the social and clinical predicament of suffering outside of a medical diagnosis, with explanations for the suffering and reasoning given for apportioning of blame being as diverse as the symptoms and levels of suffering experienced and observed.

Additionally, the aim of the research project was to explore the role of the interaction during the primary care encounter in shaping this illness category, with a particular focus on the role of prior contact and knowledge participants had of each other as individuals and of each other's lifeworlds. However the current conceptualisations for these relational phenomena in the primary care milieu, those of 'the mutual investment company' and 'continuity of care' were found to lack precision; an alternative terminology and conceptualisation was then needed in order to explore the phenomena in an alternative way. The term 'familiarity' emerged as a possible discursive construction with utility.

Thus whilst systematic reviews within the medical literature are generally systems-based a more innovative approach was needed to explore the utility of 'familiarity' and thus the 'heuristic' review method adopted by Jutel was adapted and implemented (Jutel, 2010). As predicted this did indeed allow for greater intertextual connectivity, critique, interest, expertise, independence, tacit knowledge, chance encounters with new ideas, and dialogic interactions between researcher, 'literature' and 'data' (MacLure, 2005).

Having completed a review of the literature which allowed for such a broad view of 'familiarity' in the primary care setting, observing discursive constructions of the concept in relation to all aspects of primary care, rather than simply from the perspective of one of the participants or in relation to one particular patient group, through one particular methodological approach, a sufficiently robust theoretical framework was needed within which to situate the research, to explore the complexities of GP work and the primary care encounter, and to construct an innovative methodological approach utilising a variety of methods to explore the phenomena in question. GP work is inherently complex, thus an appropriately complex research methodology must be adopted in order to embrace the lifeworlds of the research participants as they converge during the primary care consultation.

In considering the research questions a number of theoretical frameworks and methodological approaches emerge as having possible utility, however given the complex nature of the subject matter and the interdisciplinary nature of the research team, the fact that 'bricolage' is "grounded on an epistemology of complexity" (Kincheloe, 2005a), does not attempt to reach a "reductionist notion of 'the proper interdisciplinary research method' but retains an awareness of the diverse tools in the researcher's toolbox" (Kincheloe, 2001), 'bricolage' was selected as the theoretical framework within which to situate the study.

3.7 Conclusion

A theoretically informed framework is important when conceptualising a research project. Whilst there is a certain safety in adopting a tried and tested epistemological position which offers justifications for use of certain methods and checklists for the purposes of validity and rigour, these frameworks limit the creative input and scope for imaginative development within the context of the research and risk wasting valuable experience and knowledge which could be brought forth by the researcher.

It may seem paradoxical therefore to state that this project will be situated within a specified framework, however *'Bricolage'* not only allows for this kind of desired flexibility but actively encourages, if not demands it. The approach taken in this project will therefore be honest and will fully embrace the messiness of the knowledge making process.

The next chapter will set forth the research methodology of the study.

Chapter 4: Methodology

4.1 Introduction

The function of a methodology chapter is to describe, explain and justify the means by which the researcher will acquire the knowledge and data for the study of the phenomena in question (Denzin & Lincoln, 2005a).

Each aspect of the research process will thus now be explained in detail, including: the study design; ethical considerations; access and recruitment; sample selection; data collection methods; triangulation and crystallization; data analysis; presentation of findings; and considerations relating to rigour, quality and credibility.

It was established in part one of the thesis that the study seeks to explore *how* the primary care consultation is co-constructed and mutually negotiated by patients presenting with Medically Unexplained Symptoms and the GPs involved in delivery of their care. Specific attention will also be paid to *how* and *what kinds (nature)* of impact *'familiarity'* and *'non-familiarity'* may have upon doctor-patient interaction and thus the overall co-construction. Questions regarding the definitional nature of Medically Unexplained Symptoms as an illness category and also the nature of *'familiarity'* and *'non-familiarity'* will be explored, as will *why* these aspects of the encounter have the impact that they do.

Given the nature of these questions, qualitative methods will form the basis for most of the enquiry since they are better suited to answering these kinds of questions, whilst quantitative methods are more concerned with *'what'* (in simple, reductionist form) and *'how much'*, i.e. counting of these categorised units (Kuper et al., 2008). However the researcher will also collect, where appropriate, numerical data in order to enrich the data collected and which may even yield data that proves to be as interesting as the data which is intentionally sought (Wolcott, 1995 , pp 29 – 40).

The theoretical framework of *'bricolage'* allows for the creative use of trans-disciplinary strategies, methods and materials that are to hand, and also the fashioning of new tools or techniques, including flexibility to do this whilst actually out in the field (Denzin & Lincoln, 2005a , p4). All aspects of method selection were therefore orientated to specifically address each facet of the research question, and methods were modified along the way based on observations of their performance and utility, and any other issues arising.

4.2 Study design (Summary)

Fieldwork was conducted at five primary care surgeries in the North West of England. The researcher worked with one GP per session (morning or afternoon surgery) and recruited patients seeing this particular GP from the surgery waiting area, gaining informed consent for their consultation to be recorded and for the researcher to contact them at a later date to organise a semi-structured interview about the consultation.

GPs audio-recorded consultations with participating patients and completed a three-part checklist at the end of each consultation in order to determine whether or not the patients should be included in the study. Post-consultation interviews were conducted with GPs and patients separately using *'tape-assisted recall'* to focus interviews on the doctor-patient interaction within the consultation and to facilitate recall. Interviews were conducted as soon as possible after the consultation with the aim being to interview within ten days of the encounter.

Data was analysed thematically, triangulating between data sources, which in some cases consisted of the consultation and both post-consultation interviews (12 cases), whilst in other cases it was just the consultation and the GP interview (11 cases). Data analysis was discussed by the interdisciplinary research team and also presented at the data analysis group sessions for postgraduate students at the University of Liverpool; this brought multiple perspectives to the data. This also acknowledges the interdisciplinary nature of 'bricolage' and Denzin and Lincoln's (2000) call for 'bricoleurs' to employ "hermeneutics, structuralism, semiotics, phenomenology, cultural studies, and feminism" in their quest to better "interpret, criticize, and deconstruct" (Denzin & Lincoln, 2000).

4.3 Ethical considerations

4.3.1 Research governance

The location of the research study within the primary health care milieu and the recruitment of NHS staff and patients meant that it was mandatory to obtain ethical approval from the Local Research Ethics Committee (LREC), in accordance with the Research Governance Framework, before fieldwork could begin (Department of Health, 2005).

The researcher submitted detailed outlines of all aspects of the study to the LREC together with appropriate Research Management and Governance Collaborative (R&G) submissions. Approval was obtained from the LREC on: 4th July 2006 (appendix 1); approval from the R&G (subject to approval from the LREC) came through on 3rd July 2006 (appendix 2).

In addition the researcher was granted an honorary NHS contract to enable legitimate interaction with the participants (Department of Health, 2005) on the 28th July 2006 (appendix 3), and the project received sponsorship from the University of Liverpool on 4th May 2006 (appendix 4).

4.3.2 Informed consent & access

In accordance with the requirements of the ethics committee, the following recruitment materials were produced:

- Practice agreement forms
- Participant information sheets for participating GPs
- Participant information leaflets for patients
- Carbon-copy consent forms for both participants
- Expression of interest forms for patients

Participation sheets and leaflets were written in clear, accessible language and gave detailed descriptions and explanations of the research and what participation would entail. Patient information sheets were designed as fold-out leaflets and had a photo of the researcher on the front, but contained the same information as the GP sheets, tailored for patients. It was thought that this format would make the information less daunting to patients since this format had been tried previously by a postgraduate colleague.

Permission to approach primary care practices within the Mersey Primary Care R & D Consortium was granted by the executive committee on the 27th of July 2006 (appendix 5). Access was initially negotiated by the researcher through the practice manager of each surgery and then arrangements made for the researcher to attend a practice meeting and give a presentation about the research, answering any questions regarding the research process, including what participation would mean in practice for the surgery as a whole and the individual GPs. Signatures were obtained from the GPs of the practice via the practice agreement forms.

Additionally, all participating GPs and patients were required to complete consent forms which covered all aspects of their involvement in the research. These were explained to them in detail by the researcher and any questions answered. It was also stressed to them that even after they had signed the forms they had the right to withdraw at any time, without the need to give a reason.

Consent forms were printed on carbon copy paper with three layers so that the researcher could retain a copy for records, one could be held at the surgery and the participants each had individual copies for their own records. The carbon copies saved time and made the recruitment process less arduous for the researcher and the participants. Additionally this proved to be a useful tool for the recruitment of patients (see recruitment below).

4.4 Recruitment

4.4.1 Sample selection

Practices were initially approached if they were within the Mersey Primary Care R & D Consortium; the first four surgeries were Consortium members and thus can be seen as convenience sampling (Mabrey, 2008). The recruitment of the final surgery could be seen as an example of *'snowballing'* or *'chain referral sampling'* (Biernacki & Waldorf, 1981) since access was initially negotiated through a work-colleague at the University of Liverpool who was also a GP at the practice.

All GPs working at participating surgeries were invited to take part in the study. At one of the single-handed GP surgeries a nurse practitioner (NP) also took part since she undertook much the same work as the GP, with no distinction made in terms allocation relating to the patients and reasons for presenting. However at subsequent surgeries the researcher was advised that this was not appropriate since NPs generally saw patients presenting with *'acute'* health issues, whilst GPs saw patients with *'chronic'* issues. The participating NP did not identify any patients presenting with MUS thus all participating practitioners were GPs.

As discussed in Chapter 1, there are currently no agreed research diagnostic criteria for primary care patients presenting with medically unexplained symptoms. There are many different criteria which can be applied, for example: Morriss et al recruited patients in the waiting room "in a way that was independent of their management by the GP". This involved the use of screening questionnaire to classify patients as "true somatisers" or "part somatisers" depending on whether or not they ticked "physical cause" exclusively, or else "physical cause" and either "I don't know" or "emotional cause" in response to a question regarding their belief of the underlying cause of the physical problem with which they were presenting (Morriss et al., 1999).

Whilst this criterion does reveal something of the patient's thought processes it may be influenced by the setting in that the patients are awaiting an appointment with the doctor and may be less inclined to reveal psychosocial concerns as the reason for their visit. Other problems include the fact that the categorisation of patients at this early stage as "somatisers" by the researchers, according to a screening questionnaire, will undoubtedly shape the perceptions of the patients for the remainder of the research and this may be limiting. In addition, this criterion does not consider the doctor's clinical opinion, which is important in terms of placing the patient's consultation in context of the clinical reality as experienced by the GP.

Other criteria emanating from psychiatric diagnoses of somatisation disorder, for example: "somatic fixation" (Biderman et al., 2003) and "abridged somatisation disorder" (Escobar, 2007) are problematic because of poor agreement between them and, again, they assume that the underlying cause of the symptoms is psychological distress manifested as physical symptoms. Likewise, standardised instruments can only be used to identify cases of particular "disorders" within the range of medically unexplained symptoms and are thus restrictive. Ring et al noted that, since their study focused on "the difficulties that patients present for doctors" a "less restrictive criteria" was needed which would enable the identification of patients that "in the doctor's opinion, have unexplained symptoms" and thus the criteria proposed by Peveler et al were adopted (Peveler et al., 1997; Ring et al., 2005).

Whilst this study sought to explore the co-construction of the primary care encounter, the doctor's clinical opinion regarding whether or not the patient would be perceived as presenting 'Medically Unexplained Symptoms' was considered to be very valuable, particularly in terms of the GP's thought processes during the interaction; this would further be explored with the GP during their post-consultation interview and the same exploration conducted with the patient in their corresponding interview. The fact that the criteria were less restrictive and thus more likely to reflect the cohort in the wider, clinical sense was also appealing.

Thus sequential patients attending their primary care surgery to see the doctor who was taking part in the study that day were recruited and informed consent obtained prior to the consultation. Following the consultation the GPs filled out a three part checklist based on criteria proposed by (Peveler et al., 1997), namely that, during the course of the consultation:

- Patients presented physical symptoms
- That had been present for at least three months
- That could not entirely be explained by a recognisable physical disease.

Consultations satisfying these criteria were retained for analysis. These criteria were chosen as they could be readily understood and applied by participating GPs and they allowed for the clinical reality that GPs' perspectives vary with regards to whom they would define as having Medically Unexplained Symptoms.

Since this definitional phenomenon was of interest to the researcher, the checklist was given as a guide and autonomy of selection was left entirely to the GPs, with discussions taking place during their post-consultation interviews regarding their categorisation of patients and decisions to include the patients they selected.

Thus sampling of GPs and patients was *'purposive'* which was important in order to select GPs and patients who had experience and knowledge of the topic being studied (Mabrey, 2008; Morgan, 2004); for the GPs this was knowledge and understanding of how patients are categorised as having Medically Unexplained Symptoms and subsequent interactional and management strategies; whilst for patients this was an understanding of what it is like to live in the social and clinical predicament of having symptoms but living without a diagnosis.

The fact that patients were recruited sequentially as they presented for an actual consultation reduced elements of bias which could have resulted from alternative methods, for example: prior selection by the GPs looking through their notes to identify cases; this would have run the risk of only one kind of patient or person being included in the study and would certainly have excluded a large group for whom Medically Unexplained Symptoms were a secondary concern and were often introduced following the main part of the consultation, with the caveat *"while I'm here doctor"*.

This method of sampling was also preferable to *'self-selection'* by patients since it was unlikely that many patients would identify with this label, or indeed any other label from the field (e.g. somatisation). The sample therefore reflected the clinical reality of medically unexplained symptoms in primary care practice; furthermore the observation of the subsequent interaction, and the further exploration of emerging themes during post-consultation interviews, enabled the generation of theories regarding factors which influenced the interaction and all aspects of the encounter, including symptom management and outcomes (Robson, 2002).

The sample size was based on the principle of *'saturation'*, through thematic analysis involving constant comparison of data as it was collected and reflections on observed or developed themes (Braun & Clarke, 2006; Strauss & Corbin, 1998) until the researcher noticed that themes which had already been adopted as part of the analysis framework were emerging from the new data.

Whilst it is likely that more new themes may have emerged if more data were collected, given the multi-data collection technique and case study approach there was sufficient data to build an interesting account of Medically Unexplained Symptoms in the current primary care milieu and to produce "local theory or petite generalizations" (Mabrey, 2008). In addition, the researcher felt that it would have been unethical to continue collecting data, and taking up the time of participants, given that it was unlikely that any new data would be able to be incorporated into the study.

Probability sampling would have been useful if the study was seeking to describe the characteristics of patients with medically unexplained symptoms or to test an empirical hypothesis (Arber, 2001 , p61). There are many studies which have adopted probability sampling, with randomised selection, in order to describe characteristics of medically unexplained symptoms and estimate population parameters – for example: those looking at prevalence rates and specific burden represented by the cohort for the healthcare system. There are also many studies which have used probability sampling in order to test an empirical hypothesis, for example: the study by Ring et al which confirmed that, contrary to popular belief, where medically unexplained symptoms were discussed in the primary care encounter, physical intervention was proposed more often by the GP than by the patient (Ring et al., 2005).

However the focus of this study was on exploration of the interaction between GPs and patients presenting medically unexplained symptoms during the primary care encounter and the way in which this interaction was perceived, interpreted and experienced by the participants, and subsequently theory development regarding influencing factors, including familiarity and non-familiarity in their various guises. Thus non-probability, purposive sampling was the most appropriate sampling strategy (Arber, 2001), p61).

Quota and dimensional sampling are often used in an attempt to make a sample representative of the population by setting and filling quota controls (Arber, 2001 p64), specified criteria (Seale & Filmer, 1998) and/ or tables or matrices (Robson, 2002 , p265). However this would have been difficult given the definitional issues regarding this cohort described in chapter 1; in addition, applying quotas in this way would again alter the representation of the clinical reality of medically unexplained symptoms in the primary care setting.

Snowball sampling would be useful in terms of exploring certain aspects of medically unexplained symptoms, particularly patient narratives regarding some of the named syndromes – for example: Gulf War syndrome, for which identification would, to some degree, be self-selecting and perhaps hidden. In such cases first contact may be best initiated online through a discussion forum on the topic and subsequent participants obtained through recommendation by previous interviewees acting as informants (Biernacki & Waldorf, 1981). However since this study was concerned with patients presenting in the primary care setting, whom were thought by their doctors to have unexplained symptoms (whether the patients would agree or not), and also the subsequent 'naturally occurring' data from the consultation, as well as the 'contrived' data from the post-consultation interviews (Speer, 2008 , p290), snowballing would not have been an effective sampling strategy.

4.4.2 GPs and patients: consultation stage

Having gained initial agreement from the GPs and the primary care practices generally, suitable days for data collection were then negotiated with the practice managers who liaised with the GPs to organise for the researcher to work with one GP per session.

The researcher arrived before surgery was due to begin, gained informed consent from the GPs, answered any additional questions and showed them how to operate the audio-recording equipment (DSS player digital recorder with a booster microphone). The three part inclusion checklist (see section on sampling) was also issued as well as instructions regarding additional criteria for patient inclusion:

- Being over the age of 16
- Deemed to have sufficient levels of English language skills
- Attending for themselves rather than for someone else
- Not attending for a routine screening (unless the MUS identified was a separate component of the consultation)

The researcher then departed to the waiting room to await the arrival of patients. Patients seeing a particular doctor would be informed of the study and asked if they were willing to take part. This function was performed differently at different surgeries. For example surgeries one and two were single-handed GP practices and this made it reasonably easy to track patients since patients knew the name of their GP and were definitely seeing this particular GP.

At surgery three there were several GPs operating simultaneously, however appointments were all pre-booked and patients booked in with the receptionists on arrival; the receptionists therefore informed the patient that the GP they were seeing was taking part in some research and handed them the information leaflet. This served as a signal to the researcher who would wait a couple of minutes before approaching the patient. Often the patient would recognise the researcher from the photo on the leaflet and discussions began and developed naturally.

At surgery four however, there were several GPs operating simultaneously and patients would book in using a touch-screen booking system and thus the researcher approached each patient as they entered the waiting area and asked which doctor they were seeing; if they were seeing the doctor with whom the researcher was working, the researcher would explain the research to them, give them the leaflet and be on hand to answer any questions and to take informed consent if they agreed to take part.

The final surgery, number five, operated a portion of the appointments as *'open access'* and several GPs were operating simultaneously, thus the receptionist would hand out leaflets where possible but the researcher also approached people in the waiting room to maximise recruitment potential.

In all scenarios the researcher then explained the study, answered any questions, and gained consent using the consent forms and gained the patients' contact details via the expression of interest forms. Those who agreed had to give consent before their consultation in order that it could be recorded. The fact that they had agreed was signalled to the GP if the patient handed one of the carbon copies of the consent form to the GP upon entering the room so that it could be kept for surgery records.

Upon receiving the consent form the GP would switch on the digital recording device and record the consultation. The fact that the device was small, easy to operate and had a powerful microphone enabled this to be a reasonably unobtrusive process. Following each consultation the GP would fill out the three part checklist (see sampling below) to denote whether or not patients met the criteria for the study. At the end of each session the researcher would retrieve the sound equipment and discuss the checklist with the GP to see if any patients had been identified for inclusion in the study.

Patients who had agreed AND who met the criteria were included in the study. No recordings were made of consultations where patients had not consented and all recordings not included in the second part of the study were erased.

4.4.3 GPs and patients: post-consultation interviews

GPs that had identified patients for inclusion in the study were asked to take part in a semi-structured interview at a convenient time and date within a ten day window of the consultation. For 12 GPs concerned, this involved discussions regarding one patient only; however for two GPs discussions involved two patients each, whilst another GP identified three patients and the final GP in the study identified four patients in the space of one morning.

One GP interview took place immediately following surgery and the consultation was played back all the way through; this did not cause any ethical difficulties since the GP was a participant in each consultation and thus it did not matter whether he heard other consultations whilst the correct consultation was located.

It would not have been appropriate to have conducted any of the patient interviews in this way since the GPs were simply pressing record on the digital device each time a patient came through who had consented to take part, thus consultations were recorded back to back as a continuous recording; locating a specific consultation when recordings were in this format would have involved a risk that patient's might hear other people's consultations, which would have been a breach of ethical agreement. Once the digital recordings had been downloaded onto a computer, they could be separated (see 4.5.1 for details) Most GP interviews took place a few days following the consultation and all were conducted at the primary care surgeries where the GPs were employed.

Patients were contacted by the researcher via phone and asked if they were still willing to take part in a semi-structured interview to discuss their consultations. Of 23 patients, 12 took part in semi-structured interviews, with the remaining 11 confirming that the data collected from their consultation could still be used for the study. Reasons given for non-participation related to time pressures and general life events, some of which were discussed during the consultations in relation to the ill health experienced, with one patient returning to her parents' house to convalesce following an operation, to which part of her consultation pertained.

Patients were given the choice of where to have their interviews:

- Their primary care surgery where they were recruited;
- The University of Liverpool;
- or in their own homes.

Seven interviews were conducted at the University and five in patients' homes. The reasons people gave for wishing to have interviews at the University included: decorating taking place in their homes; an interest in research and the work of the University; working in town and thus the University was convenient for their interview during lunchtime; three participants were students who had been recruited at the student health centre and thus the University was conveniently *'on-campus'* and the final participant lived in town and preferred to have the interview at the University.

4.5 Data collection methods

4.5.1 Audio recorded consultations and annonymisation

Having been recorded with an Olympus Digital Speech Standard (DSS) player digital recording device, in continuous form (all recorded consultations within one sound file) sound files were downloaded to computer and *'cut'* into individual sound files using *'Audacity'* software, which is free, open source software for recording and editing sounds (http://audacity.sourceforge.net/).

Once opened in *'Audacity'* the file could be viewed as a sound wave, with the facility to focus on very specific moments of the consultation and also the ability to cut specific parts of the consultation if necessary.

This function proved most useful for patient interviews since it enabled the separation of consecutively recorded consultations for the purposes of playback, thus facilitating the data collection process whilst retaining patient anonymity and rights to confidentiality with regards to their clinical records and data generated by the study (Department of Health, 2005).

4.5.2 Post-consultation interviews involving tape-assisted recall

An innovative approach was taken to the post-consultation interviews, utilising a method known as tape-assisted recall which involved recording the primary care consultation and then playing it back to participants during separate, semi-structured interviews, either in its entirety or as selected highlights identified by the researcher.

This approach was originally developed for use during psychotherapy sessions and was explored in a study looking at *'significant events'* during therapy sessions, with researchers identifying its merits for allowing the "linking of private experiences of clients and therapists to specific observable events" (Elliott & Shapiro, 1988).

A recent study on identifying and isolating significant therapeutic incidents during psychotherapy sessions used tape-assisted recall to develop a new method, which they named "participant critical events", to "identify and locate critical events nominated by clients and therapists" (Fitzpatrick & Chamodraka, 2007).

The value of tape-assisted recall as a new, more sensitive method for exploring the "complexities of human interaction" was explored in a study about social support, expressed through conversation, between couples where one partner had been diagnosed with breast cancer, and also in a study regarding communication of empathy in couples during the transition to parenthood (Pistrang et al., 1997; Pistrang et al., 2001).

Its applicability as a method for studying the primary care encounter has recently been explored, with one study using tape-assisted recall to facilitate exploration of consultations pertaining to psychological problems, with a particular emphasis on which aspects of the consultation the patients found to be helpful or unhelpful (Buszewicz et al., 2006).

More recently a study looking at how patients develop an understanding of common mental health problems from their discussions during the primary care encounter, utilised tape-assisted recall to explore the issue with both GPs and patients, in separate semi-structured interviews (Cape et al., 2010) This last study is the most similar in design to the research undertaken here since it explores the point of view of both participants and produces three data sources which can be triangulated and compared.

Drawing on the techniques described in the previous studies noted above, the post-consultation interviews involved asking similar questions of each participant, for example: general feelings about the consultation, previous contact with and knowledge of the GP in question (and patient for GP interviews). The main body of the interview was then tailored using the tape-assisted recall. In some instances the researcher asked specific questions relating to possible themes identified prior to the interview by listening to the consultation; obviously this happened more towards the end of the study as themes were developed and further explored.

However there was also usually a component where the researcher simply played the recording and participants were encouraged throughout to comment on anything they felt was significant or interesting. This provided additional insight from the perspective of the participants, although there was a tension between the importance of this and time constraints and associated, potential danger of overwhelming the participants.

In addition to identifying themes within the recording, the researcher made notes of themes and potential questions arising and this proved useful in some instances where GP time was too limited for extensive playback of the recordings (particularly where more than one patient was identified by each doctor) and also in the case of some patients who were uncomfortable with the idea of hearing recordings of their own voices.

It may have been possible to collect the naturally occurring data from the primary care encounter using visual recording equipment and this would have had the advantage of recording body language and eye contact (Heath et al., 2007) it might also have been more intrusive and risked deterring potential patient participants from taking part first of all from the initial recording of their consultation and then secondly in taking part in an interview where they would be asked to view the video footage of themselves and discuss it in detail with the researcher.

Other forms of semi-structured or unstructured interviewing might also have been used for the post-consultation interviews however the tape-assisted recall helped to focus discussion on the primary care encounter. Whilst participant perspectives might have been evaluated using questionnaires and screening instruments, semi-structured interviews enabled participants to recall, reflect and respond in their own words, often presenting ideas and information which would not have occurred to the researcher beforehand and thus would not have been accounted for in any research instruments such as questionnaires or screening tools selected beforehand.

In utilising this approach which was taken from outside of her own disciplinary background, the researcher-as-bricoleuse was able to adapt and develop the technique as the fieldwork progressed, according to what appeared to work well and what did not; thus existing tools and techniques are pieced together as required, often inventing a new and unique technique, tailor made for addressing the needs of the research study in question (Denzin & Lincoln, 2005b).

4.6 Data analysis

4.6.1 Notation system

The recording of the consultations provided data of naturally occurring talk-in-action (Heritage & Maynard, 2006) and enabled the study of participants *'in situ'* (De Morgan et al., 2002). Thus a notation system was developed based on the Jefferson system which enabled the recording and observation of *how* things were said, in addition to *what* was said (ten have, 2007). Such notation systems have demonstrated great utility within the healthcare setting, particularly in relation to the primary care encounter (Heritage & Maynard, 2006).

The notation system provided invaluable cues for the researcher in terms of anything that appeared interesting or a little out of the ordinary, including pauses, exhalations and laughter, short utterances and alterations in volume, pitch, emphasis and speed of speech. The full application of the Jefferson system however was unnecessary and would have been time-consuming and perhaps distracting since the project was not specifically conversation analytic in approach.

The notation system was also applied in parts to the participant interviews, where the researcher noticed elements of the interaction to which the notation would be particularly beneficial (see in particular example 8.1 in the findings of this study).

In this instance the researcher-as-bricoleuse adapted the well-established Jefferson system of transcribing to fit the needs of the research question, including producing an abridged notation system for application to the consultation data, which would have been hampered by too much emphasis on precise pronunciation and other detail provided by full use of the Jefferson system.

Additionally the unusual step of adapting the notation system for parts of the participant interviews, which were not talk-in-action, was taken as careful consideration of the data suggested that recording some of this detail would be useful. This would not have occurred if the researcher had been acting within the confines of a strictly conversation analytic approach, but the researcher-as-bricoleuse had the freedom to act upon the patterns she saw emerging in the data.

For details of the notation system please see (appendix 6).

4.6.2 Thematic analysis

Thematic analysis is "essentially independent of theory and epistemology, and can be applied *across* a range of theoretical and epistemological approaches". The result of this theoretical freedom is a "flexible and useful research tool, which can potentially provide a rich and detailed, yet complex account of the data" (Braun & Clarke, 2006). This of course fits in very well with the theoretical framework of the study, with the researcher as *'bricoleuse'* and *'maker of quilts'*, since it is a well-established and respected tool within the field of health care research which embraces the kind of interdisciplinarity which is at the heart of the bricolage approach (Kincheloe, 2001).

Broadly speaking this method of analysis involves the iterative reviewing of the dataset in order to identify *patterns* within the data which are then analysed and developed by the researcher to form themes (Mabrey, 2008) Themes capture phenomena within the data which relate to the research question. The decision as to whether something is or is not a theme is largely down to the judgement of the researcher and is often driven by the particular analytical question with which the research is concerned, rather than quantifiable measures such as how many times it appears in the data. The most important consideration is whether or not it "captures something important in relation to the research question" (Braun & Clarke, 2006).

Ziebland and McPherson 2006 note that in qualitative research "sampling strategies typically aim to represent a wide range of perspectives and experiences, rather than to replicate their frequency in the wider population. Thus, even if an experience is relatively rare" the qualitative researcher may seek to include it (Ziebland & McPherson, 2006). In accordance with this, analysis within this study aimed to present the breadth of perspectives and experiences observed within the data regarding the impact of 'familiarity' on doctor-patient interaction. The prevalence of themes presented in the findings varied considerably throughout the data, for example the theme *"the disempowered doctor"* could be said to have been observed in 13 of the 23 cases collected; meanwhile the theme of *"behavioural epidemiology as cultural inevitability"* was only observed in one case of the 23, but was included since it revealed interesting insights regarding the possible impact of *'familiarity'* between a doctor and the particular community in question about which there is a paucity of literature relating to health care (see example 6.3 in the findings).

There are many different ways to conduct thematic analysis, for example some researchers may provide a rich thematic description of their entire data set. However for the purposes of this project it was decided that a detailed and nuanced account of a particular theme (Braun & Clarke, 2006), namely that of the impact of *'familiarity'* and *'non-familiarity'* would be presented, thus the results are structured within four sections: the positive aspects of familiarity; the negative aspects of familiarity; the positive aspects of non-familiarity; the negative aspects of non-familiarity.

4.6.3 Coding

The first step in observing and developing themes is to code the data. The aim of coding is to provide a means by which all selected data extracts considered to be related to a particular heading or topic can be retrieved with ease and to ensure that the volume of data under each heading is manageable and meaningful (Ziebland & McPherson, 2006).

The process of coding began following the collection of the three data sources from the first case. The researcher repeatedly listened to the recordings and read the transcripts, before beginning to formulate codes, triangulating between the data sources. In this sense, the method of tape-assisted recall might also be seen as a preliminary form of analysis since much of the discussions within the post-consultation interviews related directly to specific points within the consultation and therefore the interviews also often related to each other specifically, in ways that individually collected interviews might not. This aspect of the methodology emerged during the research process as the researcher-as-bricoleuse adapted and developed the tape-assisted-recall technique based on her observations of the data sources collected (Denzin & Lincoln, 2005b).

There are now many different ways in which to practically apply coding. Traditionally coding methods have involved the use of coloured pens, scissors and glue, whereby text was cut and paste (literally) onto cards which could be moved around and thus examined together. Increasingly however this process is being facilitated by the use of Computer-assisted qualitative data analysis software (CAQDAS) packages, such as NVivo, ATLAS and MAXqda, which enable transcripts and other data sources to be uploaded and stored within one file. Such packages have obvious benefits in terms of storage and retrieval and the electronic coding of data extracts which can aid analysis later on in the process (Ziebland & McPherson, 2006).

Initially the researcher was keen to utilise such a package and attended a course on *'Analysing Qualitative Interviews'* at the University of Oxford for the purposes of learning how best to apply such software to the analysis of the project. However, upon discussing the three-data-source per case nature of the project with one of the course tutors, Sue Ziebland, a strong proponent of the use of CAQDAS in qualitative research, it was decided that, in the case of this particular project, the use of CAQDAS would not be quite as straightforward and useful as it would in a project which, for example, resulted in 30 interview transcripts with patients.

The researcher was advised that, whilst it would be possible to use CAQDAS to arrange the emergent codes, this would need to be done after the extracts from each of the data sources had been drawn together to form coded data which would eventually be presented together. Thus whilst the use of CAQDAS may have some utility in terms of storage and later linking of coded extracts into reports, it would initially be quite time consuming and the resultant reports would be much longer and perhaps more unwieldy than reports produced for the grouping of data from single data sources (Personal communication, Ziebland, 2007).

Additionally, the researcher did explore the use of NVivo and found it useful as a storage device for transcripts, with the useful function of being able to switch between one transcript and the next onscreen, however there were some incompatibility problems between the transcripts and the software package since the transcriptions were formatted in a certain way to include the notation system and this had to be painstakingly amended before the transcript could be read in its entirety onscreen and it was envisaged that this might cause additional difficulties later on with the running of reports.

The researcher therefore produced documents (in Microsoft word) for each case containing bullet point descriptions of all coded extracts which drew on the 2-3 data sources available. These descriptions were used to identify codes for expansion and each of these was explored in detail with accompanying vignettes, descriptions and reflections.

It was during this process that the utility of a data box was identified as a useful tool to make the data less unwieldy. A result of the data box was that vignettes from all three data sources could be viewed together, without the influencing descriptions of the researcher (which began underneath the box); this was useful since vignettes are important for revealing how meanings were expressed in the respondents' own words, whilst the overall compilation of the *'cases'* enabled the researcher to explain why certain vignettes had been selected and others omitted (Bryman, 2001; Silverman, 1993).

From the very first case the researcher noted that, contrary to the original focus of the research which was set to explore: *the impact of doctors' perceptions and emotional responses (during consultations pertaining to MUS)*, the consultation was clearly a *'co-constructed'* event as described by Heritage et al (Heritage & Maynard, 2006) and that the construction of the encounter was negotiated by both parties through the interaction between them.

This was also in-keeping with the approach to the data which involved conducting interviews with both participants, not just the doctors. The focus of the research was thus changed to explore: *factors influencing doctor-patient interaction during the consultation (pertaining to MUS).*

Also evident from the first case was the fact that prior knowledge and contact between doctor and patient had a significant bearing on the interaction and interpretations of the participants. Interestingly the researcher noted that, contrary to the dominant thinking in the field of primary health care, the *'familiarity'* in case 1 appeared to be having a negative impact on relations and thus the overall satisfaction and outcomes of the consultation.

As more cases were collected several instances of coded data relating to *'familiarity'* were observed and developed, with positive and negative effects observed; thus the focus of the thesis was refined to: *the impact of familiarity on doctor-patient interaction during primary care consultations pertaining to Medically Unexplained Symptoms.*

Since the focus of the research had changed due to the unanticipated issues raised during the first case, the interview schedules were also amended to reflect this, with the incorporation of additional questions regarding *'familiarity'* providing prompts for subsequent interviews, enabling a focussed exploration of this emerging theme. This kind of revision and amendment during data collection is considered good qualitative practice (Ziebland & McPherson, 2006).

In terms of data coding therefore, the researcher demonstrated the kind of 'methodological negotiation' involved in bricolage described by Kincheloe, "respecting the demands of the task" and promoting its "elasticity" (Kincheloe, 2005b); whilst CAQDAS are becoming increasingly popular in the realm of qualitative research, and are considered by some to demonstrate a more rigorous approach to data coding, further investigation of the topic by the researcher, including consultation with experts in the field, revealed that they were not the most effective way of preparing the data in this study for analysis (Personal communication, Ziebland, 2007).

4.6.4 Analysis

Once data was coded, analysis began in earnest. It is at this stage that all text coded under a certain heading is gathered together for closer examination. As described above, CAQDAS have a function whereby a *'report'* can be produced, which draws together all data extracts coded by the researcher (highlighted electronically) under a certain heading. This usually results in a document around 30 pages long for each code, in which coded extracts appear one after the other (Ziebland & McPherson, 2006). In this study the word documents described above, produced for each case and containing detailed descriptions of coded data and extracts, were collected together and read and re-read.

Despite the fact that the focus of the research had been refined and narrowed to concentrate on the impact of *'familiarity'*, as with all qualitative data of this nature, 23 cases containing 2-3 data sources obviously represented many different perspectives and accounts of experiences within the primary care encounter, thus a method of ensuring holistic inclusion in the analysis was required (Ziebland & McPherson, 2006).

The first step was to prepare an OSOP analysis (One Sheet of Paper) which involved reading through each coded document in turn and noting (on the OSOP) all the different issues that were raised by the coded extracts, along with the relevant case number. So from case number 1, one of the observable issues was that of the *'disempowered patient'* but there was also evidence of the *'disempowered doctor'*, as well as many other themes. These headings were written on flipchart paper and then the report for the next case was examined which, amongst other issues, also highlighted an observable instance of *'the disempowered doctor'*, thus the case number was added to this *'theme'* heading.

During research team discussions of the OSOP it was observed that there also appeared to be positive and negative effects of *'non-familiarity'*, a phenomenon characterised by the fact that *'familiarity'* was not present in any of the previously noted forms. It was at this point that the final framework for the findings was determined, presenting coded data in four main sections: *positive effects of familiarity; negative effects of familiarity; positive effects of non-familiarity; and the negative effects of non-familiarity.*

The researcher began to *'populate'* each section with what were emerging as case studies for the triangulated data sources, setting forth themes to highlight particular observable phenomena. These case studies were refined (described below) and vignettes were reduced as much as possible, with less relevant text omitted and descriptions provided of any lengthy exchanges or other observed phenomena considered pertinent to the analysis.

In some cases themes related to very short extracts of text and could be concisely presented; other examples were complex and related to the case as a whole and in some cases extended beyond the consultation to many years of prior knowledge and contact between participants, their communities and the health care system generally.

In order to refine the document to something manageable and appropriate in length for a thesis, the researcher spread all of the cases out on the floor arranged under their headings and produced a four page Word document of the titles (which were descriptive). This final stage OSOP allowed the most illustrative examples of each theme chosen to be presented in the final document.

The multi-stage analysis described here is consistent with the description of thematic analysis as a process described by Braun and Clarke 2006. Furthermore, given the data-driven nature of these themes, and the fact that the themes identified bear little relation (at least initially) to the specific questions asked of participants, the approach adopted in this research could be said to be *'inductive'* and as such bearing similarities to grounded theory (Braun & Clarke, 2006).

As mentioned on page 64 therefore, the approach to analysis within the project of study was very much in the spirit of researcher-as-bricoleuse, since thematic analysis and the use of 'OSOPs' are established and popular techniques in health care research, which are applied across disciplinary boundaries within the sphere of qualitative research and as such embrace the interdisciplinarity of bricolage (Kincheloe, 2001).

4.6.5 Presentation of findings as case studies

Examples are arranged as case studies with descriptive titles and brief overviews, followed by a data box containing a summary description of the related vignettes to be presented and then selected vignettes from the consultation, followed by vignettes from the separate, semi-structured interviews with participants. This is followed in each case by a detailed description of the vignettes and finally a reflection by the researcher of what is being presented in each case.

Thus the data presented here reflects Mabrey's assertion that "the *raison d'être* of the case study is deep understanding of particular instances of phenomena" with this overriding goal influencing decision making in all aspects of the research. Mabrey also describes data collection for case study which are consistent with the methods we have described above: "direct observation" (in this case of the clinical encounter) "and semi-structured interviews, which allow probative follow-up questions and explorations of topics unanticipated by the interviewer" (in this case post-consultation interviews with both participants using tape-assisted recall to follow up topics observed by the researcher and also to elicit responses which the researcher might not have picked up on (Mabrey, 2008).

According to Mabrey, these techniques facilitate "development of subtle understanding of what happens in the case and why" and also "rigorous penetration of the unknown and depend on the researcher to recognise the importance of new input, to generate pertinent questions, and to maintain curiosity rather than jumping to interpretation – that is, on intuitiveness and on methodological commitment to emergent design" (Mabrey, 2008).

Given the detailed and nuanced nature of the case study data presented, and in the interests of brevity, 13 examples were selected for presentation. Examples are unevenly distributed between the sections and this reflects the messy reality of research and in particular the nuanced, qualitative research approach to specific phenomena.

Alternative ways of presenting the findings were considered and these included grouping themes together across case, which is a common way of presenting qualitative findings, with vignettes from various participants presented together to highlight each theme. So for example: all coded data relating to disempowerment might have been presented together, possibly being split into disempowered doctors and disempowered patients. Another theme which could have been presented in this way would have been the concept of *'cylchdroi'*[9], which again would probably be split into doctors' and patients' accounts of the phenomena. However this would not have been particularly more illuminating in terms of themes and would not have maximised the rich insights afforded by the triangulation of the 2-3 data sources relating to each primary care encounter in the same way as presentation by case study was able to.

Presenting the data sources in this way demonstrates the researcher-as-bricoleuse's understanding of 'the fictive dimension of research findings' which Kincheloe explains is a recognition, by the researcher, that "because of the zone of complexity no fact is self-evident and no representation is 'pure', any knowledge who believes research narratives are simple truths is operating in a naïve domain. Thus, bricoleurs or bricoleuse assert that there are fictive elements to all representations and narratives. Such fictive dimensions may be influenced by a variety of forces, including linguistic factors, narrative employment strategies, and cultural prejudices" (Kincheloe, 2005b). Thus juxtaposing the various accounts of the encounter in this way serves to highlight the differences of the representations, reducing the temptation to accept the narratives as 'simple truths' or indeed to take the audio recording of the consultation at face value.

4.6.6 Triangulation and crystallization

The concept of *'triangulation'* originates from navigational, military or surveying contexts where it refers to the use of two known and fixed points in order to locate the position of a third (Nolan & Behi, 1995). When applied to qualitative research, this metaphor refers to strategies employed during the research process to reduce the risk of findings being an artefact of a single method, research bias, participant perspective or overall theoretical approach (Litva, 1996). It is generally agreed that there are four main types of triangulation based on those set forth by Denzin 1970: Method; data; investigator; theoretical (Nolan & Behi, 1995).

As discussed above, this study deployed two main methods of data collection: audio-recording consultation data and then conducting semi-structured, tape-assisted recall interviews. This is an example of *'methodological triangulation'*, since the direct observations made from viewing the consultation data can be compared with the accounts of the participants in their interview testimony. In addition, since interviews with both participants were conducted in just over half of the cases, this could also be seen as an example of *'triangulation by data source'* (Mabrey, 2008).

Triangulation by investigator or observer involves the use of different researchers on the same project and is based on the idea that different observers may interpret the same things differently and thus this kind of triangulation can help balance interpretations and guard against undue researcher subjectivity (Mabrey, 2008). Since this study is a postgraduate thesis, this form of triangulation would not have been appropriate; however the issue of balancing interpretations was explored and addressed in other ways (see below).

'Theoretical triangulation' entails "recourse to different abstractions that might explain the data" (Mabrey, 2008); that is to say, asking different questions of the data and analysing them according to this way of thinking, which will of course yield very different pictures. For example: observation of interaction between members at a deaf club in a rural, Welsh-speaking community in North Wales, might focus analysis on the extent to which conversations demonstrate the use of conventional BSL and local 'dialects'. This analysis is likely to yield very different results from one which perhaps focuses on how participants construct their Welsh identity outside of the linguistically-defined

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[9] A Welsh word literally translating as: *'circle-turn'* for which no satisfactory English term seems to exist which could not be inappropriately construed, for example: circulation, revolving. This term is being used here to describe the agenda of patients which appears to be in a state of flux as they move in a circle between equally unfavourable options of living with MUS and undergoing investigations or surgery which might lead to them receiving an unwelcome diagnosis or else result in them living with subsequent Iatrogenic harm.

community of their families, which they are largely unable to access. These would be different again from an analysis which took as its subject of study the degree to which gender appeared to influence topic of conversation at the deaf club.

In many ways this form of triangulation occurred organically as the study progressed; as described above the focus of the thesis evolved as data was collected and phenomena observed, moving from the influence of the doctor on the consultation generally, to the influence of both participants, to the impact of *'familiarity'* and finally to the positive and negative effects of both *'familiarity'* and *'non-familiarity'*. In addition the multi-stage analysis process involved the detailed exploration of several codes which represented nuanced representations of these themes.

Janesick (1994) proposed an additional form of triangulation: *'interdisciplinary'* which involves drawing on knowledge and theories from a range of disciplines (Nolan & Behi, 1995). Again this was a natural part of the research process for this study since the researcher studied an undergraduate degree in Sociology and History and previously worked as a researcher in the field of behavioural epidemiology before taking up the research study in question; meanwhile the supervisors are senior clinical professionals in the fields of Clinical Psychology and Primary Care, as well as being seasoned researchers in the interdisciplinary field of health and social care research.

There have been some interesting discussions regarding the application of 'triangulation' as a metaphor in qualitative research, with the principle challenge being levied by Laurel Richardson, who highlights the inappropriateness of the original notion of a 'fixed point' since this implies the existence of an *'objective reality'* (Nolan & Behi, 1995).

More recently, Richardson and St.Pierre drew on their own field of Creative Analytical Processes (CAP) ethnographies to emphasise how qualitative research in many fields is being "blurred, enlarged, and altered with researchers writing in different formats for a variety of audiences". Researchers draw on a variety of sources, including literary, artistic, and scientific genres – often breaking genre boundaries. Richardson and St.Pierre therefore propose a *"postmodernist deconstruction of triangulation"* stating that they "do not triangulate; we crystallize". Explaining the utility of this new metaphor, Richardson and St.Pierre speak critically of the triangle as "a rigid, fixed, two-dimensional object" and offer instead "the crystal, which combines symmetry and substances, transmutations, multi-dimensionalities, and angles of approach". Furthermore they describe how "crystals are prisms that reflect externalities and refract within themselves, creating different colours, patterns, and arrays casting off in different directions. What we see depends on our angle of repose – not triangulation but rather crystallization" (Richardson & Adams St.Pierre, 2005).

This metaphor does appear to have some merit, particularly in terms of highlighting the fact that "there is no one 'correct' telling" of an event and thus the 'voices' from the different data sources are like "Like a light hitting a crystal" and that "each telling of an event reflects a different perspective" (Denzin & Lincoln, 2005a).

However, whichever metaphor is drawn upon, essentially it is about recognising that there is no *'objective reality'* which can be captured and that there is no *'correct'* interpretation of a phenomenon, such as: the primary care encounter and the interaction which takes place during the consultation. Thus the task in hand is to "simultaneously display multiple, refracted realities" thereby facilitating an in-depth understanding of the phenomenon in question through a combination of multiple methodological practices, empirical materials, perspectives, and observers in a single study (Denzin & Lincoln, 2005a).

Thus the concepts of *'triangulation'* and *'crystallization'* sit well with the concept of *researcher-as-bricoleuse* since all involve moving between and within competing paradigms and perspectives, employing methodological practices along the way which are best suited to addressing the question at hand, and taking into account the complexities of the research process and the objects of study.

The use of 'crystalisation' or 'triangulation' within data collection and analysis further demonstrates the researcher's commitment to the recognition of 'the fictive dimension of research findings'(Kincheloe, 2005b) as described above with the presentation of the examples as case studies.

4.6.7 Reliability, Validity, Rigour...and seeking analytical depth

A common criticism of qualitative research if that it 'lacks scientific rigour'. This criticism has been particularly prevalent in the field of healthcare which has a tradition of biomedical research using conventional, quantitative, and often experimental methods (Mays & Pope, 1995).

As a result the topic of how to ensure reliability, validity and rigour has been much debated and numerous strategies have been formulated, for example enhancement of analysis reliability by arranging for independent assessment of transcripts by additional skilled qualitative researchers and comparing agreement between the raters and safeguarding validity through 'triangulation' (Mays & Pope, 1995).

Whilst the researcher has paid careful attention to these issues, which are of course an important consideration in terms of professional credibility, the researcher has also been mindful of the idea of treating qualitative research as quantitative research, particularly given that these kinds of measures have been proposed more pressingly in contexts where qualitative research is often poorly understood (Barbour, 2001).

Jansick 1994 coined the term 'methodolatory' to describe the inappropriate elevation of importance assigned to methods above the actual focus of the investigation in hand (Janesick, 1994). This over-focus on 'methods' has become a part of the process for evaluation of qualitative research, often involving a checklists for examiners and reviewers to follow; Salmon 2003 terms this 'methodologism', and is critical of the idea that "quality can be guaranteed simply by following procedures" (Salmon 2003).

These sentiments are also expressed by Barbour 2001, who acknowledges that such 'checklists' have contributed to the wider acceptance of qualitative research in healthcare research, but nevertheless warns that they can be counterproductive if used prescriptively. According to Barbour "the uncritical adoption of a range of 'technical fixes' (such as purposive sampling, grounded theory, multiple coding, triangulation, and respondent validation) does not, in itself, confer rigour (Barbour, 2001).

Furthermore there are other measures which are considered to be important in the evaluation of qualitative research to which the 'methods' proposed by such checklists are better suited, for example Flick 2002 states that: "Triangulation is not a tool or a strategy of validation, but an alternative to validation. It is best understood as a strategy that adds rigour, breadth, complexity, richness, and depth to any inquiry" (Flick, 2002).

Ziebland and McPherson 2006 propose some qualitative-appropriate ways in which qualitative data can be 'enriched', including: returning to the literature to explore where insights from the study fit and how they can be further informed by the theoretical literature (Ziebland & McPherson, 2006). This was done on numerous occasions as codes began forming, including a previously unanticipated review on *'familiarity'* within the existing literature as the focus of the research altered.

Furthermore Ziebland and McPherson suggest discussing the data with colleagues from other disciplinary backgrounds as this can provide new insights and interpretations (Ziebland & McPherson, 2006). As discussed above the researcher and the supervisors were from different disciplinary backgrounds and thus discussions regarding the researcher's progress naturally drew on these diverse insights and interpretations. Additionally, examples of data were presented to the postgraduate data analysis sessions at the University of Liverpool and discussed in-depth with fellow post-graduate students from a diverse range of backgrounds, ranging from clinical and laboratory-based to anthropological ethnographers.

Finally, bricolage is concerned with adopting an active approach to methodology, avoiding reductionism and the monological quest for order, and the pursuit of new rigour (Kincheloe & Berry, 2004). Thus the theoretical framework underpinning this research is sensitive to the importance of rigour and also to the perils of becoming too focused on how the knowledge is produced, at the expense of losing sight of the purpose of the research. With this in mind, given the setting, it is important at all stages to consider the utility and implications of the findings for clinical practice and research (Guba & Lincoln, 1989).

In summary, bricolage as a theoretical framework promotes 'multiperspectivism' in the researcher-as-bricoleuse, and a 'multimethodological' approach to the research strategy; this approach is, according to Kincheloe "the proto-articulation of a new rigour" in the increasingly interdisipliarity of qualitative research (Kincheloe, 2001). The interdisciplinary approach to the literature search and construction of the methodology has been in-keeping with these notions. Each aspect of the methodology has been discussed and carefully considered, and will now be applied to the collection and presentation on the findings, discussion and conclusions, demonstrating methodological rigour.

The next chapter will explore the empirical findings of the study which were the product of this methodological approach to the research aims.

Part 3: Empirical Findings

The positive and negative effects of *'familiarity'* and *'non-familiarity'* on doctor-patient interaction in the primary care setting

A clear theme which emerged in the early stages of the fieldwork was that prior knowledge and *'familiarity'* often had an impact on the nature and course of the interaction which took place during the consultation. This was true in a variety of guises, including where a patient had prior knowledge of: the health care setting generally; a particular practice; and also of a specific GP. In addition, a GP's knowledge of, and familiarity with, the patient and their family, and/ or their wider cultural context, for example their specific community and background, also influenced the GPs' perceptions of their patients and the way that their presentations were interpreted; this in turn affected the course of the interaction and thus the subsequent outcomes of the consultation.

The observation of this emergent phenomenon within the data led to a re-focussing of the research in order to further explore and develop an understanding of its characteristics and implications. An additional review of the literature was conducted in order to develop and refine working definitions of *'familiarity'* and *'non-familiarity'* specific to the primary health care setting and doctor-patient interaction, within which to situate our findings.

Familiarity

As discussed in Chapter 1, the concepts of sustained relationships within a *'mutual investment company'* and that of *'continuity of care'*, as they relate to the primary care milieu, have been extensively researched, studied and discussed (Balint, 2000; Dicker, 2006; Haggerty et al., 2003; Jee & Cabana, 2006; Saultz, 2003b). Each has its own literature and has been the centre of much debate and controversy. *'Familiarity'* on the other hand is an emerging concept which is distinct from these two models since it refers to a particular component which exists *within* both of these fields of study, but which can exist independently and is not associated with the wider connotations of either (Baik et al., 2010; Broom, 2008; Broom, 2003; Gabel et al., 1993).

Essentially *'Familiarity'*, within the context of this study, refers to the prior knowledge patients and GPs have of each other's life-worlds and how they draw upon this to make sense of each other's actions; this can range from the very personal to the broadly general. From the patient's perspective, it may be a personal association developed over time within the context of a *'sustained relationship'* with a specific GP, who may or may not be engaged in delivery of *'continuity of care'* to the patient. It may, however, be a knowledge of, and familiarity with, the health care setting generally, which may or may not involve any *'sustained relationships'* or *'continuity of care'*, but which may lead to an increased understanding of the nature of health care and the way in which it is organised and delivered.

Also, within a primary care surgery where there are several GPs, a patient may have a *'familiarity'* with several or all of the GPs, as well as the general context of the surgery, but may not feel any particular need to see the same GP each time and thus any relationships would be characterised as *'occasional'* rather than *'sustained'*. From the GPs perspective *'familiarity'* can again vary, from a close association developed within a *'sustained relationship'*, which may include extensive knowledge of a patient's medical and personal history. Alternatively it might be that a GP has had little or no prior contact with a particular patient but has worked extensively within their community and thus developed some knowledge of the cultural context of the patient, which may help inform their interpretation of the patient's behaviour and actions.

The findings presented here demonstrate that a range of variables also influenced the resulting impact of the observable *'familiarity'*, including: personalities and situational factors. As a result there appeared to be both positive and negative effects of *'familiarity'*. Furthermore, familiarity was found to elicit positive and negative effects from the perspectives of both doctors and patients. In some cases it was either the doctor or the patient who perceived positive or negative effects, whilst in others it was perceived by both parties simultaneously (or else one party perceived positive effects whilst the other party perceived negative effects). Familiarity was also found to have positive and negative effects within the same consultation thus demonstrating the complexity of the primary care encounter.

Non-familiarity

Once the phenomenon of *'familiarity'* was explored and defined, it was perhaps inevitable that the significance of its opposing position of *'non-familiarity'* should also begin to assert itself. *'Non-familiarity'* can be broadly defined as a definition by exclusion – it is what is left over when *'familiarity'* is not present in any of the various forms outlined above. In some cases a *'patient'* consulting a GP may in reality be experiencing the health care milieu for the first time (or certainly the first time in many years) and thus may be unfamiliar with the structures and concepts of the setting; they may also see their status of '*patient*' as decidedly temporary and thus feel no need to build any *'sustained relationships'* or enter into considerations regarding *'continuity of care'*. Patients may alternatively be quite familiar with attending secondary care, having experienced prolonged periods of serious illness (or the care of others with serious illness), but upon being discharged find themselves in the *un-familiar* primary care setting.

Another possible predicament arises when patients move to a new geographical area and thus have had to change GP surgery; in such instances the patient will be unfamiliar with the particular surgery, and the GPs within the surgery and therefore also the particular GP with whom they have their consultation. The GPs in turn will be unfamiliar with the patient and most likely their community context; in cases such as these patients and GPs could be classified as having the least *familiarity* possible with each other's life-worlds, or else the purest form of *'non-familiarity'*.

In terms of *'sustained relationships'* and *'continuity of care'*, some patients may actively seek to *resist* becoming too familiar with any particular practitioner since they have no desire to build any such relationships or care plans, and instead place greater value on privacy and autonomy regarding their health. As with *'familiarity'*, a range of variables influenced the resulting impact of the observable '*non-familiarity'*, and positive and negative effects were observed from the perspectives of both doctors and patients, and also positive and negative effects within the same consultation – mirroring that of familiarity above.

A final point to note is that an asymmetry exists between the knowledge it is possible for each party to obtain about each other on an individual level, since GPs have access to a patient's medical notes and therefore at least a kind of categorical knowledge of them, and perhaps a more comprehensive knowledge if a patient is a frequent attendee and/ or has detailed notes within their files on various aspects of their health.

Framework of findings

Examples were constructed by drawing together relevant extracts from the consultation and the corresponding, post-consultation interviews with the participants within each *'case'*. For some examples all three of the data sources are used (consultation, GP interview, patient interview), whilst others may include only the consultation and the GP interview or else draw inferences across cases; one case however draws from only the consultation and the patient interview since the issue was not addressed with the GP in question during his post-consultation interview.

The examples are presented as case studies, with introductory outlines, extract summaries, vignettes, specific discussions regarding the vignettes, followed by reflections on each case as a whole. Cases are arranged to convey the variety of phenomena observed which could be considered to be positive or negative effects of *'familiarity'* or *'non-familiarity'*, as defined in this study. In the interests of brevity, the most illustrative examples have been selected where phenomena may have been apparent in numerous cases.

Chapter 5: Positive aspects of Familiarity

The first empirical chapter presents findings which support the widely held belief that familiarity has a positive impact on doctor-patient interaction, and thus on health care (Kelleher et al., 1997; Morris, 1976; Pathman et al., 1998). The first three examples in this chapter convey how shared meaning between doctor and patient can facilitate various intended actions within the consultation, without the interaction being hampered by misunderstandings.

The first example shows how familiarity can assist in the correct interpretation of a patient's agenda even when all outward appearances may appear to convey a different motive; in this particular example, the researcher (or indeed the GP without familiarity) viewing the consultation in isolation might interpret the patient's opening presentation as *'pressing for a prescription'* (Britten, 1995; Chew-Graham & May, 1999; Wileman et al., 2002), however it transpired that both parties understood that such action was neither the aim of the presentation, nor indeed would it have been sufficient in itself.

The next example demonstrates how familiarity between a physician and a particular patient can enable the GP to pick up on specific cues from the patient regarding the desire to initiate certain kinds of discussions. In this example, three *"Okays"* in a row during the course of a complex interaction, prompt the GP to begin a line of questioning regarding self-harm which elicits previously undisclosed information from the patient regarding this issue; it transpired that these new disclosures were pertinent to the overall consultation and the ongoing health trajectory of the patient.

These kind of interactional cues or discourse markers (Elwyn & Gwyn, 1999) and correct interpretations were a strong theme throughout the data and are echoed in the next example, which demonstrates how a GP's familiarity with a patient, as well as their wider community context, can enable them to see past presentations of physical symptoms to recognise that the patient wishes to discuss difficult to raise issues, in this case *'un-doctorable'* grief (Heritage & Robinson, 2006a), which may not be considered a culturally acceptable reason for someone of the patient's community to visit the doctor (Kirmayer & Young, 1998).

Another strong theme in the data was that GPs often engage in complex discussions with patients, sometimes over a period of many months, in order to help patients to achieve a more helpful and positive health trajectory. There were many examples within the data which illustrated this, showing how a detailed knowledge of a patient's circumstances and behavioural patterns can be beneficial in complex cases which may otherwise have appeared puzzling.

One such phenomena is the *'cylchdroi'**[10] experienced by some patients stemming from a quandary of indecision about investigation and/ or treatment, which ultimately led to patients' symptoms remaining unexplained; in these cases it seemed that knowledge and insight was invaluable to understanding the presentation where the cognitive motivations, agendas, and needs were confused by the emotional turmoil being experienced by the patients. The final example presented here then explores the concept of *'cylchdroi'* in the context of a patient's fears regarding the possible diagnosis of genetic infertility following years of unsuccessfully attempting to conceive.

Collectively the chapter demonstrates how *'familiarity'* can have a positive effect on doctor-patient interaction during primary care consultations, and thus impact upon subsequent outcomes. However this is only part of the story and this is therefore mirrored by an exploration in the next chapter of the possible negative effects of *familiarity*. This is then set in context by contrasting with the next two chapters which present the positive and negative effects of the opposing position of *'non-familiarity'*.

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[10] A Welsh word literally translating as: *'circle-turn'* for which no satisfactory English term seems to exist which could not be inappropriately construed, for example: circulation, revolving. This term is being used here to describe the agenda of patients which appears to be in a state of flux as they move in a circle between equally unfavourable options of living with MUS and undergoing investigations or surgery which might lead to them receiving an unwelcome diagnosis or else result in them living with subsequent Iatrogenic harm.

Positive aspects of familiarity

5.1 (Case 6)	The accurately perceived *'non-pressure to prescribe'*
5.2 (Case 7)	Familiarity brings clarity to non-specific cues: The three *"Okays"*
5.3 (Case 18)	Familiarity brings clarity: Desire to talk about *'un-doctorable'* grief
5.4 (Case 4)	Identified cylchdroi*[11] and attempts to rationalise *(Fears of genetic infertility)*

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[11] A Welsh word literally translating as: 'circle-turn' for which no satisfactory English term seems to exist which could not be inappropriately construed, for example: circulation, revolving. This term is being used here to describe the agenda of patients which appears to be in a state of flux as they move in a circle between equally unfavourable options of living with MUS and undergoing investigations or surgery which might lead to them receiving an unwelcome diagnosis or else result in them living with subsequent Iatrogenic harm.

Example 5.1. (Case 6) The accurately perceived *'non-pressure to prescribe'*

The patient's opening presentation, during which she alludes to the possibility of a prescription, would seem in isolation to be an example of the well documented phenomena *'pressure to prescribe'*. However a familiarity between doctor and patient enables them to place this in context of their shared understanding and interpret it as a natural progression of their ongoing discussion of options for the management of the patient's symptoms.

Summary:

The consultation extract shows the patient beginning the sentence as if to request a prescription but then switching to an acknowledgement of the GP's comments from a previous encounter regarding there being limited prescribing options for management of her MUS of *'dizzy spells'* due to her being pregnant. She immediately follows this with an elaboration that the symptoms have worsened since she last consulted the GP.

This seemingly implies a request for a prescription of some kind, which, given its position at the beginning of the consultation, could be interpreted as *'pressure to prescribe'*. However in his interview the GP reveals that he felt that this presentation seemed reasonable given that the patient had previously been through the appropriate prior investigations; he thus did not feel pressured and felt that the request was part of the wider context of the patient seeking to manage her symptoms. The patient meanwhile confirms that she wants more than just a prescription and would in fact not be happy if this was all she was given.

Consultation:

P: "I was just wonderin if there was anythin (.) I know you said there wasn't much you could give me with me bein pregnant now...but these dizzy spells they just seem to be getting worse ((coughs))... I phoned up the other day for the results and they said everythin was okay on the blood results...but it's just slowly but surely they're getting worse and lasting longer and longer when it's happenin [hhh]" (L2/11)

GP interview:

GP: "I think probably when she initially presented or when she came in to see me or that she'd presented somewhere else she was looking for something to help with this influence erm and that was one of the things that had probably been discussed at a previous consultation but then I said well you know we'll do some tests first and see if there's something obvious erm and that's probably what she's remembered from that and that's what she's looking for coming back investigations are normal but you know erm can't you give me something to help me with the symptoms so erm I think I wouldn't say that was unusual to be honest that is typical of you know people come in with symptoms and want something to settle it or at least alleviate it to an extent so I wouldn't have thought it was unusual...although she did sort of that was her first statement I suppose" (L13/15)

I: "Yeah so you didn't feel from that that she was trying to pressure for erm prescriptions" (L16)

GP: "Well not so much pressure I think sometimes when patients come in that they erm coz she's already been seen a couple of times that she knew that I'd already taken some details down of what was going on erm so I think she probably thought you know she's been in she's had some investigations and now it's time for something to treat it... erm but she just wanted that more or less straight away (L17/19)

Patient interview:

I: "So there you you sort of say erm you you've you've come because you're hoping maybe he can give you erm...something (.) to er to help...stop them erm I was just wondering was it actually specifically you were hoping he could give you something or maybe (.) whether he could explore and find out..." (L70/76)

P: "A bit of both I want something to stop it from happening but I want to know what it is that's causing...I mean I don't want him to just say "here you are take these and don't come back sort of thing" I want to know exactly what it is that's causing it and something that can say "right well this is going to stop it or it's at least going to make it (.) less of a pain for you sort of thing"...know what I mean...so I just want him to try and find out what it is really" (L77/85)

Consultation

A sense of familiarity between doctor and patient is clear from the patient's opening presentation as she acknowledges that, in their previous discussions, the GP has said there wasn't much he could '*give*' her for her symptoms due to her pregnancy. Since the patient begins this presentation by making what appears to be a request for medication saying "*I was just wonderin if there was anythin*", before switching to acknowledging the GP's previous assertions of limited prescribing options, it is reasonable to assume that the purpose of this section of speech is to explore the possibility of a prescription for her symptoms.

This presentation is then followed by an assertion that the symptoms of "*dizzy spells*" are getting worse. There also then follows a caveat regarding the blood tests organised at the last visit, which were negative, and finally a short elaboration of how the symptoms have worsened. The nature of the presentation and the fact that it is made at the beginning of the consultation, mean that it could reasonably be perceived as an example of the phenomena '*pressure to prescribe*'. (Britten, 1995; Chew-Graham & May, 1999; Wileman et al., 2002)

GP

Responding to the question of what was in his mind when the patient began the presentation in this way, the GP explained that the patient was probably simply remembering that medication had been mentioned as a possible treatment, pending negative test results, which she had now received, and thus he had not thought the presentation unusual, although he did reflect that it was the first thing the patient had said.

This could be viewed as the GP saying that perhaps it *was* quite a sudden presentation, however, given that the question was quite leading and his initial response negated this view, it is reasonable to assume that this was not the case; in fact, it is probably more likely that the GP perceived that his answer to the question was unfavourable and thus he may have sought to change it in order to please the interviewer and/ or be '*helpful*'. I therefore asked the GP if he had felt the patient had been trying to press for prescriptions, phrasing the question negatively: "*so you didn't...*", and the GP confirmed that he had not.

Patient

When asked if she had specifically hoped the GP could '*give*' her something for her symptoms or whether she wanted him to explore the symptoms to find out more about what was causing them, the patient revealed that it was actually "*a bit of both*"; she did want something to stop the dizzy spells, or at least to make them more manageable, but she also wanted the GP to find out what was causing them and to provide an explanation.

Furthermore, she made it clear that she would not be happy if the GP simply gave her medication and told her to take them and not come back. This would seem to indicate that the patient was determined not to be dismissed without a satisfactory explanation and thus was *not* pressing for a prescription.

Reflections

Viewed in isolation the consultation extract seemed to fit with the idea of '*pressure to prescribe*' which is an established phenomena in the literature surrounding MUS and which has been offered as an explanation for the disproportionate amount of prescriptions received by this cohort of patients despite the absence of observable, organic disease (Britten, 1995; Ring et al., 2005; Stanley et al., 2002; Wileman et al., 2002).

The patient's initial statement of "*I was just wonderin if there was anythin*" and subsequent switching to an acknowledgement of the GP's previous advice that there was not much he could "*give*" her, seem to suggest that not only was she requesting a prescription of something to be '*given*', but that she is also seeking to change the GP's mind in order to achieve the outcome of a prescription. This analysis receives further credence since it is followed by the information that the patient obtained the results of the blood tests discussed at the last consultation and that these were negative; this is interesting because it shows that the patient is recounting the advice from the previous encounter and is showing how she has made what could be seen as a *'good faith effort'* to follow the advice at each stage: have blood tests, receive results, return to the GP for further discussions (Heritage & Robinson, 2006b).

The final part of the presentation could also be viewed as supporting the idea of *'pressure to prescribe'* since the patient is reasserting the fact that the symptom is getting worse and elaborates saying that the dizzy spells are *"lasting longer and longer"*. In short, without the benefit of being able to speak to the participants, it would be reasonable to equate this extract with the phenomena *'pressure to prescribe'* as documented in the contextual literature. However, when this idea was put to the participants of the encounter, both separately refute it. In fact, rather than appearing to have felt pressured, the GP empathises with the patient's position and explains that this presentation does not appear unusual to him at this consultation given that the patient has followed the usual steps to explore other options and possibilities.

The patient meanwhile asserts that she is keen to find out the cause of the symptoms and that a prescription in the meantime to alleviate the symptoms would be welcome but would not be enough in itself. The extract ends with the assertion: *"I just want him to try and find out what it is really"* and this was echoed subsequently throughout her interview, during which it was revealed that she had experienced several bouts of unexplained symptoms during her lifetime and that she had some anxieties regarding her health and, subsequently, the safety of her young son whilst she was experiencing her current symptoms of *"dizzy spells"*.

From this example then, it can be deduced that the interpretation of interaction can greatly affect the subsequent actions of participating parties. This particular case shows how familiarity between doctor and patient can help to build a shared meaning, thus avoiding misunderstandings that can lead, for example, to patients being labelled as *'heartsink'* (Mathers & Gask, 1995) and their behaviour being viewed negatively as *'pressure to prescribe'* (Britten, 1995; Wileman et al., 2002).

This example therefore resonates with the dominant ideas in primary care that familiarity can be beneficial to the primary care encounter (Gabel et al., 1993; Morris, 1976) and furthermore demonstrates how familiarity can be particularly pertinent in relation to patients with Medically Unexplained Symptoms as it facilitates the avoidance of such negative assumptions being made of the patient.

However, there is a danger that once the assumption *is* made that a patient is *'heartsink'* and that they *'press for prescriptions'* as a part of their usual presenting pattern, any *further* familiarity will only serve to exacerbate this assumption and give rise to further tensions and misunderstandings between GP and patient.

Example 5.2. (Case 7) Familiarity brings clarity to non-specific cues: The three *"Okays"*

Following a discussion about anxiety management there is an interesting exchange of three *"okays"* in a row; this appears to serve as a discourse marker for the GP who, in the absence of other cues, begins a line of questioning regarding self-harming. This in turn elicits the presentation of previously undisclosed, long-term overdosing as self-harm by the patient.

The seemingly unprompted nature of these exchanges is puzzling to the observer but the GP and patient place them within the context of their ongoing discussions regarding the patient's overall health trajectory.

Summary:

The first consultation extract shows the interesting interactional phenomenon of the three *"okays"* in a row, followed by the GP's seemingly unprompted line of questioning and the subsequent discussion regarding self-harm and overdosing. The second consultation extract shows how the discussion then developed to reveal the extent of the overdosing which has spanned many years.

The first two extracts from the GP's interview demonstrate the detailed knowledge the GP has of the patient's medical history and cultural context. However the third extract reveals that the extent and time frame of the overdosing was previously undisclosed, thus this was new information for the GP. The patient meanwhile reveals that she felt comfortable discussing these issues with the GP because of their previous discussions on this topic.

Consultation:

Extract 1

P: The propranolol I can take more than one at a time can't I
GP: You can well you can take one of those three times a day
P: **Okay**
GP: **Okay**
P: **°Okay°**
GP: You've never sort of (0.2) done anything to harm yourself or anything like that have you (°have you°)
P: Erm (   ) but not properly
GP: °M okay° well what I'll do is I'll just give you a couple of weeks
P: Yeah
GP: Right and forward date that for the erm er erm (.) sort of er 15th of June which is when you're due to run out and then I'll see you towards the end of June
P: Okay
GP: Erm when was the last time you tried to do anything (.) being honest
P: Erm probably during the exams
GP: M (.) and what did you do
P: Just took pills

Extract 2

GP: And when did you first ever start taking an overdose when was the first time you ever took an overdose
0.5
P: (°don't know°)
GP: How old were you
0.3
P: (   ) erm
GP: And you're 22 now
P: Yeah before GCSEs
GP: M so when you were about 15
P: °probably° yeah
GP: M and since that time so we're looking at the last five or six years would you have taken would you say you've taken a few overdoses every year
P: No no it's just exams and things that just h really bad
GP: M
P: **But it's happened more this year**

GP:

Extract 1

"...she's quite a **private girl that presented with somatic symptoms** to start with...and it's **taken her a long time to talk about a lot of these problems** and her problems are a lot more entrenched than she first admitted...and similarly when you've got people like that you've got to give them the time and space in the consultation and part of the general practice sort of craft work side of things is being able to identify when patients have got what they've wanted...and you know they've got what they wanted when the light goes out... and it's important to identify that moment because once that moment is reached everything else you say to that patient is a waste of time" (L369/ 385)

Extract 2

"...we'd talked about some minor self-harm behaviour quite some time ago in June last year I specifically asked her if she had no suicidal nor deliberate self-harm intent... and then we got talked about anxiety a lot in the following consultation... we didn't really come back to that subject for quite some time... the problem she had was that towards the beginning of last academic year when she came back **her gran died...so she had a lot of problems and she had to go to ((home city)) a lot because there were lots of rituals that had to be performed coz they're Hindu...so that was obviously meaning that she was backwards and forwards and ... quite disrupted**... you know what was going on normally and really didn't return to self-harm until March this year when in fact she said when her exams were over she'd feel better so that then **implies a situational component** to it but she said that she scratched herself a lot... calibrating her emotions so she needs to put...the way she felt into some sort of point of reference...one of the reasons why they do it...but I deliberately asked her and she said she didn't cut and she didn't have any suicidal intent...and then...later that month she started to say in fact she had taken some overdoses and she's taken one two weeks earlier when you know she'd denied any intent... and then she'd also said that she'd taken in November...so she was also cutting a bit... and she started talking about that again in April the self-harm"(L446/482)

Extract 3

"but what we didn't know was the fact that she's actually this is a sort of pattern of behaviour since she was 15 or 16...and it's much more of a problem than she actually was admitting to and this is actually so now we're getting a picture of someone who's actually had anxiety for several years...not just for the last year and a bit...so she's obviously a you know a **slightly more complicated**" (L487/499)

Patient:

248	I	You have told him °about that before°
249	Pa	Yeah
250	I	Erm do you feel quite comfortable talking to him about (those sorts of things)
251	Pa	**Erm because he has asked me before**
252	I	Yeah
253	Pa	Erm yeah I do ( )
254	I	Yeah is the doctor going to tr:y and (.) help you (.) manage that or...
255	Pa	Erm he's taken everything hhh ((indicating boyfriend by turning around and making a head gesture))
256	I	Oh right so you're taking responsibility for that ((speaking to boyfriend))
257	Pa	But erm yeah it's just well everything's finished now so
258	I	mm
259	Pa	I don't really have a reason to get (0.2) I do get upset I just need to find another way [to manage] (my
260		problems better)
261	I	[yeah]
262	Pa	And (stuff like that) h
263	I	H yeah and are you going to work ( ) and go through the...
264	Pa	Yeah I thought maybe ( )
265	I	Yeah
266	Bo	( ) and try and ( ) (to relax in) certain situations and things ( ) things like that so ( )
267	I	Yeah yeah so do you feel that that's going to be quite positive
268	Pa	Mmm well I'm not sure but I think I hope so (.) you don't want to take pills hh

Consultation

Following a discussion about the patient's medication for anxiety, there follows a section of interaction where there are three sequential *"Okays"*: one by the patient, the second by the GP and then a third by the patient. The GP responds to this by beginning a seemingly unprompted line of questioning relating to self-harm which the patient readily engages with, revealing that she has used overdosing as a method of self-harm for 5 – 6 years and which seems to be focused around the pressure of educational attainment.

GP

Responding to this section of the recording, the GP explained that he had previously explored the issue of self-harm with the patient and that this had been a gradual process which had taken quite some time and was linked to the patient's initial presentation of *'somatic'* symptoms (namely hair loss, fatigue and headaches).

The GP explains that picking up on subtle cues such as the three *"okays"* is an important skill to develop in the course of general practice as a kind of *"craft work"* in terms of identifying and thus meeting patient needs. The GP then displays a detailed knowledge of the patient's recent psychosocial history as well as an understanding of her cultural context and possible related pressures caused by the death of her grandmother and the subsequent, associated burial rituals and inevitable disruption to everyday routine.

Commenting on the revelations regarding the overdoses spanning several years, the GP reveals that he had not previously been aware of the extent of this particular issue and comments that the patient is thus *"slightly more complicated"*.

Patient

The patient interview was conducted, in the same way as the consultation, with a third party actively present: the patient's boyfriend. Of this section of the interaction, the patient comments that she has discussed the overdoses with the doctor before and is thus comfortable discussing it with him.

The patient and her boyfriend then explain that the boyfriend has now taken charge of the patient's medication (which is discussed elsewhere in the consultation) and that the patient is trying to make changes to her coping mechanisms so that she can avoid being anxious and thus not need to resort to *'taking pills'*.

Reflections

Whereas in the previous example viewing the consultation extract in isolation might lead to a superficial reading and incorrect assumption regarding *'pressure to prescribe'*, the consultation extracts here are puzzling by themselves since both participants appear to be interpreting sections of the interaction in an unusual and yet shared manner.

The observer is left with questions: What is it about the *'three okays'* in a row, following a conversation about dosage for an anti-anxiety drug, that prompts the GP to initiate a change of topic? And why does he choose such a specific line of questioning regarding self-harming? Even if the concept of *'discourse markers'* in primary care consultations is taken into account (Elwyn & Gwyn, 1999), there is clearly more going on here than simply an interpretation of interaction at face value; somehow the GP realises that not only does the patient have more she wishes to discuss but he also has a strong inclination as to the nature of the topic.

A measure of the GP's astuteness on this matter can be deduced by the fact that this turn in the conversation comes approximately 10 minutes into a consultation which in total lasts approximately 18minutes, with the discussion around self-harming and the management of self-harming dominating the remainder of the consultation; thus just under half of the whole consultation is given over to the discussion of this topic.

Another interesting feature is the frankness with which the patient answers the GPs questions on this sensitive matter, even volunteering the information that *"it's happened more this year"*. In exploring this issue with both participants therefore, it was important to understand how this discussion had, in their view, come about and what was the context and background of their discussions on this topic.

In his interview the GP responds to the extract commenting that picking up on these kinds of cues is an important part of the professional skills he feels are integral to general practice work; however he does this having reflected on the trajectory of this particular patient for whom time and space were key in eliciting reflection on issues of anxiety which it seems were connected to her initial presentation of *'somatic symptoms'*.

A striking feature of the GP's responses is the extent to which he reflects, firstly on the work required to elicit these revelations and then also the detailed knowledge of various aspects of the patient's life and the impact that life events have on her anxiety and related behaviours. This detailed knowledge enables him to pick up on the discourse marker, estimate what the issue in question may be i.e. a desire to discuss self-harm, and thus he is able to take the initiative to begin the conversation.

Commenting on the resulting interaction the GP reveals that this is new information regarding the time frame of the patient's self-harming through overdoses. Interestingly, the patient's interview is characterised by short answers with minimum reflection on each issue raised. This would seem to resonate with the GP's assertion that she is a very *"private girl"* and thus it has taken quite some time for her to talk about these problems. Similarly her reassertion during her interview that *"everything is finished now so I don't really have a reason to get (upset)"* resonates with the GP's comments during his interview regarding *"situational components"*.

It would seem therefore that a familiarity between doctor and patient has led to a shared understanding on a number of issues, which supports the dominant thinking within the literature that familiarity between doctor and patient is beneficial to rapport and understanding and thus to the interaction within the consultation as well as the outcome itself (Gabel et al., 1993).

The patient's response in her interview to the question regarding feeling comfortable discussing such sensitive topics with the GP, where she says: *"because he has asked me before"* may also be significant since this may indicate that she would not feel comfortable raising such issues herself or certainly that she finds it easier once the topic has initially been addressed with this particular GP. This provides insight as to why such a discourse marker is necessary in order to initiate such a turn in discussions and how the GP was able to interpret its purpose with such accuracy, given his knowledge of the patient's presenting style.

Example 5.3 (Case 18) Familiarity brings clarity: Desire to talk about *'un-doctorable'* grief

The consultation is initially characterised by presentations regarding routine tests, prescriptions and new physical symptoms. However, having explored these issues with the patient in some detail, the GP comments that the patient looks *"fed up"*. This seems to be a mutually understood signal and they begin discussing the patient's ongoing grief at the loss of her husband.

Knowledge of the community context of the patient enables the GP to deduce that the patient wishes to discuss psychosocial issues which she does not feel able to raise herself. The GP thus initiates the turn in the discussion and they are able to explore helpful, non-medical solutions which the patient can engage with as culturally acceptable.

Summary:

In extract 1 the patient gives a mandatory review for tablets as the premise for attending but then proceeds to make a presentation of a physical symptom with the caveat: *"While I'm here"*. While the GP initially explores this presentation of *"pins and needles"*, upon finding that the patient appears unengaged by these efforts (spanning several minutes), she switches to a psychosocial discussion by commenting that the patient looks *"fed up"* (extract 2).

The patient engages with this and it transpires that she is having trouble dealing with the loss of her husband 3 years ago. In extract 3 the patient asserts that she was *"alright 'til you said that"* which gives an interesting insight into her self-reliance, which is echoed in extract 4 when the GP offers to prescribe something for the patient, to which she responds quite strongly: *"No I don't want tablets"* and then *"No I think I'll be alright"*.

In her interview the GP explains that she was closely involved in the treatment of the patient's husband's illness and subsequent death. Reflecting on the presentation, the GP comments that the patient *"doesn't fuss"* and that it was the lack of usually *"good rapport"* which prompted her to begin the new line of questioning (extracts 2 and 3).

Reflecting on the patient's self-reliance the GP comments that the patient is *"a real stoic"* and that she probably would not feel comfortable presenting for grief and distress, especially since she did not require any intervention (extracts 4 and 5). It was not possible to interview the patient.

Consultation

Extract 1

1 GP Right come in and have a seat (3.0) that's great
2 Pa: ((Cough)) (2 sec) **I'm here for me review for me Tablets**
3 GP: Ah ha
4 Pa: **But while I'm here I keep getting pins and needles in this arm**
5 GP: Do ↑you

Extract 2

100 GP: ...we could get an x-ray of your neck (.) do you get much pain down your back
101 Pa: No
102 GP: Have you had any (.) sorts of things that might be causing it (1 sec) **you look fed up**
103 Pa: **I am I'm a bit down**
104 GP: What's getting you down at the moment
105 Pa: I don't know (4 sec) I've been like that for a couple of weeks

Extract 3

120 GP: **How long is it now**
121 Pa: 3 years
122 GP: Still it must be (.) very hard (8 sec) is it about the bereavement d'you think that's [°got to you°]
123 Pa: [I think so]
124 GP: I think it's it's a very recognised thing that you know you get through something and and erm er you
125 know and you and and it can just sort of hit you again you know I mean I think it's a big loss isn't it
126 Pa: I think it's more because I'm by meself
127 (5.0)
128 Pa: **I was alright 'til you said that**

Extract 4

169	GP:	[So] so it's it's not °a big issue ° (1 sec) **shall I give you something**
170	Pa:	**No I don't want tablets**
171	GP:	(5 sec) Would it help to talk to somebody
172	Pa:	**No I think I'll be alright (8 sec) I'll be alright**

GP interview:

Extract 1

I: "Erm (.) so it seems from the recording erm that you've seen this patient before"

GP: "I know her very well (0.5) erm (..) her husband died erm (..) so it a couple of y- 3 years ago... which is a very horrible respiratory slow death and she's stoic... looked after him fantastic he died at home and they were really childhood sweethearts they'd never been abroad so they used the money you know for the asbestos...they used the money to travel and they went to all sorts of fantastic places like Cuba (.) and places like that (Lines 4 – 11)

Extract 2

GP: "She doesn't fuss you...know she's **she minimises herself** so how she was when I saw was very different...from how she was you know obviously feeling with what didn't sound like absolutely horrendously bad symptom she was obviously feeling awful with it...she doesn't seek out medical care she's not a somatiser...nor is she dependent you know **she's sort of strong...sort of (place name) woman really (L26/40)**

Extract 3

I: "Then you say erm **you look a bit fed up** and then she says oh yeah I am I'm feeling very down and that's then...the conversation goes erm I was wondering if you could remember what made you ask that at that point"

GP: "I normally have very easy rapport with this woman and and nothing I was saying was clearly hitting the spot I mean...it was alright but she was just sort of accepting it she was just ... I wasn't we weren't getting anywhere really...er I I didn't really feel that she's actually that bothered about her well she was she was fed up about that erm but I didn't really feel the and she just **she looked actually she looked angry rather than upset... we needed to kind of see what the problem was because I clearly wasn't sort of** she ...wasn't happy with where we got to and then she just sort of started crying you know and...actually you know she's having a pretty miserable time at the moment" (Lines 100–123)

Extract 4

I: then she says er **I was alright 'til you said that** and I thought it was really interesting...

GP: Yeah no I I think I think I think I think she **was an apology a bit she's a real stoic** and all through (Husband's name) thing you know (husband's name) really awful respiratory death...she never asked for anything for herself in and when you sort of offered it she said I'm fine concentrate on (Husband's name)...you know she's not i- i- it it's this is not an easy position for her so she was sort of saying you know **sorry to (.) breakdown I think...e::r and and but you slightly asked for it didn't y(hh)ou..** (L156 – 172)

Extract 5

GP: I think she's a woman who would feel much more comfortable coming to see a doctor about a physical problem I think she would feel she might be wasting her time coming because she was miserable because her husband had died because what would you expect her be...and and she doesn't want me to do anything for her...you know I mean she's she doesn't I mean if she came to the decision and it's possible she might ( ) that actually she did want to have tablets with this...that then I think she might feel ok about coming but actually you know **she doesn't want counselling she doesn't want tablets and therefore (.) she would feel she was wasting time** (Lines 312 – 324)

Patient interview:

The patient was not able to be interviewed for the second part of the research

Consultation

In the first extract the patient initially says she has come to have a review of her tablets (which she is apparently required and reminded to do). However having established a *'doctorable'* reason for presenting she proceeds with making a second presentation relating to a physical symptom of a *"pins and needles"* sensation in one arm. The GP explores this with the patient for quite a few minutes, offering possible explanations and examining the patient, before finally commenting that the patient looks *"fed up"*. The patient agrees that she is and it is at this point that there is a turn in the interaction towards psychosocial issues (extract 2).

Initially the discussion is centred on the patient's early return from her caravan, but the familiarity between GP and patient is evident as it enables them to place this in context of the patient's grief surrounding her husband's death and the doctor initiates a discussion about the patient's grief by asking *"How long is it now"* (extract 3).

Having engaged with this line of questioning and following a silence of approximately 5 seconds the patient comments *"I was alright 'til you said that"* which is one of many, notable assertions of self-reliance on the part of the patient and appears to be designed to remind the GP that it was not her who initiated the discussion (extract 3).

Despite this the GP continues the discussion regarding the patient's grief and emotional distress and the patient engages with this for several more minutes, even agreeing to come back to see the GP in 3 or 4 weeks to let the GP know how she is getting on.

In the final extract, which is from near the end of the consultation, the GP offers solutions including tablets and counselling and again the patient's self-reliance is evident as she rejects both offers of intervention, finally stating *"No I think I'll be alright"* (extract 4).

GP

The GP confirms that she knows the patient well and has a long-term acquaintance forged over a period of time whilst dealing with the long and painful illness suffered by the patient's late husband and his subsequent death (extract 1).

The GP comments early on in the interview on the patient's self-reliance, including that she does not *"make a fuss"* and that she *"minimises herself"* and she places this in the cultural context of her specific community saying "*she's sort of strong...sort of (place name) woman really* (extract 2).

Responding to the question of why she had initiated the turn towards psychosocial discussions, the GP revealed that she normally has a *'good rapport'* with this patient but that on this occasion this did not appear to be the case as nothing she was saying was *"clearly hitting the spot"* and that the patient actually *"looked angry rather than upset"* which thus prompted her to try to find out what the problem was since she clearly wasn't *'happy' (extract 3).*

Responding to the section of recording where the patient says *"I was alright until you said that"* the GP returns to the patient's self-reliant nature, commenting that she felt this was almost an *'apology'* from the patient for breaking down and comments *"she's a real stoic"* . She goes on to explain her belief that this is not an easy position for the patient to find herself in, commenting that the patient is perhaps reminding her that it was the GP who initiated the discussion and that she (the GP) had *"slightly asked for it"* (extract 4).

Reflecting on the consultation as a whole, the GP comments that this patient *"would feel much more comfortable coming to see a doctor about a physical problem"* and thus may find it difficult to present with grief as the primary reason for the visit, particularly since she does not require any intervention, and that she may be worried that she was *"wasting time"* (extract 5).

Reflections

There are similarities between this case and the previous one in that there is a discernable turn in the conversation initiated by the GP and readily engaged with by the patient. In both cases it is clear that the participants are interpreting the interaction based on a shared understanding which runs further than just the consultation in question. However there are important ways in which this case differs from the previous case, beginning with the fact that there is no observable, spoken *'discourse marker'* (Elwyn & Gwyn, 1999) during this consultation, but rather it is characterised by what is *not* said by the patient prior to the GP's observation that she (the patient) looks *"fed up"*.

The observer is thus again left with questions: How did the GP realise that there was more going on than the patient was verbalising? Having established that the patient was indeed *"fed up"* how did the GP deduce that this was related to the patient's grief at the loss of her husband 3 years ago?

Addressing these issues with the GP in her interview immediately brought helpful insights to bear, beginning with the fact that she knew the patient very well as a result of having treated her husband through a protracted respiratory illness until his death 3 years previously. This is an important insight since it not only confirms the familiarity between GP and patient but also gives some context to the patient's ongoing grief, particularly the information that the patient and her husband were *"childhood sweethearts"* and that she had cared for him until he died at home (extract 1).

The main insights from extracts 2, 4 and 5 are that the patient is generally a *'stoic'* and that, given the community she comes from, she would find it very difficult to specifically present with psychosocial issues. This is significant, both in terms of the cultural context of the patient, and thus her presentation of this *'un-doctorable'* issue (Heritage & Robinson, 2006a), but also in terms of the GP's understanding and knowledge of the patient's cultural context and therefore her ability to pick up subtle cues, even where they relate to body language and rapport rather than actually verbalised *'discourse markers'* (Elwyn & Gwyn, 1999)

This knowledge and skill is then drawn upon in order to address these issues in an appropriate manner which the patient can engage with as *'culturally acceptable'* (Kirmayer & Young, 1998; Kleinman, 2004). In this case, and also in the previous case, the long-term, positive effects of familiarity have improved interaction to enable the GP and patient to work together, over time, towards a more positive health trajectory. In this case that particularly involves finding ways to recognise and manage the grief and emotional distress that the patient feels at the loss of her husband.

Example 5.4. (Case 4) Identified *cylchdroi**[12] and attempts to intervene *(Fears of genetic infertility)*

The consultation is complex and appears to relate to several disparate concerns including: genetic testing, unexplained infertility and menorrhagia. However a familiarity between doctor and patient enables them to place these presentations in context of the patient's ongoing concerns surrounding infertility.

The GP's familiarity with the patient's medical history enables her to reflect on the potentially disruptive connotations of the genetic diagnosis (and implications for fertility) and this elicits some feelings of empathy regarding the patient's erratic presentations; she is also aware that the patient's trajectory has, in part, been unnecessarily prolonged due to delays emanating from the health care system.

The GP is therefore keen to help the patient reach a resolution, even if the news is unwelcome, rather than to continue to '*cylchdroi*' between unfavourable options and thus remaining in a state of '*diagnostic limbo*'.

Summary:

The consultation extracts show discussions from various components of the consultation, including: genetic testing, menorrhagia and infertility, which do not appear to be particularly connected. During her interview however the GP explains that there may be a genetic reason for the patient's infertility and that the investigation of this link has been delayed partly due to mistakes by the health care system but that these were also compounded by the patient's erratic presentation style (extract 1).

The GP then reflects on the impact of this delay on the patient and comments that she wants to help her to resolve the issue but that in order to do this the patient must *'help herself'* by presenting with greater consistency (extracts 1 and 2). The patient meanwhile remains (outwardly) sceptical of the suggestion of there being a genetic cause for her infertility but nevertheless values the progress made with the help of this GP.

Consultation:

Extract 1

1	P	Hello
2	GP	Long time no ↑see
3	P	°I know° stranger
4	GP	I ↑kno:w how's it ↑been
5	P	It's been okay
6	GP	↑Yeah (0.2)
7	P	**Oh god I'm still waiting for that (.) genetic thing**
8	GP	Are ↑you
9	P	Yeah
10	GP	Did they write to you
11	P	They wrote and erm (.) the they cancelled the appointment so I phoned them up I think it was in September
12	GP	Yeah 'cause I was going to say I I made sure that you had it before I went hhh
13	P	yeah and I'm still waitin' now
14	GP	Are ↑you (.) d'you want me to chase that up
15	P	°mm°
16	GP	'cause that was donkey's ago (.) that was really a long time ago
17	P	I know it was
18	GP	It wasn't that you didn't turn up or anythin'
19	P	No they just sent me (one) saying "it's been cancelled" but
20	GP	Do you still want to go
21	P	Yeah
22	GP	Sort of yeah yeah
23	P	Yeah
25	GP	Yeah no I'll chase that up actually and say what happened that was that was months ago I've had a baby
26		since then (0.2) how are you
27	P	**I'm fine, I've just come about erm me periods**

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[12] A Welsh word literally translating as: *'circle-turn'* for which no satisfactory English term seems to exist which could not be inappropriately construed, for example: circulation, revolving. This term is being used here to describe the agenda of patients which appears to be in a state of flux as they move in a circle between equally unfavourable options of living with MUS and undergoing investigations or surgery which might lead to them receiving an unwelcome diagnosis or else result in them living with subsequent Iatrogenic harm.

Extract 2

GP I'm just wondering erm whether it's worth doing a scan while we're waiting for the geneticist to make sure your bits are okay have you ever had any scans on your tummy or anything no basically I will get a geneticist to see if there's erm a reason why you're not getting pregnant okay and then to refer you to a gyne yeah cos you're quite young cos it would be awful sending you to the gynaecologist and they do all their surgery and stuff and then all you need is the geneticist to see whether it's related to your arm

P the woman came out to the house, what's her name ((geneticist)) I think her name was and then that's when she said she'll refer me to the ((hospital 1))

GP the ((hospital 1))

P yeah because she first said

GP ((hospital 2))

P yeah she said ((hospital 2)) first cos that's where the main thing is and she done the family

GP stuff

P yeah my family tree or something she came out of the house with that but then she said she'll refer me to the ((hospital 1)) that's where that other thing is but that's the letter what I was waiting for

GP ah

P but that was last year

GP it was last year wasn't it you kind of got half way and then right well okay let's chase that up I'm just wondering in the meantime whether to do a scan to make sure everything's okay your periods have suddenly gone off

GP interview:

Extract 1

GP: I think she's not sure if she doesn't want to go because when I did an x-ray of her arm and I looked on the internet I said "come in I don't know anything about this but from what I've read this could be really serious and impact on your life" and so **we had this chat about how it might be really bad news to have a genetic thing that would make you infertile and stuff and she'd been trying to get pregnant and she wasn't sure** and I said I think it's worth investigating rather than going to see a gynaecologist you might as well talk to someone first rather than getting half way through gynae so she was really really unsure at the time and **I didn't see her for a long long time** and she'd also seen a fortune teller who told her that she would be unable to have children...and she was really really upset about it and they'd looked at her hand and everything else she'd said so far had come true, there was quite a lot of facts from the past and when I've spoken to her you know I said "well come in" and I haven't seen her for another 6 to 9 months after that so it was quite you know **she came when she was ready and I wasn't sure that she really wanted to go** (L43/51).

Extract 2

I: So there you're clearly really keen that she comes back...because that seems to be a problem

GP: It is and certainly as I say before in the past **"I really want to get to the bottom of this** you know you have to help me to help yourself" and that's why I think I was so do this do this and come back and I was really quite "Oi you know play the game **I want to help you but you have to help yourself** and it's obviously worrying you and that's why you've come and you know do come back" (L186/189)

Extract 3

I: Whereas in this patient's case it's actually...she remains unexplained...her presentation the way she presents herself...she's quite an interesting case I thought because she's unexplained more because of her behaviour

GP: Yeah and if she'd come in and come back I think I saw her when I first started in 2006 can't remember when I started working **it's taken me years to get that far** years and years cos **if she came back we could have sorted it all out and she wouldn't have been infertile for 4/5 years** it would have been a year and would have gone and got it sorted and you know the geneticist thing that has been a bit of a mistake on their part and erm they did apologise and they said they would send out an appointment that day which obviously they did so you know that side if we'd got that sorted out sooner and then I mean she's still quite young that's on my side that she's actually you know not too young to refer for fertility thing and I have said bring him along as well so **it is quite difficult she needs to help herself really** (L198/205)

Patient interview:

Extract 1

I: ((Commenting on recording)) Okay so that's obviously there that something that you've talked about at a previous consultation what was that for the genetic test

Pa: I've got a deformity in my right arm called madelung deformity I think it's called and erm when I seen her last time before she went on maternity erm she said that it might be to do with not getting pregnant it might be a genetic thing so I went to see ((Dr 1))...and he got like an x-ray and stuff... hospital and then after that I went to physio just to try and make it a bit better cos it was paining all the time and that erm and then I've actually got the letter the other day about going to see the genetic person in the ((Hospital 1))...just after that

I: So they've referred you on to a different hospital

Pa: Yeah and they might tell me more about this deformity and if it is connected to anything else

I: Okay so you've seen another doctor and then physio and now you're going to see the geneticist

Pa: Yeah cos she came here last year, the woman, and was explaining like what was going to happen and stuff and they sent me a letter last year saying cancel the appointment what it said there and make another appointment and lucky enough I got connected the other day (L43/56)

Extract 2

I: okay so the doctor... sort of diagnosis... was that she couldn't reach one entirely so she...has referred you to see the geneticist and then to the gynaecologist hasn't she erm and she's given you some drugs were you happy with the outcome

Pa: Yeah I felt at the time that I was getting somewhere...that's why I felt like celebrating ( ) (L195/198)

Consultation

A sense of familiarity between doctor and patient is clear from the outset, with the doctor saying *"long time no see"*. This familiarity is then further demonstrated by the first presentation regarding genetic testing, which takes just one, short sentence to introduce: *"Oh god I'm still waiting for the (.) genetic thing"* (extract 1).

Following the second presentation of menorrhagia the GP makes the links between the two presentations and the ongoing (unvoiced) problem of infertility (Barry et al., 2000), thus demonstrating the brevity afforded through the familiarity and prior knowledge, and also the involvement of the GP in the patient's ongoing health trajectory (extract 2).

GP

In the first extract the GP gives a detailed picture of the patient's ongoing concerns regarding infertility and her own concerns regarding the possibility of a genetic cause, together with her additional sense of anxiety for the patient since this might have been picked up sooner but for mistakes made on the part of the (extract 1).

Responding to a question regarding her attempts to get the patient to come back she confirms that she herself is keen to *"get to the bottom of this"* (extract 2) and comments more than once that whilst she is keen to help the patient *"she needs to help herself really"* (extracts 2 and 3).

Responding to a question regarding her reasons for defining the patient's symptoms as medically unexplained the GP reflects on the patient's role in prolonging her MUS, commenting that it has *"taken me years to get that far"* and that *"if she came back we could have sorted it all out and she wouldn't have been infertile for 4/5 years"* (extract 3).

Patient

The patient reflects on her prior discussions with the GP regarding the possibility of there being a genetic link between the abnormality in her wrist and her current infertility and reveals that since the consultation she has been issued with another appointment (extract 1).

Responding to the question of whether or not she was happy with the outcome of the consultation the patient responds positively, commenting that she felt that she was *'getting somewhere'* and that she thus felt like *"celebrating"* (extract 2).

Reflections

The consultation extracts show a range of seemingly unrelated presentations which the patient and GP nevertheless appear to view as linked, placing them in the context of ongoing discussions regarding the patient's concerns regarding infertility; in this sense the extracts are representative of the consultation as a whole which, even in its entirety, viewed in isolation, is confusing and difficult to extrapolate from since the GP and patient are clearly operating within a framework of shared knowledge which enables them to discuss various issues with a limited amount of explanation.

Unlike the previous two examples, there is no particular turn or switch in the consultation, which instead seems to be largely characterised by fluid shifts between various voiced and unvoiced issues. There is clearly a lot going on within the consultation and also outside of the consultation, including prior discussions, involvement of secondary care as well as a verity of situational components.

Interviewing the participants brings clarity to how the seemingly disparate issues are connected, how the participants are able to interpret the interaction which lacks sufficient details for a superficial interpretation, and how the participants are responding to this complex situation more generally.

The GP's comments in her interview bring clarity to the situation in as much as we learn the perceived link between the delayed genetic testing, new symptom of heavy periods and the possibility of infertility (possibly due to a genetic syndrome).

The GP also reveals the sporadic nature of the patient's presenting style and the fact that this is why she defined her as having Medically Unexplained Symptoms for the purposes of this study. This is particularly interesting since it highlights the complex nature of MUS as a defining criterion for a cohort of patients in a particular predicament (Kirmayer et al., 2004) and demonstrates that the disease category *'Medically Unexplained Symptoms'* is not always interchangeable with *'Somatisation'* in terms of definition, despite this being the common presumption (Fielder et al., 1996; Nettleton, 2006).

Meanwhile, the patient reflects on the ongoing nature of the genetic testing by focussing more on the delays caused by the missing referral and mistakes on the part of the health care system; she comments *"I felt at the time that I was getting somewhere...that's why I felt like celebrating"*. This resonates with findings of previous studies of patients experiencing MUS and their desire for diagnosis, even where this may be negative in terms of their health trajectory since it affords them legitimacy for their suffering and gives them 'permission' to be ill (Nettleton, 2006).

From this case it can be deduced that, in situations where a patient may have a complex health trajectory, possibly complicated by their own presenting behaviour, a familiarity between doctor and patient can give the GP important insight into why a patient may be presenting in a potentially unhelpful way, thus prolonging the period of uncertainty over diagnosis.

In this instance it would seem that the patient finds herself in a quandary and is continuing to *'cylchdroi'* between the unfavourable options of various referrals because she is afraid of a potentially devastating diagnosis, whilst also sporadically presenting to the GP with various related symptoms and theories relating to the underlying issue of infertility.

The familiarity and shared knowledge between GP and patient enables them to work together, moving forward with each consultation, with an eventual aim of breaking the cycle of avoiding clarification.

Chapter 6: Negative aspects of familiarity

Introduction

The findings presented in chapter 5 supported the widely held belief that familiarity has a positive impact upon doctor-patient interaction in primary care and that it thus benefits health care generally. However a growing body of evidence is emerging from across the health care specialties which sets forth the idea that perhaps this is not *always* the case and that, in certain circumstances, familiarity at a range of different levels can in fact *harm* doctor-patient interaction and thus the health care experience generally (Broom, 2003; Chew-Graham et al., 2004).

The findings presented in this empirical chapter will draw on evidence from the data which supports this idea that familiarity can harm doctor-patient interaction, thus contrasting the ideas explored in Chapter 5. As in the previous chapter examples are organised to demonstrate patterns of themes which were observed in the data, with the most illustrative examples being chosen to highlight phenomena observed in a variety of ways across cases.

The first two cases relate to disempowerment and convey the idea that, as familiarity increases between doctor and patient, particularly over a long period of time, a degree of conflict can occur leading to increasing feelings of disempowerment on both sides as they struggle to gain the desired amount of respect and cooperation from each other.

The first example explores the sense of disempowerment as experienced by a GP who feels exasperated by repeated consultations with a patient who appears to experience numerous intractable health issues and who frequently insists on referrals to secondary care rather than accepting health advice from the GP. This example supports ideas previously set forth in the literature regarding GP perceptions of reduced ability to intervene medically in a meaningful way with certain patients, particularly where patients attend frequently with MUS (Chew-Graham et al., 2004).

The second example mirrors this phenomenon from the patient's perspective and explores the experience of presenting over a number of years with MUS and feeling that the GP is dismissive of these health concerns and is unwilling to offer any medical interventions; the patient thus feels there is little point raising these issues anymore. This example supports the ideas set forth by (Broom, 2003) that familiarity can lead to new symptoms being missed, whilst also echoing the findings of Dowrick and Salmon et al regarding the ways in which patients may seek to alter their presentations depending on their perceptions of the doctor and the ways in which their presentations will be received (Dowrick et al., 2004).

Taken together, these examples of disempowerment support the ideas set forth by Adamson (1997) regarding the considerable degrees of clinical and *'existential uncertainty'* often experienced by doctors and patients with regards to Medically Unexplained Symptoms (Adamson, 1997; Nettleton, 2006). This also highlights the usefulness of this particular label for the predicament of symptoms in the absence of identifiable, organic pathology, since the emphasis is divided between participants rather than attributed to one or the other; as (Dowrick, 2005) comments, the phrase neatly encapsulates the fact that both the doctor and the patient have a problem: the patient has symptoms which cause them to suffer, whilst the GP may feel their professional expertise is challenged.

The third example further explores the concept of the disempowered doctor and draws in the theme of *'cultural competence'* as the GP expresses initial resignation regarding a request for an anti-depressant from a patient who is from the Irish traveller community[13] for whom such drugs are routinely prescribed, without much attempt to intervene medically. The GP explains that this is because

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[13] The primary care surgery included a population of Irish Travellers who had been granted by the council the right to a permanent encampment at a city-centre site which had been their home for 30 years. The recent decree meant that steps were being taken to ensure health care and education arrangements for the group and thus they had joined the demographic of the surgery and certain health trends had been observed.

it is widely accepted that members of this community suffer with long-term depression due to experiencing a unique range of pressures and situational factors and thus long-term dependency upon anti-depressants is seen as a cultural inevitability.

However this view is then challenged when the patient requests a prescription for sleeping pills and this causes a turn in the conversation which subsequently leads to a number of psychosocial revelations. As well as suggesting that the patient may in fact have been seeking psychosocial intervention rather than a prescription, this case then highlights how familiarity on the part of a GP with a patient's community context can, conversely, have a negative impact on doctor-patient interaction and lead to incorrect assumptions. In this instance then, 'cultural competence' (Fox, 2005) can be seen to have impacted negatively since the assumption was made that all members from this particular cultural group were assumed to have similar health needs where, sometimes, perhaps they did not.

The final example reveals the subjective nature of familiarity in that there may be an asymmetry in the perceived sense of familiarity held by each party – in this case, the patient feels a greater sense of familiarity with the GP than he feels with her. The impact of this disparity is clear in their very different interpretations of the interactional extract presented. Whilst this does not cause any conflict or other problems in this particular case, and in fact appears to go unnoticed, there is obvious potential here for the disparity to lead to confusion, hurt feelings, frustration, miscommunication and conflict.

Collectively the chapter mirrors the previous chapter, demonstrating how *'familiarity'* can have a negative effect on doctor-patient interaction during primary care consultations, and thus impact upon subsequent outcomes. These two chapters will then be contrasted with two chapters exploring the positive and negative aspects of *'non-familiarity'*.

Negative aspects of familiarity

6.1 (Case 2) The disempowered doctor: *"How do you think the GP is feeling?"*

6.2 (Case 1) The disempowered patient: *"It's rather...a bit destroying really"*

6.3 (Case 23) Contextual familiarity: behavioural epidemiology[14] as a cultural inevitability?

6.4 (Cases 5) Familiarity but disparity: Talking at cross-purposes

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[14] The distribution of health-related behaviours and lifestyle factors in populations that may be associated with disease occurrence, mortality and morbidity rates, e.g.: smoking and heart disease Heggenhougen, H.K. and Shore, L. (1986) Cultural Components of Behavioural Epidemiology: Implications for Primary Health Care, *Soc Sci Med*, 22, 11, 1235-1245Sallis, J.F., Owen, N. and Fotheringham, M.J. (2000) Behavioural Epidemiology: A systematic framework to classify phrases of research on health promotion and disease prevention, *Ann Behav Med*, 22, 4, 294-298.

Example 6.1 (Case 2) The disempowered doctor: *"How do you think the GP is feeling?"*

This consultation, which spans approximately twice the average length, is complex and characterised by a steady flow of presentations of physical symptoms followed by requests for referrals and prescriptions.

However there is a turn in the conversation when the GP asks the patient *"how are you feeling in yourself"*; this appears to be a mutually understood signal to begin discussing the patient's ongoing grief at the loss of his mother. The patient readily engages with this but also switches back and forth between making presentations for physical symptoms and requesting referral.

In his interview the GP reveals his frustration regarding the nature of similar ongoing consultations with this patient, including his feelings that his professional skills are not valued by the patient. Meanwhile the patient appears to value the familiarity with the GP but reveals that his preference for seeing specialists is driven by the fact that his mother's refusal to be seen by a specialist played a significant role in her death.

Summary:

The consultation extracts show three separate presentations of physical symptoms: acid reflux, sinus trouble and eczema. Each of the three extracts show the patient favouring the opinions of '*specialists*' above those of the GP.

The first extract from the GP's interview reveals that he feels pressure from the patient to make referrals and dispense prescriptions and also pressure from secondary care *not* to refer patients. This has resulted in him feeling frustrated and angry, which is clear when he answers the question of whether or not he felt *"tense"* with the strongly worded: *"I'm pissed off yeah"*.

Extract 2 shows the GP reflecting on why he initiated the psychosocial turn *("How you feeling in yourself" L92)* and also his anger regarding the patient's apparent lack of respect for his medical knowledge. In extract 3 the GP reflects that the patient's choice to see him is probably centred on familiarity as well as anticipation that he will make the desired referrals and or prescriptions. In extract 4 the GP comments on the discussion around eczema and makes a revealing comment regarding what he sees as the misappropriation of his role within the diagnostic process.

The extracts from the Patient's interview in many ways mirror the comments made by the GP. In extract 1 he comments that he does not mind the GP asking probing questions regarding his grief since the GP knew his mum and is therefore showing concern for him and the loss that he has felt. In extract 2 the patient confirms that he prefers to see a specialist, revealing that his mother refused to see a specialist or take antibiotics and that this contributed to her death of a simple chest infection. In extract 3 he comments that he values the fact that the GP is happy to order tests and to put him in hospital if anything is wrong. In extract 4 the patient comments that speaking to the GP helps but again expresses a preference for seeing the specialist (in this case a dermatologist) for each particular physical health issue.

Consultation:

(Extract 1 – Acid reflux)

21	GP	do you want to try that first
22	P	Still stay on the Losec ↑yes
23	GP	But u:se tablets to <u>empty</u> [your stomach as well]
24	P	[Mm yeah or could I] (.) see (.) **or would be better see the specialist first** ( )
25	GP	That would be the other alternative
26	P	Yeah
27	GP	Well I think there are choices so I'm offering you the choices
28	P	I'd rather see [the]
29	GP	[I] mean you'll <u>wait</u> to see a specialist a number of weeks [won't you]
30	P	[yeah I don't] mind waiting erm

(Extract 2 – Sinus trouble/ psychosocial turn)

79	P	**Sometimes er the specialist sometimes sort it out doesn't he like**
80	GP	Hhh we:ll I'm not sure that [you]
81	P	[°no°]
82	GP	=I mean you'll be having cameras tubes up [everywhere]
83	P	[oh hhh]
84	GP	=I don't think you've done all of the [things yet]
85	P	[n(h)o hh]
86	GP	=you know I don't think you've done all of the things [yet to to justify that]

87 P [I know yeah yeah yes]
88 GP I think we should try some antibiotics [and see if that helps]
89 P [yes yes]
90 GP **How you feeling in yourself**
91 P **Erm not bad erm not bad erm erm coping best I can but erm (.) know ( ) like I still miss me mum**
92 **like but erm sometimes I get ache there know like you get ache there erm it's not cough I dunno**

Extract 3 (Eczema)

243 P [Er but er] you think erm I mean know I don't know you had a
244 letter from ((Dr.4)) to say what's if I've got eczema or what you ↑see
245 GP mm
246 P Coz he said he'd sent you [( )]
247 GP [well] I do think you've got eczema yeah °yeah I do°
248 P Erm [well]
249 GP **[well] I know you've got eczema**

GP:

Extract 1 (Acid reflux)

I: *Oh I see so you felt quite tense at that point then*

GP: *"I'm pissed off yeah...how many referrals has he had you know* ***how many times does he want to be told he hasn't got this that or the other*** *I mean... and we go in to it... anything is possible in this world but you know yet I'm under* ***pressure not to refer*** *so ((Consultant.1))...who audits me says "you refer three times more patients than any other GP in this surgery" makes me feel under pressure as if... I should be bringing some generic erm thing into force so... and then I'm gonna be sending him for a second opinion when he's already had a decent opinion whether he has or he hasn't...* ***that's why I wouldn't send him to ((Hospital.1)) coz you're just actually setting up conflict*** *(L20 - L44).*

Extract 2 (Sinus trouble/ psychosocial turn/ the importance of seeing a specialist)

"I've had years of him remember so you know... ***I'm saying pull the other one*** *as well you know I'll put up with it I'll put up with it coz that's my job but...but you know I've also got my own thoughts because it actually* ***three symptoms two minutes how do you think the GP is feeling...*** *how do you think as a GP... how do you think as a fellow of the College you feel when somebody just talks through your words all the time and doesn't even let you finish your sentence" (L100 – 104)*

Extract 3 (Sinus trouble/ anticipated action)

"I mean he comes back to me for two reasons familiarity and there is an anticipation I will do something... *there's lots of there's lots of stuff that goes on that pre-selection even before you get into consult you know erm...* ***whether each of them are good for each other is another matter...*** *Whether I'm just trying to put out the fuel with er you know the barbeque with lighter fuel rather than water... you know it was non-evidence based for the antibiotic but I thought it was better than a referral... so you know I have to... make a compromise don't I...Or you know whereas there's other people who won't compromise and and therefore that's why these patients will come and see me because they know that you will bend and be pragmatic and do things that are not strictly evidence evidence-based...* ***whether you believe long term relationships are actually of any value to patients is er another thing*** *(L152 - L176)*

Extract 4 (Eczema)

"Mm I say "I know you've got eczema" coz I do yeah ***I don't need a consultant to tell me... It's part of the misappropriation of what my role is in within the diagnostic process*** *" (L246 – 248)*

Patient:

Extract 1 (Psychosocial turn)

I: *I was just wondering how you felt when he asked you that*

P: *Erm I don't mind...er no 'cause erm he he's probably thinking "how's this man coping how is he coping without me mum" 'cause he knew me mum (L260 – 265)*

Extract 2 (The importance of seeing specialists)

"she didn't like to go see a specialist me mum...me mum and dad neglected themselves I don't like to neglect meself...it did annoy me and me sisters me brother and... ***she never took antibiotics...she only died of a chest infection"*** *(L338 – 350)*

Extract 3 (Anticipated action)
*"I feel quite relaxed with ((GP05))...he's put me on the dermatologist whose another erm ((Dr 3)) know for the nerves and...**anything wrong he sends you for tests** and quite erm quite erm...content...I know someone told me if ((GP05)) can't get down to he says hospital...**he has put me in hospital with me chest I had a chest infection once"** (L420 – 432)*

Extract 4 (Eczema)
"Yeah I think when I talk to ((GP05)) helps me...but erm yeah I'm under ((Dr.04)) for the dermatol erm the skin" (L602)

Consultation

In the first two extracts, the patient shows a clear preference for going to see a specialist, firstly for acid reflux and then for *'sinus trouble'*. In the third extract he refers to the opinion of a specialist he has seen regarding the fact that he has eczema.

What is striking about these extracts when viewed together is the apparent higher importance the patient places on medical *'specialists'* over that of the GP. It also reflects the high utilisation of health care by the patient who, during the course of the consultation and his interview, mentions: 11 doctors, 3 medicine-based professors, 3 hospitals, 1 consultant, and 1 health care centre, all by name and stresses the conversations he has had with them regarding his own health and that of his mother whilst he was acting as her full-time carer prior to her death.

Meanwhile the GP appears to be trying to dissuade the patient from seeking so many referrals and also from focussing on physical symptoms. He initiates several seemingly unprompted turns in the conversation back to discussing grief and anxiety management and eventually succeeds in gaining agreement from the patient to try the counselling service offered within the clinic.

GP

The GP responds to the first extract by revealing that he is annoyed by the patient's apparent preference and thus pressure for referrals to see specialists, whilst he also feels pressure from his colleagues in secondary care *not* to make so many referrals.

Reflecting on the second extract the GP explains that his initiation of the psychosocial turn was partly a way of confronting the patient regarding the relentless presentation of physical symptoms, commenting that *"I'm saying pull the other one"*. He also comments on how this style of presentation by patients makes him feel and it is here that he makes some salient remarks regarding disempowerment, including: *"three symptoms two minutes how do you think the GP is feeling"* and he also remarks on the patient's apparent lack of respect towards him as he *"talks through your words all the time"*.

The third extract from the GP's interview shows the GP reflecting on why he feels the patient chooses to come to see him, commenting that it is familiarity and the anticipation that he will *"do something"*, for example being pragmatic and prescribing antibiotics where other GPs might not if it did not seem to be strictly evidence-based. Interestingly, it seems here that the GP is discussing these actions as ways in which to maintain relationships with such patient as he ends with the observation: *"Whether you believe long term relationships are actually of any value to patients is another thing"*. This could also be interpreted as the GP making a critical comment regarding the emphasis placed in primary care upon retaining relationships.

In the final (fourth) extract, the GP comments on the fourth extract from the consultation which relates to eczema and further reveals his exasperation at the patient's apparent lack of respect for his medical knowledge as a GP, commenting: *"I know you've got eczema...I don't need a consultant to tell me"*.

Patient

The patient makes several interesting and revealing comments pertaining to these extracts. Essentially it would seem that the patient's anxieties regarding his own health are related to having witnessed both of his parents dying because, in his opinion at least, they did not pay enough attention to their health and *"neglected themselves"* which is something he is therefore keen to avoid. As a result he feels that he must pay close attention to his health and that going to see a specialist and having lots of tests and check-ups is the best way of ensuring that you remain healthy.

Interestingly, he also reflects on why he likes to be seen by this particular GP and his comments mirror those of the GP in that it is to do with familiarity and anticipation that *"anything wrong he sends you for tests"*.

However since qualitative interviews elicit justifications as well as explanations, the patient's comments regarding his reasons for presenting and heavy engagement with health care should be viewed in context of the case as a whole and not taken at face value or as *'truth'*. For example, as mentioned above, the patient appears to *'name-drop'* throughout the consultation and his interview, in terms of medical professionals from primary and secondary care with whom he has had contact, past and present. He also reminisces on the respect afforded him by some of the doctors at the hospital whilst they were treating his mother, as they asked his opinion of how he felt his mother was coping, and also the level of responsibility entrusted to him in terms of his mother's care, including the dosage of her medication.

It is tempting to extrapolate further regarding the patient's reasons for the desired contact, drawing on the GPs comments regarding the fact that the patient does not work and that *"if I don't refer him you know what the hell else is he going to do with his life (L116)"*. It would be possible therefore to build a picture of the patient as enjoying the contact with health care professionals and therefore, now that the contact has ceased with the death of his mother, he now wishes to find ways to reinitiate this contact. However this would be theorising and would be largely based on the opinions expressed by the GP rather than comments made by the patient or any observable evidence.

Reflections

From the consultation extracts we can begin to see a picture of a patient who has a clear preference for being referred to specialists and who frequently requests such referrals from his GP. There is clearly a familiarity between GP and patient and this appears, in part, to aid the conversation in much the same ways as observed in chapter 5, including the enabling of detection, on the part of the GP, that the patient may have psychosocial needs which he may not feel comfortable raising himself; in this case the issue is grief and many of the issues surrounding this presentation are similar to those observed in case 5.3.

However there also appears to be some tension in the consultation and the GP reveals that this is indeed the case, at least from his side and that in fact he has learned to accommodate and live with this patient, who can otherwise be *"incredibly maddening" (L394)*. This could be seen as an example of familiarity breeding mutual contempt which is a direct contrast to the positive *'mutual investment company'* described by Balint in terms of the shared experience and trust that doctors and patient accumulate over many years of continued familiarity in general practice (Balint, 2000). It also fits with the literature around MUS and the *'heartsink'* patient (Mathers et al., 1995; Mathers & Gask, 1995).

During the course of his interview the GP explains that consultations such as this one are difficult since they challenge his professional role within the diagnostic process and appear, to him, to be disrespectful. He also reveals the wider, contextual information that he is under pressure from the side of the specialists in secondary care not to make so many referrals and that this also complicates the decision of which hospital to send the patient to since referring him back to a hospital from which he has already been discharged could *"set up conflict"*.

This brings an important insight into the role of additional variables in this case, such as the organisational structures of the NHS, and how these impinge upon the care of patients. However again this is a problem created by familiarity, this time between the patient and the secondary care setting; the GP resolves this perceivable issue by making the patient's referral to a new and different hospital, where no familiarity will exist.

The GP also reveals that he finds himself having to be pragmatic and write prescriptions which may not be strictly evidence-based in order to avoid issuing another referral. This is particularly interesting since it suggests that patients experiencing MUS may receive an unnecessary prescription due to the GP feeling pressure to prescribe, which fits with the current literature and is the flip-side to the *'non-pressure to prescribe'* example presented in case 5.1 (Britten, 1995).

It would appear that, in this case, a doctor-patient familiarity over time, whilst beneficial in many ways, has led to some quite considerable frustration and feelings of disempowerment on the part of the GP, which supports the emerging literature regarding disempowered doctors, particularly with regard to consultations pertaining to medically unexplained symptoms (Chew-Graham et al., 2004).

Also, on the part of the patient, a familiarity with the health care milieu has become an *over-familiarity* leading to an *overreliance* on this setting in terms of his everyday interaction and also possibly an over-anxiety regarding his own health. This resonates with the concepts of the *'entrenched sick role'* and *'heightened health awareness'* (Kwan & Friel, 2002; Salmon & Hall, 1997; Semple et al., 2005).

Whilst the patient much admires and likes the GP in question, the patient's prior experiences surrounding his mother's health choices and subsequent death have led to him feeling that the medical knowledge of the GP is insufficient in itself, preferring instead to be seen by a *'specialist'* and also to undergo regular health checks and receive prescriptions.

The GP's reflections regarding the non-evidence based prescription obtained during this consultation and also reflections on the invasive and possibly harmful consequences of unnecessary visits to secondary care also indicate the possibility that the patient's over-familiarity with the health care setting might also lead to *'Iatrogenic harm'* (Kouyanou et al., 1998; Kouyanou et al., 1997; Salmon, 2006; Salmon & Marchant-Haycox, 2000) and reflect the literature on the overprescribing of antibiotics and associated risks (Stivers, 2006).

Example 6.2 (Case 1) The disempowered patient: "*It's rather...a bit destroying really*"

This case took place at a single-handed GP practice and thus a familiarity has existed between doctor and patient spanning many years. On this occasion the GP feels that the MUS of dizziness and strange visual *'twisting'* that the patient presents are not that important given her more immediate risk from high blood pressure. Placing the symptoms in context of the patient's ongoing symptoms of migraine (spanning several years) he feels that the patient and he can both *"live with it for a while"*. Meanwhile the patient's comments make it clear that these recent symptoms are having a significant impact on her life to the point that they are *"debilitating"*.

Both participants place these new symptoms in context of previously discussed health issues and it would appear that the current presentation and subsequent interaction follow an established pattern which leaves both parties feeling exasperated with each other and to the patient feeling disempowered regarding her ability to initiate medical interventions.

Summary:

The consultation extract shows the patient's presentation of MUS, specifically dizziness and visual *'twisting'*. The GP briefly explores the symptoms with the patient, focussing specifically on whether they are unilateral or bilateral, before returning to their previous discussion regarding the patient's high blood pressure.

In his interview the GP explains that he is primarily concerned with the patient's current high blood pressure and that whilst unilateral symptoms might indicate a serious health condition, the bilateral symptoms described by the patient were likely to be *'psychological'* and thus there was no urgency to explore them (extracts 1 & 2).

In the third extract the GP reflects on the patient's psychosocial context and makes an interesting comment regarding the patient having her *"own ideas about her health"*. In her interview the patient explains that the MUS are having a significant impact on her life (extract 1).

The next two extracts show the patient reflecting on discussions with the GP regarding her health over time, including his lack of interest in her migraines (extract 1) and his negative view of her eating habits (extract 2).

Consultation:

64	P	Well er lately I've had a few strange bouts you know I mean I have a lot of migraine I had that
65		yesterday very bad
66	GP	mm
67	P	But erm I had to go to the shops yesterday and (.) while I was there (.) all of a sudden I didn't know
68		what came over me my I felt like my eyes were all twisting whether this has got something to do with
69		the with the high blood pressure I don't know but I went really strange and it's happened to me about
70		three times recently.
71	GP	So what with your eyes?
72	P	With my eyes I don't know [whether it is]
73	GP	[Going]
74	P	(.) Like as if everything was close up and twisting in my head and my eyes go all peculiar you know
75	GP	Mm
76	P	And…
77	GP	Both eyes?
78	P	(.) [( )]
79	GP	[Both] eyes both [eyes]
80	P	[Yes]

(Omitted text regarding details of the dizziness episode)

91	GP	Ah ri:ght well that that's part of your migraine isn't it ↓
92	P	But of all the <u>yea</u>rs since I've been eleven and a half and I've had migraine I've never had [this ( )]
93	GP	[You've]
94		never never had the eyes eye business [like that]
95	P	[Oh oh I've] had terrible eye business you know with all the
96		lights flashing and looks like erm (.) barbed wire twisting around [you] know
97	GP	[Yeah] fireworks or whatever
98	P	Yeah hh I call it barbed wire twisting around it's horrible erm (.) but these other sensations as I say
99		I've had it three times lately (.) and you just (.)
97	GP	[Maybe]
98	P	[Absolutely] nearly [collapsed]
99	GP	[maybe] when you blood pressure is a bit lower your migraines will be better

GP:

Extract 1:

*"Er I I think get her blood pressure down that's the main thing facing us and then see how she is... I'd like to see her blood pressure settled it is rather high...and erm you know you don't want to see her with a stroke...you see she's that I did ask her whether she had... erm bilateral symptoms or unilateral symptoms and she says "yes it affects both eyes" ...whereas you know if she's got some sort of aneurism that's about to pop in her head you'd think that would be one sided ...erm s:o or if she's going to have a stroke you think she'd get symptoms in one eye only...but she hasn't **she's got both eyes (.) s:o it doesn't (.) erm imply something rather central to affect both eyes...and that is more likely I think to be psychological than physical**...so...if she'd had unilateral symptoms...then I would be very concerned about her...but she's got (.) both eyes involved and I'm not as concerned" (L35 – 69)*

Extract 2

*"**So some things are more important than others...**a unilateral symptom is important (.) bilateral symptoms **well we can live with that for a little while**...on a level of risk erm you know maybe she has got some weird and wonderful illness that I don't know about...can I live with that well yes I can can she live with that well yes you know if it was severe **let's say for the sake of argument that this was these symptoms were dominating her life and here's a lady who's out shopping goes a bit funny when she turns her head to one side**...and it just happens that she's on loads of medication and she's got raised blood pressure well you know who knows how everything is acting there...or even whether she's worried about her blood pressure and therefore she's got symptoms...**so I think we could live with that** and I don't have to refer her to a specialist at this point of time and it may be that her symptoms will just settle...**so I'm prepared to live with that...and I think she's prepared to live with that**... I'm going to see her in two weeks as well...so you know if her symptoms have worsened then we've got a problem...so let's say for (   ) she's got a midline brain tumour or something...erm then she's going to get worse...and I'm going to know about it because I'm seeing the lady...so I can live with that..so I am doing...we live with our anxieties hh °sort of°" (L100 – 127)*

Extract 3

*"She's been widowed for twelve years now and since her husband passed away she finds life a struggle she's got nobody to talk to she doesn't she rarely goes out of the house she's quite isolated... erm (.) you know she **she's got her own ideas about her health** an:d I I don't think she's a very active person...she is obviously getting out shopping and she does seem to be a lot better than she used to be but I think she probably doesn't get out a lot" (L11-13)*

Patient:

Extract 1: Dizziness and visual 'twisting':

*"Well I used to be terribly sick when °they used to first° well for a long time when I got them (.) erm but they're very frequent at the moment and one of the reasons...**I'm scared of going out** (.)...because (.) I've had them when I (.) °when I've gone out°...well you can't see properly and everything's...you know ahm ...well erm I can have those any time and erm (.) you know say say the morning's fine it doesn't matter what time it is but it can start you know and erm this all these lights and everything they last for between a half an hour to three quarters...and it's (.) **your vision's very impaired** with it you know you can't see...ahm and erm... it really is...you know er **sort of... er like debilitating** you know 'cause you think "hhhh I feel so (   )" ... (L204 – 222)*

Extract 2: Ongoing symptoms of migraines:

*"Years ago the doctor said to me erm he doesn't seem to you know really bother about °you've got migraines° he said to me "oh you could go to a clinic you know" and I thought "oh that might be an idea to learn more about it...you know because you don't really know much about it and erm anyway **he never made any arrangement for it and I never pursued the matter you know...because I don't like sort of asking for things"** (L248 – 256)*

Extracts 3 & 4: Digestive tract:

"But I haven't been able to eat them for a long time because I get...very acidy then and then ...sort of sickly and that makes me feel...puts me off eating...you know I think he thinks I'm just fussy and faddy...to be honest...you know...I think erm...they don't look at you as in the whole you know" (L552 – 566)

*"well that seems to be something I can't get rid of anyway...**I think because he's known about it a lo:ng time that it's just... sort of erm (0.3) neglected**...you know...and when I (.) told him you know about my appetite he now refers...to it as erm "your peculiar eating habits"...Hh you know **it's rather... a bit destroying really**...(L849 – 858)*

Consultation

Midway through a consultation which has been primarily focussed on the patient's very high blood pressure, the patient begins a presentation regarding her recent unusual symptoms of *"dizziness"* and *"visual twisting"*. The GP initially engages with the presentation, exploring the symptoms relating to her eyes and establishing whether they are unilateral or bilateral, before attempting to formulate explanations.

Firstly he suggests that they may be to do with sudden movements, which the patient appears to reject and proceeds to describe the incident in more detail. The GP then picks up on the description of the *"flashing lights"* and makes a second attempt at explanation, this time linking the symptoms to the patient's ongoing migraines.

The patient again rejects this, emphasising that, in her many years of experiencing migraine, she has never experienced these symptoms. There is then a fascinating exchange around the language used to describe the symptoms, with the patient describing it as being like *"barbed wire twisting"*, then the GP says *"yeah fireworks or whatever"* upon which the patient reasserts: *"I call it barbed wire twisting"*. This is interesting as it hints at some conflict/ tension.

The patient begins to elaborate on her presentation, stating that *"it's horrible"* and that she has experienced them *"three times lately"* and that she *"absolutely nearly collapsed"*, however the doctor seems keen to get back to discussing her blood pressure and closes down the presentation by giving a final explanation that the symptoms may be linked to her blood pressure and thus they may very well improve when her blood pressure is being better managed.

GP

When discussing the patient generally, the doctor reveals that he has known the patient for many years and that he feels her symptoms are probably psychosocial in origin rather than linked to physical disease. He explains that the patient has been a widow for 12 years following the death of her husband who she nursed through leukaemia. It is his belief that, since they were very much a couple, it has been difficult for the patient to adjust to life without him and that *"she's never <u>really</u> got life going after that"* (Extract 3).

Reflecting on the unexplained symptoms the doctor reveals that he feels the most important concern at this time is to bring the patient's blood pressure under control, and that the symptoms relating to her eyes sound as though they are more likely to be psychosocial in origin since they are in both eyes, rather than in one thus he is not overly concerned by them (extract 1).

In the next extract the GP comments that, all things considered, the unexplained symptoms (which he feels may be a part of her ongoing symptoms of migraine) are not something he is particularly worried about and that he and the patient can probably *"live with them for the time-being"*. He does also comment, however, that he will be seeing the patient soon and so will be able to respond appropriately should the symptoms worsen (extract 2).

In the final extract the GP makes an interesting comment regarding the patient having *"her own ideas about her health"* which would appear to echo the sense from the consultation that there is a certain degree of conflict felt between doctor and patient.

Patient

Reflecting on her recent episodes of *"dizziness"* and *"eye twisting"*, the patient appears to link them to her ongoing symptoms of migraines and explains that they are restricting her life to the extent that she is becoming afraid to go out; she comments that she finds this quite *"debilitating"* (extract 1). She then comments on the doctor's lack of interest over time in pursuing possible solutions for her ongoing symptoms of migraines and reflects on her own sense of disempowerment in terms of pursuing referrals, explaining: *"because I don't like sort of asking for things"* (extract 2).

On the subject of her digestive discomfort and subsequent eating habits, the patient expresses some feelings of embarrassment, revealing that she has not told the doctor that she gets acid and that he just thinks she is *"fussy and faddy"* (extract 3). In the next extract the patient also goes on to say that she feels that her problems with her digestive tract are *"neglected"* and that she feels this is because the doctor has known about these problems for *"a long time"* and comments that the GP now refers to her problems as *"your peculiar eating habits"*. The patient also then makes the quite revealing comment that the GP's dismissal of her difficulties is *"a bit destroying really"* (extract 4).

Her comments here are particularly interesting given that they come at the end of a lengthy interview and are unprompted. Even at this stage in the interview the patient seems reluctant to make disparaging comments and the criticisms are couched in caveats such as *"just sort of erm"* and *"it's rather is a bit"*; they also come following a pause and are mixed in with the explanation that it is due to the doctor having known her for such a long time. This may suggest that the patient would be unlikely to voice dissatisfaction in other forums, for example a patient satisfaction questionnaire.

Reflections

The consultation is dominated by biomedical concerns regarding the treatment and management of blood pressure with a slight deviation midway through when the patient presents a new symptom of *"dizziness and eye twisting"*. These symptoms are briefly explored before being tied into the ongoing symptoms of migraine and current concern regarding high blood pressure.

The GP appears to make several attempts to *'normalise'* these symptoms by trying to tie them into the patient's ongoing symptoms of migraine, however the patient appears to at least partly reject this, asserting her own expertise in terms of *"all the years"* that she has had these symptoms (from the age of 11 to 78) she has never experienced these particular symptoms. This is in-keeping with the findings of Dowrick and Salmon et al who found that *'normalisation'* is often unsuccessful as a method of reassurance when dealing with medically unexplained symptoms (Dowrick et al., 2004). The patient's response to the attempts at *'normalisation'* is also noteworthy since it supports the idea that patients seek to amplify and elaborate their symptoms in order to ensure that they are taken seriously (Dowrick et al., 2004).

It is clear that there is a familiarity between doctor and patient and there is a hint that there may also have been some 'conflict' over time (Salmon, 2007). The interviews with both participants confirm the familiarity, which it seems spans several years; both interviewees also confirm that there has been some degree of conflict.

Whilst it initially seems that the GP formulates the patient empathically, commenting on her emotional feelings and her isolation as a widow of 12 years, this may demonstrate another example of where qualitative interviews elicit justifications as well as explanations; it is clear from other, more disparaging comments made by the GP regarding the patient, that he is frustrated by her lack of cooperation. It is also clear from the patient's comments that the GP has made some less than sympathetic comments over the years regarding her health beliefs and feelings.

The GP's comments in his interview about the patient having *"her own ideas about her health"* appear to reflect the feelings of disempowerment on the part of the GP from the previous case and also this theme in the literature where it relates to GPs feeling that they become unable to intervene medically in a meaningful way (Chew-Graham et al., 2004). What is most striking about this case however is the fact that these feelings are echoed quite strongly by the patient, who also appears to feel unable to initiate meaningful medical interventions from the GP.

So it would seem that, whilst a familiarity over many years does lend the advantage that the GP will retain knowledge regarding certain health issues experienced by the patient, thus negating the need to go through various steps of the primary care encounter (e.g. taking the history), there is a *negative* aspect in that such symptoms become *'normalised'* and forgotten or marginalised.

This in turn can lead to the patient feeling unable to raise the issue again, even if there are new developments in the nature of the symptoms and thus they remain neglected and there is a risk of *"delayed diagnosis"* of emerging illness; this is a theme which has begun to emerge in the literature, particularly around the detection and diagnosis of new cases of type 2 diabetes (Broom, 2003).

In summary therefore, it would seem that, where patients and GPs hold differing views regarding the symptoms and overall health trajectory of the patient, an ongoing familiarity can lead to both parties feeling a sense of frustration and *'disempowerment'*.

Example 6.3 (Case 23)

Contextual familiarity: behavioural epidemiology[15] as a cultural inevitability?

The consultation opens with the initial presentation of vaginal discharge. However following a physical examination and discussion of treatment, the patient requests a prescription for an anti-depressant she has been taking, followed by a request for some sleeping tablets. Whilst the GP does not initially question the ongoing use of anti-depressants or associated psychosocial issues, the subsequent request for sleeping pills prompts the GP to begin exploring the context of the request and thus the patient's current difficulties are revealed.

Here the GP's familiarity with the patient's community context (Irish Traveller) has brought knowledge and empathy but also results in a degree of resignation regarding the patient's use of anti-depressants, since (in this GP's view at least) long-term use has been observed at this practice as a common phenomenon amongst the women of this particular social group. Whilst this could be viewed as *'cultural competence'*, it can also, when viewed in context of the patient's next request for sleeping tablets and subsequent discussions, be seen as a missed cue for psychosocial support.

Summary:

The consultation extract shows the end of the discussion about the physical symptoms of vaginal discharge, which was the initial reason given for presentation. This is followed by a request by the patient for a repeat prescription for antidepressants and also then immediately a request for some sleeping tablets. The GP makes the prescription for the antidepressant without question; however she queries the need for sleeping tablets which leads to a discussion of psychosocial pressures affecting the patient.

The extracts from the GP interview reveal that her familiarity with the Irish travelling community, through her work at this particular practice which serves a permanent, local encampment, meant that she was aware of the high prevalence of long-term anti-depressant use amongst women from this community and thus it was something which was simply *'accepted'*. She also reveals empathy for the patient's overall situation but her feelings of disempowerment in terms of not knowing how to help her.

Consultation:

GP: so that's ok (1 sec) right so I think we don't do anything else until we get the results and the results might take about a week
Pa: yeah can I have some (.) >could you give me some prescribe me some depression tablets please<
GP: mh↑m (0.5) erm (.) the ones that you're normally on
Pa: yes
GP: the (medicine name)
Pa: er yeah
GP: yeah
Pa: >you couldn't give me some sleeping tablets could you< (0.5) coz I find it very hard to sleep
GP: <Yeah> we're not (.) very keen on sleeping tablets because your (.) body gets used to them so they help you for a little while but then your body (..) breaks them down quicker and they don't work anymore
Pa: cause I (.)
GP: you get sort of (0.3) hooked on them (0.4) so we're not really keen on starting them (.) especially [with]
Pa: [could] you >just give me like< (.) a week's course or something like that coz (0.3) I get all drowsy in the day and I can't sleep
GP: °right° (.) and do you have any idea why you're not sleeping at the minute
Pa: th- (.) I er it's since I'm watching my little boy my little boy's very wild >d'you know what I mean<
GP: he isn't very well
Pa: no he's he's wild
GP: right
Pa: and things going on in the past °d'you know and°
GP: °right°

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[15] The distribution of health-related behaviours and lifestyle factors in populations that may be associated with disease occurrence, mortality and morbidity rates (Heggenhougen, 1986; Sallis 2000).

GP interview:

Extract 1
"She's a traveller...**Irish traveller**...there's a traveller's site (location) which was refurbished by the council and so now has got running water and electricity and renting rates so it's like an official place to live and there's only a certain number of...plots so **they're all registered with us**...I've seen her last summer...and I haven't seen her since...but she's seen lots of other people in the meanwhile" (L2292 – 2341)

Extract 2
R: She asks for a prescription but I didn't catch what it was erm and it's something that she's had before

GP: Antidepressants (se-tam-pra)...**we have got a I think there's a big problem with the travellers' mental health (..) psychological health...in that a lot of the women are on antidepressants...a lot of the women seem to have problems with anxiety and depression...and a lot of them have ended up on antidepressants long term** (..) erm the men seem to more go for the alcohol...so there's no drug problems among...the travellers but there's quite a lot of alcohol problems but they don't seem to be alcohol problems much among the women...so so I think it's different ways of (..) erm categorising things and with different ways of seeking help and what-have-you... but certainly er so I think **I've just kind of accepted now that lots of these people on long term antidepressants and that's it**...I mean I thought I couldn't give you figures but that that's my sense of it...so we didn't even her depression or...concordance or whatever we just I said *"yeah ok there they are"*

P: Yeah then she actually says you couldn't give her sleeping tablets could you...and er that opened up everything else the rest of the consultation

GP: So is this the child that doesn't sleep and all this (L2453 – 2499)

Extract 3
"**I cannot imagine how hard it must be to live with 4 children in a caravan I really can't** 'cause I find it hard I've lived with 2 children in quite a large house and find that hard but I guess you can get used to it as I sup- you know they if this is the way you have lived but it must be hard if three of them settle down for the night fine...and then there's this one creating all this problem...and you know the absentee father thing with boys is harder...**so she would have my sympathy but I would also be at a loss as how to help her** but as I say I was reassured once I did talk to (Name of health visitor for traveller community) 'cause she came to talk about something else and once I'd read that letter as well in that they were getting regularly supportive sessions with their psychologist and that I felt I couldn't do any more than that (L2664 – 2682)

Patient interview:
The patient was not able to be interviewed for the second part of the research

Consultation

The initial focus of the consultation is on the physical symptom of vaginal discharge. Having examined the patient, taken swabs for testing and discussed possible treatment options the conversation turns to smear tests.

The patient begins a new presentation by requesting a repeat prescription for antidepressants. An immediately striking feature of the interaction regarding this issue is that the GP does not explore this with the patient but agrees to make out the prescription once she has confirmed which particular drug it is for.

However having gained this prescription, the patient immediately begins a second prescription request, this time for sleeping tablets. At this point the GP explains that she and the other GPs at the practice are not keen on starting courses of sleeping tablets given their habit-forming nature and also the complications caused by long-term use, including that they begin to have reduced levels of efficacy.

The GP then begins to explore with the patient what might be causing her sleeping difficulties and thus opens a wider psychosocial discussion regarding the patient's recent difficulties regarding her eldest child's problematic behaviour. The nature of these requests for prescriptions, in such short succession, could be perceived as an attempt by the patient to initiate a turn in the consultation towards psychosocial matters, in which case the GP's initial acceptance of the anti-depressant request could be seen as a missed cue despite the supplementary information gained through *'cultural competence'* (Fox, 2005).

Additional credence is brought to this idea by the very fact that the patient appears to engage so readily with the psychosocial exploration and it is later revealed that this is part of an ongoing issue being dealt with by a variety of health professionals and social workers associated with the practice and the specific community in question.

GP

The GP explains that this patient is from the local Irish Traveller community, and gives some history of the connection to the practice, which is now the regular health care provider for this community. She reveals that the patient is a frequent attender to the practice but that she has not personally seen her many times in the past year.

Commenting on the consultation extract the GP explains that the patient was requesting an antidepressant she had previously been prescribed, which was not unusual or surprising as this was a common phenomenon amongst women from the travelling community, whilst high levels of alcohol use were evident amongst males from this community.

The GP adds that this long-term use of antidepressants is a widely accepted phenomenon, amongst GPs at the practice, for this particular cohort of patients and that it is perhaps even an inevitability given the unique pressures they face as a community (extract 2). In the final extract the GP reflects on the living situation of the patient within this community and reveals her empathy with the patient's situation but also makes an interesting comment regarding her feelings of not knowing how she could *'help her'* (extract 3).

Patient

The patient was not able to be interviewed for the second part of the research

Reflections

The interaction in this consultation pertaining to antidepressants and sleeping tablets is interesting even when viewed in isolation. The request for an antidepressant is not met with the discussions which might usually accompany such a request but is granted with minimal discussion. To the non-clinical observer this may in itself be puzzling – why does the doctor not explore this issue with this patient? However a clinician observing this section of the interaction might conclude that it is treated with minimal discussion since it is a repeat prescription and that whilst this might not be the ideal or preferred handling of such a presentation, it is however a practical reality.

The prescription request for an anti-depressant is then, however, immediately followed by a request for sleeping tablets. It would be possible to draw all kinds of inferences from this: maybe the patient's request for antidepressants was actually an attempt to initiate a turn towards psychosocial discussions? Or, conversely, perhaps the ease with which the antidepressant was obtained prompted the patient to seize upon the opportunity to obtain sleeping tablets whilst the GP seems happy to prescribe things which are usually more difficult to obtain? There is no way of knowing for sure one way or the other, particularly given that it was not possible to interview the patient. However it is clear from this, and the subsequent revelations, that the patient's health needs are complex and that the GP is responding to this by adapting her *'usual'* behaviour.

In her interview the GP reveals that the practice has been building links with the local traveller community, which has been given a permanent site by the council and thus also the health and educational services afforded to all local residents. She also comments that she personally has been involved in treating many members from this community. Through this regular contact, and her liaison with the dedicated health visitor for the community, the GP has developed an understanding of the issues facing this specific community, including the behavioural epidemiology, specifically substances of choice for dealing with depression and anxiety amongst the members of this community.

It is this familiarity and knowledge of the wider community context of the patient which leads her to deduce that the request for a prescription of anti-depressants is nothing more than a repeat prescription and is also a cultural inevitability; thus, despite misgivings, she feels resigned to the fact that the patient will be a long-term user of antidepressants, as it is a cultural health trend amongst women of her community. This insight, along with the comment: *"she would have my sympathy but I would also be at a loss as how to help her"* resonate with the literature already mentioned previously in this chapter regarding doctors feeling unable to intervene medically in a meaningful way and therefore feeling disempowered (Chew-Graham et al., 2004).

The diagnostic decision making process, whereby GPs feel it is important to take into account the social and cultural context within which their surgery operates has been noted elsewhere in the literature (Maxwell, 2005; Pilgrim & Rogers, 1999; Thomas-MacLean & Stoppard, 2004). Furthermore, Maxwell 2005 observed that in some circumstances the role of the GP was limited in terms of the impact they might have on the patient's emotional state and that in fact, it was sometimes important to realise that since they could not exact change either by alleviating the patient's social or financial problems, or forcing them to change their lives, it may even be unethical *not* to prescribe something to help them to *"cope a bit better"* (Maxwell, 2005).

This argument also finds resonance in the wider sociological context regarding the way that negative health behaviours, such as smoking, can actually be viewed as beneficial since they help people to cope under tremendous pressures, which might otherwise render them unable to function (Graham, 1993a; Graham, 1993b; Graham, 1994; Graham, 2009; Graham et al., 2006; Robinson, 2008). This theme is also present in the next chapter (Chapter 7, case 7.1).

Interestingly, another GP from this practice revealed that inconsistent requests for prescriptions of antidepressants amongst this community are explained by its members in terms of their being a culture of sharing medication and thus use is continuous, despite the time-laps between prescription requests being inconsistent with that which would be required in order to provide the correct amount of medication (Reeve, 2011).

Whilst for the most part this kind of cultural competence has a positive impact on doctor-patient interaction, as in cases 5.2 (The three "*Okays*") and 5.3 (Desire to talk about *'un-doctorable'* grief) in the previous chapter, it seems here that a doctor's familiarity with a specific community or social group can also lead to the kind of lack of exploration of ongoing health concerns in much the same way as discussed in case 6.2 (The disempowered patient) above, which came about through the long-term familiarity between a particular doctor and a particular patient. Again this fits with the emerging literature around delayed diagnosis noted by Broom et al (Broom, 2003).

One of the most striking features of this case is obviously the statement by the GP that she has *"just kind of accepted now that lots of these people are on long term antidepressants and that's it"*. Whilst it initially may seem strange and perhaps unlikely that routine prescriptions would be issued for antidepressants amongst any particular community, this general observation was given credence by another GP operating at the practice who shared the GPs view that there were several specific health behaviours indigenous to the traveller community, including depression and alcoholism, which are compounded by high levels of illiteracy, low levels of education, and inconsistent attendance, resulting in a trend towards urgent, acute appointments rather than follow ups (Reeve, 2011).

A lack of appropriate data or figures regarding prescribing rates for anti-depressants amongst travellers as compared with other cultural groups or communities makes it difficult to confirm or refute the belief of the GP on this matter, however it is enough to note that the GP personally explains this section of the interaction in terms of this belief and what this means in practice when dealing with this specific community.

It is also perhaps interesting to note that this picture is in keeping with the findings of (Parry et al., 2007) who found that significant health inequalities existed between the Gypsy and Traveller population in England and their non-Gypsy counterparts, even when compared with other socially deprived or excluded groups, and with other ethnic minority communities, with a 6% higher reported level of both moderate anxiety and extreme anxiety (Parry et al., 2007).

One of the concluding findings for policy implication from Parry's study was that a strong sense of ethnic identity and coherent cultural beliefs and attitudes, underpin health-related behaviour in this group, and that health experiences need to be understood in this context, alongside the specific effect of the social and economic hardship and social exclusion they face (Parry et al., 2007). This again brings us back to the debate regarding the diagnostic decision making process and the importance of taking into account the social and cultural context within which a surgery operates (Maxwell, 2005; Pilgrim & Rogers, 1999; Thomas-MacLean & Stoppard, 2004).

However, whilst the findings here would appear to support the literature around cultural competence regarding certain communities, as well as the importance of considering the social and cultural context of the surgery, it also adds the caution that health practitioners may sometimes, through resignation to the observable health trends and associated barriers and pressures these create, actually contribute to the perpetuation of these negative health behaviours or perhaps even misinterpret a psychosocial cue and desire for support as a culturally inevitable request for a prescription.

Example 6.4 (Case 5) Familiarity but disparity: Talking at cross-purposes

During the course of a consultation, characterised by presentations for a variety of physical symptoms, the patient initiates a conversation regarding her mother who is in hospital. To begin with, the GP mistakenly thinks the patient is saying that she herself must go back to the hospital but the patient corrects him and the GP then asks how the patient's mother is.

In their respective interviews the participants appear to have very different views regarding the interaction presented in the extract and also regarding the level of familiarity which exists between the two of them.

The patient feels there is a shared sense of familiarity and that the doctor remembers details about her life and her family and thus asks about them since it affects her health generally.

However the doctor feels less of a sense of familiarity and reflects that he was probably just making polite conversation whilst printing the forms off on the computer.

Summary:

The consultation extract shows the initial presentation by the patient regarding the visit to her mother who is in hospital and the GP's initial misinterpretation that the patient is speaking about a visit to hospital pertaining to her own health. The patient corrects him and he then enquires after her mother.

The remainder of the extract is characterised by pauses and short sentences and ends with the patient presenting a new physical symptom of her own relating to headaches.

When viewing this extract the patient clearly feels that a strong familiarity exists between herself and the GP, whilst the GP feels this to a lesser extent. This leads to misinterpretation on the part of the GP, both about the purpose of the comments generally and about the interaction.

The first extract from the GP's interview shows him explaining that he is reasonably familiar with the patient through having treated her partner, but that he was probably asking about her mother's health whilst printing off forms from the computer.

In the second extract, responding to the interviewer's question as to whether he was exploring psychosocial issues, the GP does however reflect that this is a consideration.

Meanwhile the patient's comments in her interview reveal that she viewed this exchange as a demonstration of concern and caring on the part of the GP and that she was very pleased with this.

Consultation:

P: °Coz I've got to go back to the hospital°
GP: When are you going back (.) to
P: Oh sorry my mum [has had a fall and she's in hospital]
GP: [oh oh right so you're going back in]
(0.4)
GP: How is she
P: Not good she's got pneumonia now
GP: Oh right
(0.3)
P: She's getting there
GP: Mhm
P: Hhh
(0.2)
GP: (we) print all the forms off the computer you know that now don't you
P: Oh yes much easier
GP: Erm yeah I I think it probably takes just as long to be honest
(0.3)
P: ((big sigh))
(0.3)
GP: ( )
P: Hh and I'm going to have my eyes checked coz that's the only thing that I can I can say I've had some terrible headaches but my eyes are (0.2) a lot worse

GP:

Extract 1

I: "I think that was quite interesting there coz you actually you stopped to ask her how her mum is and things do you know the patient quite well?"

GP: "Erm probably her partner better coz she used to come in with him so she's familiar in terms of coming in with her partner so erm and I have seen her before but more familiar probably from that from her coming in and telling me about him while I was in the room but you know sort of bringing up her symptoms and stuff so erm I think at that point I was probably writing out the form or printing the form erm so **I was asking her about her mum as well while I was doing that coz it's straight forward to do on the computer it takes a few seconds**...that's probably why I was asking at that point" (L41 and L43)

Extract 2

"Well I wouldn't say completely but certainly erm I was looking towards how much problems that was causing in the background...coz it could possibly have a bearing on the situation as well so generally people do say that a relative's not well but I usually ask them you know coz obviously they then sort of go on to suggest that they've got a terminal illness or they're very unwell you know you will take that into account...erm you know with the other complaints" (L47 and L49)

Patient:

"Very caring doctors they really are...very **very caring and for him to stop and ask me how my mum was...and he remembered my mum wasn't well and I thought that is that's nice...for your doctor to take a concern I suppose when all is said and done it affects my health**...it's a follow on effect isn't it so but I thought it was still very nice of him to stop and ask me how she was I really was thrilled that he did you know I thought such a nice gesture that when they're so busy...always so busy but as I say it's the best doctors' I've ever had...best doctors I've ever had" (L176 – L188)

Consultation

Up until this point the consultation had mostly been directed by the GP who had steered the conversation around physical symptoms. However the patient initiates a turn in the consultation towards psychosocial discussions when she says: *"°Coz I've got to go back to the hospital°"*. This comment is made with reference to the patient's mother who has been ill and the patient has been rushing around in order to visit her.

However this is apparently initially misunderstood by the GP who asks: *"When are you going back"*. The patient corrects him and there follows an interesting exchange characterised by pauses and short utterances.

Having politely enquired about of the patient's mother the GP does not explore psychosocial issues and switches the conversation to chit-chat about the administration of prescriptions, which signals a turn in the consultation away from psychosocial issues. However the patient then initiates another turn by introducing the new symptom of headaches.

GP

Responding to the question of whether he knows the patient well the GP explains that he is familiar with her as she often comes in with her partner, whom he knows better. He also initially commented that he asks about the patient's mother whilst he is printing off the form on the computer, thus implying that this is simply chit-chat.

However upon further probing regarding whether or not the chit-chat was an exploration of psychosocial cues, the GP did remark that he would have been taking into account the impact her mother's illness might have upon the patient. The psychosocial presentation about her mother however is not explored further after this section of the interaction.

Patient

Responding to this section of the recording the patient's comments made it clear that she perceived this particular piece of interaction quite differently to the GP. She was clearly very pleased that the doctor had, in her view at least, picked up on the psychosocial cue and enquired after her mother.

Interestingly it seems that she also took this as a sign of an ongoing familiarity with the GP in that he remembered that her mother was ill, in spite of the fact that she had initially corrected his misperception during the consultation.

The patient demonstrates an awareness of the GP's thought processes in that his motivation for asking may be that it may impact on her health, and this resonates with the GP's comments in his interview. However the patient views this as a very nice gesture and further evidence of the *"caring"* nature of the GPs at this surgery, even saying that she was *"thrilled"* that he took the time to ask. The patient also acknowledges that the doctor is very busy and that this makes the gesture even more special.

Reflections

This case highlights the complexity of the doctor-patient relationship with regards to familiarity and prior knowledge. There is a disparity here between the *perceived* level of familiarity from both parties and this leads, in this particular interaction, to the participants talking at cross-purposes and also to them viewing the extract in an entirely different way.

The initial misunderstanding during the interaction about who the patient is talking about in terms of visiting the hospital does not lead to any negative consequences since the patient is happy with the GP's responses and the GP was happy with how the interaction ended.

However it does demonstrate the potential for such misunderstandings during the consultation, due to a lack of shared points of reference, and also to how each interactional exchange between two individuals can be so differently construed and developed over time. There is therefore the potential for such disparities and misunderstandings to occur in the future where they may begin to have a negative impact through time and perhaps even consequences for consultation outcomes, for example those observed by Britten et al with regards to prescribing decisions in general practice (Britten et al., 2000). In isolation these kinds of misunderstandings can be damaging enough, however if they continue through time they could begin to shape a negative health trajectory for the patient and even lead to *'Iatrogenic harm'* (Salmon & Marchant-Haycox, 2000).

For example if a patient does not feel the need to reassert symptoms since they feel the GP is already familiar with them, but where the GP in question may not share the sense of familiarity, this might lead, in a similar vein to the two previous examples (cases 6.2 and 6.3), to new emerging symptoms not being thoroughly explored, resulting in delays in diagnosis for emerging health conditions, as has also been previously highlighted in the related literature (Broom, 2003).

This case has been included here as it is a clear and concise example of where disparities of perception can arise, even where a certain degree of familiarity exists between doctor and patient. There were many examples of this within the data which were revealed primarily in the individual interviews conducted with participants.

Examples included; disparity between doctor and patient in terms of reasons for follow up appointments being made, with both attributing the appointment to the other (from Case 2, data from which was used in example 6.1); patients modifying presenting style, due to previous contact with the health care service making them wary of overburdening health practitioners – but in so doing, paradoxically, they make diagnosis very difficult since the GP only has some of the information available (from case 6, data from which was used in case 5.1; case 2); conversely, patients bringing in additional information relating to social issues and chit-chat thinking that this aids the consultation, however it only serves, in the GPs mind, to complicate matters (cases 5 and 2); patients presenting to the GP to complain about their treatment in secondary care and a lack of perceived irritation on the part of the GP of the *'anti-tablet culture'*; patient's freely sharing information with the GP regarding other health sources (and individual opinions) consulted regarding health complaints and the unperceived feeling on the part of the GP that they are *"the last port of call"* (case 3, data used example 5.4).

Chapter 7: Positive aspects of non-familiarity

Introduction

Whilst the findings presented in the two preceding chapters presented the positive and negative aspects of *'familiarity'* the next two chapters will mirror this, exploring the positive and negative aspects of *'non-familiarity'*, beginning in this chapter with a focus on the benefits of *'non-familiarity'* in all of its various guises.

The concept of *'non-familiarity'* is a little more difficult to pinpoint than that of *'familiarity'* since it is a category by exclusion, being what is left over once it is established that *'familiarity'* is not a present feature. Its parameters are therefore less well defined and can in some senses be seen in terms of the degree of perceivable *'distance'*. This concept then is less commonly referred to in the literature than that of *'familiarity'*, although there is naturally some degree of overlap with the arguments set forth for the negative aspects of familiarity, particularly in terms of the concept of *'discontinuity'*, defined as when patients did *not* see their usual GP (Broom, 2008).

Instances of *'non-familiarity'* were also less frequently encountered during data collection, which was to be expected since the participating practices generally encouraged patients to see the same GP if possible, since this is widely considered to be the most helpful way of accessing primary care at this present time and is in-keeping with the wider philosophy of primary care practice (Balint, 2000). It follows therefore that this chapter should be more contemplative in nature and also shorter, consisting of two examples rather than the four which make up the two previous chapters.

The first example presents a case where a GP, within a multi-GP practice, has seen the patient before but only briefly, a few years ago and for a different health issue. The GP therefore draws on all of the information to hand and offers a fresh perspective to an ongoing problem which has, amongst other things, led to referrals to secondary care over a five year period. This fresh perspective results in a shift in the focus of the MUS from gynaecological to bowel function, and subsequently to an improvement of at least one of the symptoms through a simple intervention; this also negated the need for a previously planned, invasive, exploratory procedure. This case is fascinating since it reflects on the very nature of MUS, as discussed in chapter two, and the fluid boundary of the continuum of contested illness, highlighting the fact that the *'unexplained'* is not necessarily always *'unexplainable'*.

The next example is taken from a case where a patient is presenting at the GP practice for the first time in approximately 15 years (almost half his lifetime) and thus he is unfamiliar with the health care milieu generally, whilst he and the GP are also unfamiliar with each other. In this instance there are none of the obvious barriers associated with MUS in that the there are no prior conflicts or matters of distrust and no prior assumptions to cloud the perceptions of the patient in terms of being *'heartsink'* or *'pressing for prescription'*, in spite of the introduction of additional symptoms during and following the GP's offered explanation.

The GP is therefore able to focus on the patient's narrative and identify the key feature that the initial biomedical concern presented is quite minor; this in itself might not be viewed as unusual if a patient were a frequent attender, suspected of somatising or heightened health awareness, however the fact that it has caused the patient to present at primary care for the first time in many years seems quite surprising and thus the doctor begins to probe regarding family history and it is this which elicits the explanation from the patient regarding his anxiety having associated the symptoms with his father's similar symptoms before his death from heart disease at a young age. Satisfied at having established the reason for the patient's presentation the GP engages with this admission and offers an explanation regarding psychosomatic symptoms and how their perpetuating nature as distress regarding the symptoms contributes to the original distress which caused them initially.

Collectively the examples in this chapter help to shape the idea of *'non-familiarity'* in terms of how GPs in this study view it, and this has applicability in the wider sphere of healthcare since it highlights how a degree of *'distance'* on the part of the GP, together perhaps with a perceivable degree of *'distance'* to the patient, can be beneficial to the primary care consultation, the subsequent outcomes and also to the overall satisfaction of the GPs regarding their role.

Positive aspects of non-familiarity

7.1 (Case 8) *"So it's sometimes nice not to be involved with the patient"*

7.2 (Case 3) *"I was expecting there to be more...so I was kind of waiting"*

Example 7. 1 (Case 8) ***"So it's sometimes nice not to be involved with the patient"***

This complex consultation begins with the patient requesting a referral for gynaecological investigation which she has previously discussed with another doctor but has so far not received. Having established that the referral was made but that the letters have been sent to the patient's old address, the GP reads out the notes made by the previous doctor regarding the referral, including the fact that HRT had been given for early menopause following symptoms of tiredness, hot flushes and pain which was causing the patient to wake up in the night.

During the remainder of the consultation the GP explores with the patient the idea that perhaps the symptoms of abdominal pain may in fact be linked to bowel rather than gynaecological function, and that the tiredness may in turn be linked to broken sleep caused by the pain during the night rather than being caused by organic pathology; he thus gains agreement from the patient to try a medicine called Movicol (a laxative).

In his interview the GP explains that non-familiarity is sometimes beneficial since the presentation can be viewed without the bias of previous contact. Meanwhile the patient reveals that the symptoms of pain have actually improved with the treatment of Movicol and that she is feeling much better, although she is still experiencing tiredness. Reflecting on the improvement of her pain and the fact that the referral could have led to a gynaecological laparoscopy[16], the patient expresses relief at having avoided the now unnecessary procedure.

Summary:

The consultation extracts show the initial questions by the GP regarding the previous explanations for the pain experienced by the patient and her referral for gynaecological investigation (extract 1) and this is followed by an exploration of the patient's ideas as to the causes of the pain (extract 2). By extract 3 the GP is making the links between the abdominal pain and the tiredness, and extract 4 shows a fascinating exchange during which the GP appears to be trying to gain acceptance from the patient as to the possibility of this link, meanwhile the patient appears more concerned about the symptom of tiredness than she is about the pain. The final extract shows the GP much later in the consultation returning to the topic of why the patient believes the pain to be gynaecological in origin to which the patient raises her voice when answering that she hasn't got a clue.

The extract from the GP interview shows him commenting on the way in which he explored the alternative possibilities and that sometimes non-familiarity can enable an objectivity which can be useful in terms of *'diagnostic acumen'*. He also makes the specific comment regarding the utility of non-familiarity in some consultations.

Meanwhile the extracts from the patient's interview show her reflecting on her role in the diagnostic process in terms of the focus on gynaecological explanations (extracts 1 and 2) before revealing that the movicol prescribed appears to have taken affect and that she is feeling much better (extract 3). She also then comments that whilst she initially found the delays surrounding the referral frustrating she is now glad not to have had the laparoscopy since it would have been an unnecessary and invasive procedure.

Consultation:

(The consultation opens with the patient requesting a referral to the Women's hospital and a subsequent discussion during which it transpires that the hospital were writing to the patient's old address)

Extract 1

42 GP **So you've you you <u>started</u> some investigations for gynae**
43 P Yes
44 (.)
45 GP °Because then one stage erm they thought (well) **one of the doctors said "well maybe it could be**
46 **something to do with your diet"**°
47 P M °Erm it could be but I've tried that and it's°
48 GP [M]
49 P °[Erm] h°
50 GP M
51 P °I think h it's made me more (.) sure that it's°
52 GP M
53 P °it's not the [diet°]

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[16] Exploratory procedure of the abdomen, fallopian tubes, ovaries and womb, involving insertion of a medical telescope and attached camera through an incision in the umbilicus (belly button).

Extract 2

126 P The main problem is that **I am constantly tired**
127 GP Tired [right]
128 P [yeah]
129 GP =okay
130 P **The pain is erm (.) sort of almost secondary**
131 GP Okay the pain do you attribute that to constipation or do you think that's something to do with
132 gynaecology
133 P I think it's something to do with gynaecology [because]
134 GP [( )]
135 P =it's very period-like pains

Extract 3

162 GP Okay right how often would your pain wake you from sleep
163 P (I'd say about) 70 80 percent of the time
164 GP Most nights
165 P M
167 GP So you're not waking to go to the toilet for a wee or anything like that it's the pain that wakes you
168 P M
((Omitted text regarding someone entering the consultation room by mistake))
169 GP Hhhhh an:d er **so quite considerable sleep disturbance**
170 P M
171 GP **Which probably makes you quite [tired]**

Extract 4

258 GP Yeah if this there was a magic wand and the pain went away
259 P The tiredness went away
260 GP Well the pain went away
261 P See the pain is not really that doesn't really bother me
261 GP M it's the tiredness
262 P Yeah
263 GP **But assuming the pain is waking you up**
264 P M
265 GP **And assuming you're getting disturbed sleep every night and assuming that's making you tired**
266 P M
267 (0.1)
268 GP Yeah
269 P Yeah
270 GP **Then if you if the pain went away then you may get better sleep**
271 P M
272 GP And you may not feel as tired (.) do you think you'd then feel better
273 P °absolutely°

Extract 5

394 GP Now why were you heading towards the gynaecology side of things (or)
395 P Because it feels like period pains
396 GP M (.) though it's quite high (.) it's not really near (lower down) it's more central isn't it
397 P Yes
398 (.)
399 GP **So is that the only reason why you were heading towards the gyne**
400 P **WELL I HAVEN'T GOT A CLUE I'm jus:t thinking I don't know [(but erm)]**
401 GP [mm]
402 P Coz I thought it the pains were so similar to period pain [( )]
403 GP [m] m
404 P °(but) I haven't°
405 GP °yeah° and you've had scans and things haven't you which have been normal
406 P M

GP:

GP: "Erm now I think she's actually on HRT she's on Eleste and she's on two milligrams which is a reasonable dose...so it's tied in with that as I said **she's not you know sort of my patient so I was...exploring that"**

I: "Does that make it difficult when you don't see patients regularly when they're not your regular patients do you find that more difficult"

GP "Well at some point none of them are your regular patients...but you have to...in some cases it does but in other cases particularly when there's some loose ends you can come to it without being erm you know biased by your previous contact...and that can be useful because obviously you know people tend to make assumptions and erm that can be bad for the diagnostic acumen **so it's sometimes nice to not be involved with the patient**...you know and just to try and come to an objective erm you know and objective thing" (L686 – 706)

Patient:

Extract 1
"...she said she was going to do that and although at the same time she was saying well you know I would like to try something else the same as this doctor did because she wasn't quite sure whether erm it was gynaecological [the problem]... and **so it was me I think who got the wrong message** (.) erm when she was saying "oh well can we try something else" I thought that that meant that erm (.) I thought that she was going to go ahead and make the referral then when it didn't come through I thought "well maybe she meant something different" ...that we that she wasn't going to do that so I wasn't clear...about whether er we were going to try something else but in the meantime she would make the referral anyway but as it turned out because of the confusion over the [addresses]...the referral had been made...erm but **it was interesting that er this doctor thought along the same lines as her that erm they don't think that it's worthwhile going to er have a laparoscopy" (L51-69)**

Extract 2
"They've then sort of gone the other way it "no we don't think that it is" or well they haven't said that outright really...they've just said "well let's try something else" they think that it's more to do with erm erm the bowels system or int er digestion or something like that as opposed to erm gynaecology **and I remember him asking me "what makes you think that it is"...Hh and I hhh "I don't know" hhh I was like I was thinking "oh my god" you know I I haven't got any evidence for thinking [that it's gyne] apart from that the pains were similar to period pains that was the only...thing I could think of**...and he was like saying "well" I think also that doctor had said laparoscopy because of not being able to pinpoint he just thought er that's what the the way to go" (L78 – 96)

Extract 3
"I thought er he he was very good you know he listened to what I was saying and erm and he came up with something as well you know he actually what I felt good about was going away with something...that he gave me erm there was something concrete you [know] "I think it's something to do with the bowel system here is something to help it" and you know well we were focussing on something...that then made me think "yeah well I don't go to the toilet regularly" but I don't know what is normal and what isn't...Hhh yeah **and erm funnily enough I think it might actually have worked erm...mm with regards the pains but the tiredness no that seems to be sort of like a continuing thing but I haven't had the erm stomach pains"** (L115 – 134)

Extract 4
"This has been as I said on the tape I think the universe is trying to tell us something here...that maybe this is not the way to go because I've had referrals to the ((Hospital 1)) before in the past now for whatever reason they've I've gone away and they have or they've given me a date for the laparoscopy this is what happened a couple of er a few times and erm I've either gone on holiday KNOWING that the you know I've got to be back for this particular date ((says excuse me whilst yawning)) but while I've been away they've sent another letter this has happened like three times I think they've sent a letter changing the date...and then send me a letter saying "you missed it you failed to show up" or and I just think "but I thought that was not the date I was given"... so that was really frustrating then I think one of the other times was erm I was going to Argentina and I think it was erm one had to be cancelled on my part erm and then of course the erm problem of the addresses which...so erm it's been...it's sort of we've gone all around the houses **but maybe it's not meant to be you know...at this moment in time I'm glad it didn't happen...because I feel so much better...erm so it would have been erm because well any surgery is like it's ...a bit of an ordeal isn't it you'd rather not have it...if er there was nay way around it but erm but I'm saying that now because I think maybe we have got to the...we might er be on to something here you know what the solution to the problem is"** (L319 – 356)

Consultation

The first extract shows the GP introducing the idea that there may be alternative explanations for the symptoms of abdominal pain. In the second extract the patient appears to be trying to establish that the tiredness is her main concern, whilst the doctor remains focussed on the symptom of pain. The third and fourth extracts show the interesting exchanges during which the GP attempts to make the connections between the symptoms of pain and tiredness whilst the patient is again keen to re-establish tiredness as the focus of the discussion.

In the final extract the discussion has returned to the alternative explanations for the symptoms of pain and there is evidence of conflict between GP and patient as she raises her voice when answering the question of why she thinks the symptom is gynaecological in origin.

Viewing this final extract in context of the previous extracts, we can see that this is at least the third time that the question of perceivable pathology has been put to the patient and she still seems quite resistant to the idea that the symptoms are not gynaecological in origin. The GP meanwhile seems quite keen to establish the possibility at least that there may be an alternative explanation for the pain and also that the tiredness may be a subsequent symptom of the pain.

GP

Whilst reflecting on the complexities of the presentation, the GP makes the interesting comment that *"she's not ...sort of my patient"* when explaining why he was exploring various points. This appeared to suggest that a lack of familiarity can be problematic, which resonates with the examples from chapter 5 and also the dominant view in primary care regarding doctor-patient interaction (Balint, 2000; Gabel et al., 1993). It was therefore reasonable to ask the question of whether seeing patients who were not familiar was more difficult.

Somewhat surprisingly the GP's answer reflected the contrary view, setting forth the idea that a lack of familiarity was sometimes beneficial since it negated the risk of bias from previous contact and therefore any assumptions which may be bad for the *'diagnostic acumen'* and that a lack of involvement with the patient was sometimes nice as it facilitated objectivity.

When viewed in light of the consultation extracts these comments bring important insights into the GP's though processes, particularly in terms of why he made such an effort to challenge the patient's thought processes and perceptions regarding the organic pathology of her symptoms. Here the GP is consciously bringing a fresh perspective to an ongoing problem and values the opportunity to do this.

Patient

Reflecting on the long-term attribution of the symptom of pain to gynaecology the patient offers the explanation that she herself must have *"got the wrong message"* and comments that it is interesting that this doctor thought along the same lines as the previous doctor she saw, in that they both felt a laparoscopy was not *"worthwhile" (extract 1)*. She then comments that she remembers the doctor asking why she believed the symptom of pain to be gynaecological in origin and she laughs whilst reflecting on her reasoning, for which she hasn't *"got any evidence"*, other than the fact that the pains were similar to those experienced whilst menstruating (extract 2). This is an interesting insight as it reveals that this discussion may have led to the patient reflecting on these beliefs and accepting some of the ideas set forth by the GP.

However when viewed alongside extract three it is possible to deduce that perhaps these thought processes have been affected by variables outside of the initial encounter as the patient makes the surprising (to her and the researcher) revelation that the symptoms of pain have been much improved by the prescribed laxative *'movicol'*. Interestingly though the patient immediately follows this revelation with the information that the tiredness remains unimproved, thus reasserting her belief that there is no connection between these symptoms.

In the final extract the patient reflects on the five years of referral requests and ongoing symptoms of pain which she had firmly believed to be gynaecological in origin. It is reasonable to view this as bringing important insights regarding the patient's overall satisfaction with the consultation and the outcomes, since she is saying that she is now glad that the referral she had requested was never realised since she is now feeling so much better and she acknowledges that the laparoscopy (and any other surgery for that matter) would have been *"a bit of an ordeal...you'd rather not have"*.

Reflections

The exchanges presented in the consultation extracts clearly show a certain degree of conflict as the GP makes several attempts to challenge the patient's long-standing belief that her symptoms of pain are gynaecological in origin and also tries to link the symptom of tiredness to the symptom of pain by proposing that the pain may be causing sleep disturbance; it is possible that the importance for the GP of making this link lies in the fact that the patient continually asserts the primacy of the symptom of tiredness rather than that of the pain, which she views as *"secondary"* (extract 2).

This is an interesting feature when considered in context of the *non-familiarity* between doctor and patient since it is in many respects similar to that which is observed in the previous chapter on *familiarity*, particularly in cases 6.1 (the disempowered doctor) and 6.2 (the disempowered patient). What sets it apart however is the fact that neither the GP nor patient chose to dwell overly on this aspect of the consultation, but rather on the perceived outcomes. Conversely, however, this of course could be attributed to the fact that both participants were satisfied with the outcomes of the consultation, unlike those in cases 6.1 (where the doctor had to make many *'pragmatic'* decisions) and 6.2 (where the patient felt some of her symptoms were *'neglected'*).

In many ways this case is quite extraordinary. For example one of the outcomes of this single consultation is that the patient narrowly avoids an invasive, exploratory procedure with the potential for *'iatrogenic harm'* which she initially gives as the reason for presenting. Such unnecessary and potentially harmful procedures and interventions have been noted elsewhere with regards to patients with medically unexplained symptoms pertaining to perceived gynaecological pathology, sometimes even resulting in hysterectomies (Salmon & Marchant-Haycox, 2000).

In her interview the patient expresses relief at having avoided a laparoscopy as it would have been an *"ordeal"* and it is tempting here to take the comments at face value and to conclude that the patient is actually expressing her true feelings regarding the referral. However it is advisable to view qualitative interviews with a certain degree of caution since they can elicit justifications as well as explanations (Barbour, 2001; Salmon, 2003) since the patient has already expressed a certain degree of embarrassment regarding her role in what now appears to have been a misattribution of her symptoms, her comments may in fact be her way of asserting that she has now accepted the alternative explanation.

Another surprising feature is that the GP offers the unprompted revelation (to a question designed to elicit the opposite) that sometimes *'non-familiarity'*, in his opinion, is beneficial and *"sometimes nice"*, thus refuting the widely held assertions in the literature that *'familiarity'* between GP and patient is the most auspicious milieu for primary care encounters and that it is preferred by all concerned, being particularly integral to the satisfaction of the GP in terms of their work (Balint, 2000).

By far the most striking feature, however, is the fact that, as a consequence of being prescribed a laxative, the ongoing symptom of pain has been successfully treated and the patient is feeling *"so much better"*. Thus it seems that one of the medically unexplained symptoms in this case has been explained and, if the patient was not still suffering with the other medically unexplained symptom, she could potentially pass through the continuum of contested illness and out of the social and clinical predicament of living in *'diagnostic limbo'* (Corbin & Strauss, 1985; Kirmayer et al., 2004).

The implications of this example are therefore far reaching since they are a timely reminder that medically *'unexplained'* symptoms are not necessarily medically *'unexplainable'* and that the boundary of the field of *'contested illness'* is fluid. The fact that the patient's symptom of pain is eventually explained and treated as originating from a biomedical, recognised, organic pathology is also a useful reminder that the common assumption that all medically unexplained symptoms are psychosocial in origin and that therefore MUS and somatisation are interchangeable terms and concepts, is problematic at best – as discussed elsewhere in the literature (Nettleton, 2006) also (Morriss et al., 2007). It is therefore important to tease out these differences and to make these distinctions when discussing patients who come under the umbrella term of *'medically unexplained symptoms'*.

Example 7.2 (Case 3) ***"I was expecting there to be more...so I was kind of waiting"***

The consultation begins with a mutual acknowledgment that the patient has not seen this doctor before, or indeed any doctor for at least 15 years. The discussion then focuses mostly on the presenting symptom of problematic bowel function which initially appears strangely slight, despite the patient's early assertion of its *"depressing"* effects. A turning point in the consultation then comes when the GP asks a question about family history and the patient reveals that his anxiety regarding the recent changes in his bowel function is largely due to memories of his father's similar symptoms prior to his death of a heart attack at the age of just 55.

Having examined the patient and made appropriate referrals the GP offers an explanation for the symptoms as *"functional"* (related to anxiety but nevertheless physically present) rather than disease-based and the patient seems to engage with this. The patient does however make two other somatic presentations during the consultation, but the GP interprets these as reasonable additions to the information surrounding the initial presentation and pragmatic use of the appointment rather than being *'heartsink'*.

In his post-consultation interview the patient comments that the explanation given by the doctor made sense to him, that he has made a conscious effort to *"think differently"* as well as making minor adjustments to his diet, and that he has since begun to feel much better. Thus it seems that a non-familiarity between doctor and patient may be beneficial to rapport since multiple-symptom presentation is not immediately viewed negatively. Meanwhile a lack of familiarity does not appear to have had any negative effects on the ability of the participants to build rapport or to understand each other and the encounter shares many of the positive features of the cases in chapter 5 where *'familiarity'* was considered to have been an important facilitating factor.

Summary:

The first consultation extract shows the GP and the patient discussing the initial presentation, most notably with the patient saying that it is beginning to get *"depressing"* and then the GP reflecting back to the patient what he understands so far: that his bowel movements have increased from once a day to twice. In the second extract the GP asks about family history of bowel health and this marks a turning point in the consultation as it prompts the patient to reveal the source of his anxieties regarding these seemingly minor symptoms, namely that his father experienced similar symptoms shortly before his death at a young age from heart disease.

In extract 3 the GP offers an explanation that the symptoms may be *'functional'* rather than disease-related; the patient immediately offers the information that he sometimes experiences heartburn and the GP responds by explaining that this reinforces his explanation since both symptoms fit in the spectrum of *'functional'* problems. The final consultation extract shows the GP elaborating on the explanation of functional problems by explaining the link between the brain and the bowel, grounding this in the concept of *'fight or flight'* and the context of human prehistory (extract 4).

In his interview the GP reveals that he had suspected that there was more to the initial presentation than was immediately obvious thus he *"waited"* to see what the patient would reveal; having heard the explanation regarding the death of his father the GP comments that he was satisfied that this was what had caused the patient to present (extract 1). Of the presentation of a second symptom of heartburn the GP comments that he feels the patient is trying to ensure that he has given all relevant information (extract 2). In the final extract the GP reflects on the fact that he felt there was a *'good rapport'* and that the patient had seemed to find his explanations convincing.

Meanwhile the extracts from the patient's interview reflect and confirm these ideas and conclusions.

Consultation:

Extract 1

15	P	but it's just ultimately like Saturday it kind of like **tends to get a bit depressing**
16	GP	okay how many times are you going a day
17	P	on average twice
18	GP	twice okay
19	P	although in saying that sods law yesterday
20	GP	yeah
21	P	once
22	GP	okay so has this ↑changed recently or
23	P	I'd probably say this year
24	GP	You've always been
25	P	Once a day maybe twice you know but
26	GP	**So once maybe twice and now it's more often than not twice**
27	P	yeah
28	GP	**is that concerning to you**
25	P	twice no but more that concerns me...

Extract 2

43 GP **anything in your family history any bowel problems in the family history**
44 P bowels I'm not (.) I'm not really massively sure **my dad died in '98 of a heart attack he was only 55**
45 <now> he sometimes and it's probably what worries me just as much and worries my wife as well erm in
46 his latter years he was quite often like that where he would be kind of like well "yes we'll go to town at
47 10 o'clock" but come five to ten he's like "I'll just run the toilet"

Extract 3

59 GP erm I think from speaking to you because you seem relatively healthy in yourself **I think this is more a**
60 **functional problem as opposed to a disease problem** I think it's the way the bowel is working as
61 opposed to a disease problem
62 P Right
63 GP I think we should play safe and do a couple of blood tests if that's okay I'll give you a form to get those
and then meet again in a couple of weeks or so I don't think there's a serious cause it's not ringing alarm
bells to make me think of serious things like cancers or inflammatory bowel disease like crohn's disease
or something like that
64 P **I sometimes get heartburn occasionally**
65 GP **okay so that fits with the same type of picture** as well the kinds of things that fit into the sort of
66 spectrum of functional problems are things like irritable bowel

Extract 4

73 GP **there is a strong link between the brain and the bowel** so hence you know if we're under pressure or
74 stress your bowel's natural response to fight or flight is to empty
75 P yeah
76 GP there's a lion in the (room) you know you pee yourself empty your bowels (   ) and you run off and that's
77 the natural response if there's more adrenalin at a certain time or you're under pressure or you're thinking
78 about things a bit more then certainly that does speed things up a bit it may well be that's what's
79 happening
80 P that I can normally comprehend when I'm flying because I get slightly nervous with it you know **I kind**
81 **of comprehend** that's fine I'll have a couple of ultimately not always but sometimes end up with
82 Imodium

GP:

Extract 1

I …as he's describing the symptoms to you he's sort of saying erm the problem is that he feels that he's going for two bowel movements a day and so was that surprising?

GP A little bit surprising erm **I thought that he was going to tell me something else as well as the fact he was going twice a day**…erm I think at this point I was thinking there will probably be more to come out in the consultation so I would just let it go I'll let it ride and see what comes out of it erm so far his symptoms don't seem too concerning but **I was expecting there to be more so I was kind of waiting**

I Oh right okay ((plays recording)) so there he kind of revealed about his dad dying you know that maybe his dad had some difficulty with his bowels in his later life so has that maybe made you think...

GP **I think this is why he's presented** it was the reason him and his wife sounded as if they've been talking about it this is probably the reason to present they probably discussed it that "you've had this for a while erm things have changed I get an urgency the second time my father used to have that as well and he died"…whether they've associated the fact with his bowels and dying or whether it's the fact that they're aware of the fact he died from heart disease perhaps erm but certainly in his later years it sounds as if he had bowel with the need to go quite urgently…**I think that that is the reason for him presenting** (L4 – 15)

Extract 2

I So there you sort of erm by that point reach a decision that you feel that it's a functional problem erm but then as you're explaining it you're saying "yes it's not so serious" he presents and says "ooh I have heartburn as well"...do you think that he's buying in to what you're saying?

GP At the time I got the impression he was I'm not sure whether that was an attempt to make sure he gets all his information and to make sure everything is taken into account of sometimes it may be because he feels it's maybe something relevant but I've not added to the or asked him about it which is probably **he's just making sure all the information is on the table**...and you can make a decision from there (L36 – 41)

Extract 3

I So were there things that you felt you did particularly well in the consultation?

GP Erm I think maybe **a good rapport we seemed to get on okay erm I think I let him speak to begin with to explain what he'd come for** I gave him the opportunity to describe what he felt the problem was erm and picked up on the fact that he mentioned was going once and was now going twice **that acted as a cue to pick up on** that and do you think that's a problem so I think that's the key point because I sense that that was one of the things he was concerned about erm the history I think you know...so we got most of the stuff from that one or two of the other things in the background that we picked up on the fact that **he volunteered that his father had bowel problems in his later years that came out and I suppose one of the things I always do is if you let the patient speak for 2 3 4 minutes to begin with**...you won't have anywhere near as much work to do...if you start interrupting and they feel pressure for time you actually miss valuable stuff and if you let them speak until they peter out and then stop or they start going off on a tangent you get far more information that way even if some of it is irrelevant you get most of the history from what they tell you but ours went well he **I think explanations that I gave him after examining him he seemed to buy into that okay it seemed to make sense to him** (L88 – 96)

Patient:

Extract 1

P I must admit now and he does kind of go into it a bit later on **I've actually improved an awful lot since...it's pretty much kind of gone back to normal**

I That's since you've been to see this doctor?

P since I've been there's actually something there **he'll say later on about the connection between the bowel and the brain**...so what I've tried to do is because I was getting to the point the **depressing point** first thing you wake up in the morning and that's the first thing on your mind however many times I'm trying to train my head to go the other way...**to not talk about it so that therefore taking it off my mind** so that I can just think anything else at that point you kind of like you're not thinking and therefore you've been fine (L70 – 74)

Extract 2

P Coz if it's on your mind first thing in the morning "Am I gonna go" and you're kind of thinking "well I don't want to get half way down the East Lancs coming to work and which I have done once in the past I've had to shoot into McDonalds you know run in and go and then carry on going to work that's fine erm so it was just getting to the point when **I'm trying to think differently** also I've changed my diet slightly I said to him I've just started probiotic drinks I've carried them on but also I've started having bran flakes for a change in the morning rather than just toast...**and actually I have been kind of normal (76 – 78)**

Extract 3

I So I thought that was interesting that fact there where the doctor asks about family history…so is that mainly you think what made you decide to go to the doctor as well?

Pa Well that and bullying from the wife to go go and sort it out cos I was getting to the point where I don't know you weren't trying to hide it but you were kind of just go and keep quiet I know it's happening but you know

I It bothers you

Pa But then it was kind of like yeah saying look sort it out you know go and make an appointment I'll come with you you know what have you kind of just sorting it out but it is kind of always there in the **back of your mind because my dad was only 55** so I don't think he necessarily had many massive problems that way in the same sense but coz you know it happened but you're **kind of thinking you know "am I going to go the same way"** coz all his well my uncle his brother also died of a heart attack as well...there was kind of heart problems there

I	So you were worried they might

Pa	Yeah is there going to be some **kind of link there you know is it a warning sign** to say I don't know do whatever (L81 – 90)

Extract 4

I	So he says he thinks it's a functional problem as opposed to a disease problem did you understand what he meant there was it clear or was it later on when he starts...

P	I think it's kind of like coz he then carried on to explain you know ultimately I don't know what kind of also **relaxes you a bit coz you kept thinking well it's not a disease problem** i.e. there's nothing that you can kind of put your finger on and say "well ultimately feels a bit iffy on your stomach or whatever" (L129 – 130)

Consultation

The opening lines of the consultation establish that the patient is not only *'un-familiar'* to (and with) this specific GP, but also to the health care context generally having not seen a GP for approximately 15 years. This is then followed by the initial presentation which, given the context of this first revelation, appears rather puzzling since the symptoms seem too slight to be the cause for the patient to be presenting with after so many years of non-attendance.

The doctor reflects back his understanding of the presentation, in that the patient is concerned now that his bowl movements have increased from one movement per day, but occasionally two, to now being more often than not two. This does not appear to elicit any new information from the patient and the GP begins to take a history of the symptoms.

However, responding to one of the GP's questions regarding family medical history the patient reveals that the reason his current symptoms concern him is that his father experienced similar symptoms prior to his death at an early age from heart disease. This opens up a new discussion regarding the possible nature of the symptoms and the GP begins to explain the concept of functional problems to the patient, drawing on the concept of *'fight or flight'* and setting the explanation in the context of human prehistory using the analogy of escaping actual, physical danger, in this case a lion. The patient appears to engage with this explanation and offers information of other somatic symptoms he has been experiencing which the GP incorporates into the picture of functional problems.

GP

Of the initial presentation the GP reveals that he had expected the patient to present with more than the symptoms he initially describes and that he therefore suspected that there was more to be revealed; he had thus resolved to *'wait'* and see what the patient would say.

Responding to a question regarding what he believed to be the reason for the patient presenting the symptom of *'heartburn'* immediately after being given the explanation for functional problems, the GP says that at the time he had thought the patient was engaging with the explanation, however he also reflects that perhaps the patient was just making sure that the doctor had all of the relevant information in order that he might make an informed decision.

When asked what he felt he had done well during the consultation, the GP reflected on various features of the consultation, including what he felt to be *'good rapport'* and the application of certain aspects of medical training, namely giving the patient the chance to speak, and the benefits that this elicited. He concludes by commenting that the patient appeared satisfied with the explanations given and that they seemed to make sense to him.

Patient

The patient's reflections during his interview mirror the thoughts the GP expresses during his interview in that he accepted the explanations given by the GP and that they made sense to him. Furthermore, he reveals that he has acted on the guidance of the GP based on the concepts of *'functional problems'* and that he is now feeling much better.

His comments regarding his reasons for presenting, namely the worry that the increased bowel movements were in some way a warning sign connected to heart disease, also reflect those highlighted by the GP in terms of why he thought the patient had presented.

The patient also reflects that he found the explanations regarding *'functional problems'* rather than *'disease problems'* convincing and comforting.

Reflections

It is interesting to note that the patient cue, GP question, subsequent turning point and revelatory information in this consultation are all similar to those observed chapters 5 and 6, where they were defined, by the participants of the interaction, as emanating from *'familiarity'* and prior knowledge. Here they emerge from a question regarding family history of disease and it is the patient who elicits the turn by offering the insight into his thought processes regarding the possible link between the bowel symptoms and heart disease, based on what he observed of his father's health prior to his death at a young age.

Thus the GP has achieved the same result, that of eliciting the relevant psychosocial information regarding presentation, underlying concerns and psychosocial issues, by picking up on cues and *'waiting'* rather than by trying to initiate certain kinds of conversations. This is particularly interesting given the GP's comments about the technique of giving patients time and space to say what they want since it results in broadly similar outcomes to those achieved through techniques associated with *'familiarity'*. This idea of *'waiting'* has been noted elsewhere in the literature as a useful technique and has been associated with a reduced likelihood of somatic outcomes (Dowrick, 1997).

By the same token the evident *'good rapport'* commented upon by the GP, which is usually attributed to an existing familiarity and prior knowledge, appears as a key feature of this consultation where *'non-familiarity'* is so clear in terms of the particular GP, the surgery and the health care milieu generally. In fact it seems that here *'non-familiarity'* may actually have facilitated this rapport because of the lack of prior bias, and therefore negative assumptions and emotional responses. This resonates with the comments of the GP in the previous case, 7.1 *("so it's sometimes nice not to be involved with the patient")* regarding how previous contact and subsequent bias can be bad for *'diagnostic acumen'* and thus a lack of prior contact can be useful and aid a GP's ability to be *'objective'*.

Here this *'lack of prior bias'* affects perceptions of certain behaviours, for example the presentation of a second somatic symptom (heartburn) immediately following the explanation of functional symptoms; rather than seeing this as *'heartsink'* (Mathers & Gask, 1995; O'Dowd, 1988), feeling pressured (Britten, 1995; Wileman et al., 2002), or as an attempt by the patient to escalate his symptoms in order to be taken seriously (Dowrick et al., 2004) this GP sees it as an attempt by the patient to be helpful by ensuring that he has given the GP all of the necessary information in order to make an informed decision.

This apparent *'good rapport'* in spite of a lack of *'familiarity'*, and indeed perhaps aided by *'non-familiarity'* resonates with ideas set forth by (Dowrick, 1997) suggesting that *'current rapport'* may be as useful, and maybe indeed *more* useful, than ongoing relationships and familiarity. This would seem to suggest therefore that it is *'rapport'* in itself, rather than *'familiarity'* or *'non-familiarity'*, which is the key to the success of the consultation.

It could be further speculated that *'non-familiarity'* can allow space in the consultation for *'good rapport'* to be established between a vulnerable patient and an attentive GP in a way that might otherwise be difficult if they were *'familiar'* with each other. This in turn links into ideas set forth by

Salmon and Dowrick regarding attachment style in that 'rapport' and 'relationships' can be created instantly where a patient feels a certain sense of vulnerability (Salmon et al., 2007).

It is interesting that the complete lack of *'familiarity'* between the participants, the patient and the health care setting, and between the GP and the community context of the patient, did not appear to be a hindrance in any way in terms of the key features of the consultation and indeed there appeared to be a great deal of similarity in these terms between this case and those observed in chapter 5 which presented the benefits of familiarity. This would appear to suggest that familiarity, per say may not be as important as the specific attributes of the consultation noted here.

The use of a *'functional'* explanation here (a useful, non-pejorative term) and an explanation of how symptoms can relate to psychosocial problems (reattribution) represents a key feature throughout the data collected and appears to be readily engaged with by patients experiencing MUS, and it is a well-documented technique for helping patients to understand medically unexplained symptoms (Dowrick et al., 2008; Peters et al., 1998).

Furthermore the use of analogies grounded in human prehistory in order to demonstrate the physical impact of the *'fight or flight'* response are also a key feature within the data collected and echoes of the example used here are present in case 8.3 in the next chapter. These analogies appear to act as a way of signalling the legitimacy of suffering by linking into concepts which have become mainstream and a part of popular culture through documentaries relating to human prehistory and evolutionary adaptation.

Chapter 8: Negative aspects of non-familiarity

Introduction

At the beginning of the findings section the concepts of *'familiarity'* and *'non-familiarity'* were set forth. The first of the findings chapters then explored the possible benefits *'familiarity'* could bring to bear within the primary care consultation and more specifically to the doctor-patient interaction therein. The subsequent chapter mirrored this by exploring the possible disadvantages which can arise as a result of *'familiarity'* in this context. Having then explored the possible benefits of *'non-familiarity'* in the next chapter, what remains for this anchoring findings chapter is to set this in context of the possible disadvantages or negative effects of *'non-familiarity'* in all of its various guises.

As noted in the previous chapter the concept of *'non-familiarity'* is a little more difficult to pinpoint since its definition rests on its not being something else (*'familiarity'*); it therefore follows that again this chapter is more contemplative in nature, including reflections on the lack of *'familiarity'* on the part of the patient with the health care milieu generally, as well as with specific surgeries and doctors.

The first example, taken from case 8, begins as a puzzle which is decrypted thanks to revelatory information from another case (case 10).

Case 10 begins with a discussion about scalp irritation, however a complication in the interaction arises when the GP seeks to confirm that she has never been a smoker but the patient corrects him saying she has and in fact that she didn't cease smoking until she was 50. The interaction appears puzzling since the revelation that the patient has been a smoker does not appear to be followed up. Whilst it wasn't possible to interview the patient and thus gain insight into her understanding of the question, the researcher was puzzled as to how this question fitted into the exploration of scalp irritation and resolved to ask the GP. The GP subsequently revealed that the question was in fact unrelated to the presentation of an itchy scalp as it was a *'QOF'* (quality outcomes framework) question, prompted by the computer.

Having gained this insight from case 10, the researcher noted a similarly puzzling interaction between doctor and patient in a previous case (case 8) regarding a patient's status as a smoker, during which there appears to be a small degree of conflict and limited follow up regarding the patient's smoking. Since data collection for many of the cases in the project were carried out simultaneously, and the post-consultation interview for case 8 was still pending when the information about QOF came to light, the researcher resolved to raise the issue with the patient.

Upon commenting on the extract regarding the GPs question about smoking and the patient's response that she does not feel that she can give up at this time, the researcher found that the patient had interpreted the question as a moral judgement and seemingly felt quite strongly regarding the inappropriateness of the question, given the severity of the MUS with which she was dealing; interestingly her comments make quite clear that this one question affected her overall perception of the GP and subsequently her willingness to engage with him. Unfortunately the post-consultation interview with the GP from this case had already been conducted and the issue had not been addressed with him since the question had not seemed significant at the time. However this GP (case 8) practiced at the same surgery as the GP from case 10 and the similarity between the ways in which the questions were asked, it is possible to draw an inference here that this may also have been a QOF question prompted by the computer, rather than a moral judgement on the part of the GP.

The second case in some senses mirrors case 5.3 (desire to talk about '*un-doctorable'* grief) from chapter 5 on the *'Positive aspects of familiarity'*. However where in case 5.3 the GP's *'familiarity'* with the patient's style of presenting and the lack of usual rapport led her to suspect psychosocial issues (namely the patient's ongoing grief regarding the loss of her husband of which the GP has detailed knowledge) and prompts her to initiate a turn in the discussion, here case 8.2 *("I'm not stressed!")* shows a similar conversation arising much later into a consultation which has similarly been characterised by presentations regarding physical symptoms. However the patient shuts down the discussion as soon as the GP enquires if she is *'stressed'*. The patient appears to interpret this term as an affront to her self-reliance and perhaps the concept of being *'stoic'* which the GP in case 5.3 explains is highly valued within the local community.

Reflecting on this aspect of the consultation the GP in this instance (8.2) echoes some of these sentiments, however it is possible that her lack of familiarity with the patient and with her community more generally have led her to use language which the patient cannot engage with as legitimate in terms of her cultural context.

The third and final case is again similar in terms of structure since the consultation is with a patient who is not familiar to the GP and the consultation is initially characterised (first 10 minutes) by presentations regarding physical symptoms. However upon asking what he describes as an *'open question'* the GP initiates a turn in the discussion towards psychosocial issues and the patient reveals that her mother has been in hospital and that this has caused her to worry. Reflecting on this aspect of the consultation the GP expresses the opinion that, had he picked this up sooner, he could probably have dealt with the patient far more efficiently in terms of time and also in terms of her actual presentation. This again resonates with some of the comments made by the GP in case 5.3 *("Desire to talk about un-doctorable grief")* and also to some extent the GP in case 6.1 *("The disempowered doctor")*.

An interesting aspect of this current chapter is that one of the examples, 8.1 *("The standard question perceived as a moral judgement")*, is drawn from the same case as an example from the previous chapter on the positive aspects of familiarity (case 8). This perhaps demonstrates better than any other argument that can be made that the nature of primary care practice and GP work specifically is inherently complex and the many influencing variables are in themselves not clearly definable in terms of their influence one way or another and instead depend upon the same subjective factors which shape the social world outside of the primary care milieu.

Collectively this chapter completes the picture of *'non-familiarity'*, offering a contrasting perspective to that set forth in the previous chapter which highlighted how a degree of distance can sometimes be beneficial to the primary care consultation; instead this chapter demonstrates how sometimes this same distance, or more or less distance, can lead to misunderstandings and slow down and hinder the diagnostic process.

Negative aspects of non-familiarity

8.1 (Case 8) *"He was like totally disgusted"* The standard question perceived as a moral judgement

8.2 (Case 16) *"I'm not stressed"*: Contextual non-familiarity & the importance of terminology

8.3 (Case 19) "*And that's when I thought: "Oh pants I could have sorted this out much sooner"*

Example 8.1 (Case 8)

"He was like totally disgusted: The standard question perceived as a moral judgement

A patient who has neither a strong familiarity with the health care setting generally, nor with the GP in question, presents with symptoms of fatigue and abdominal pain. During the consultation the GP makes a seemingly unprompted turn to a line of questioning regarding whether or not the patient smokes. The patient reveals that she does smoke, though not what she considers a significant amount. It also appears that at this point there is an element of conflict and that the patient is a little put out by the question. Informed by another case conducted simultaneously that the question was possibly a QOF question the researcher raises the issue with the patient in her post-consultation interview.

Having previously praised the doctor on various aspects of the consultation the patient reveals: that she felt this line of questioning was inappropriate given her level of suffering with her MUS; that she felt the GP was making a moral judgment of her as a smoker; and that this diminished her interest in anything he had to say for the remainder of the consultation. This revelation is interesting given that the likely background to the question was that it was prompted by the QOF targets GPs are encouraged to incorporate into their consultations.

Summary:

The consultation extract shows the question regarding smoking which appears to be seemingly unprompted by anything arising from the discussions from the consultation so far and does not appear to have any bearing on the patient's MUS of fatigue and abdominal pain.

The extract also shows the subsequent discussion between doctor and patient of how many cigarettes the patient smokes and the possibility of her ever giving up the habit. This interaction appears to be characterised by conflict as the patient responds to the questions by asserting her right to choose when she tries to give up smoking and that this is not currently a priority for her.

Further fraught interaction then ensues as the GP moves on to discussing alcohol and the patient reveals that she has not had any alcohol for a while because her fatigue has left her feeling too unwell to enjoy it. When the doctor asks if this made any difference it is clear that the patient isn't pleased as she raises her voice and categorically states *"NOT A BIT"*.

The issue was not explored with the GP from this case but is set in context of a GP's comments in another case. The extract from the patient interview shows edited highlights of the patient's response as she expresses her frustration and annoyance at what she felt was a moral judgement and an inappropriately timed attempt at a health intervention.

Consultation:

GP: **M okay do you smoke**
Pa: Yes
GP: How many
Pa: About four or five
GP: Okay do you think you'll ever be able to stop because it's quite important as a reducing your overall risk factors let's just check your blood pressure just check your (.) th:e erm do you think you'll ever stop smoking
Pa: (I don't know)
GP: Coz it's important
Pa: **Yeah I know (.) that's why I'm only [smoking about four or five]**
GP: [m m that's going to be too] tight
P: (I know)
GP: I think we need to get your arm out
P: Erm (0.9) but to be honest with you it's er I know it's a very serious thing but at the moment I just feel (.) the last thing I feel I can do [you know]
GP: [mm yeah] what about alcohol
P: Er:m well ( ) because I was feeling so tired and (other things I used to find that I wasn't in the mood for) anything any alcohol erm from (.) I think it was Christmas this year
GP: Mhm
P: Up until about a month ago
GP: M did it make any difference
P: **<u>NOT-A-BIT</u>**

GP:

Issue not explored with this GP but explored with another GP (see previous example) who revealed that the question on smoking was a 'QOF question'.

Patient:

I: Okay the doctor asks er if you smoke [at all]...and you say you don't (.) feel that you could give up at this moment

P: No because I just think erm YEAH that was like a point where I just thought "oh go away" hh [you know]...you just wanna... if people... sort of understood the impact of all of this (.) that's what I think sometimes you know... it's hard for them to empathise with everybody ...and I understand that but at the same time if he just thought "look this woman's been coming to GPs for FI:VE YE:ARS am I going to start giving her a hard time now about four cigarettes a day" you know we all know we shouldn't smoke [and]...if I said I'm smoking 40 a day it's just like ( ) well good God maybe it's the only thing that's keeping her going...Like having to put up with what she's put up with...Erm so yeah I mean I know it's not it's not a good thing to do...But (.) at the moment I just think "well °(Jesus)° that's the least of my worries...so I think er while I understood where he was coming from... **but I could tell just even by the look on his face it was just like "uh"...and he was like totally disgusted**...Hhhh and I didn't really care...at this particular moment in time... it's... not top of my agenda you know the fact that I can even stay awake...I'm happy about that ...(God) I can't be a saint [(you know)]...it's gonna happen one day but like just not quite now ...everything has to sort of like fall into place I think I have to feel better in order...yeah I'm not going to knock myself over the head about that at this particular moment in time (Lines 508 – 580)

Consultation

The doctor asks the patient if she smokes and she answers affirmatively. The GP then explores this with the patient whilst taking her blood pressure. Having made an initial comment about the importance of cessation he then appears to focus more on the taking of the blood pressure. The patient however, following a long silence and break in interaction, continues the conversation about smoking, explaining that it is not a priority at this time due to her feeling so unwell.

The doctor then asks the patient about her alcohol consumption. The patient replies that she has not had any alcohol since *"Christmas this year"* (approximately 6 months), due to her symptom of fatigue. When the doctor asks if this made any difference the patient appears slightly agitated, raising her voice and emphasising the statement *"Not a bit"*; in some ways this almost appears to be a challenge to the GP's line of questioning and possible deductions. However apart from this, the interaction does not appear to be particularly fraught and the conversation about blood pressure and symptoms resumes.

GP

Unfortunately, since this section of the consultation did not appear particularly significant until after the revelations elicited from case 10 (in which the GP revealed that a smoking question was related to QOF and was prompted by the computer) this issue was not explored with this GP (from case 8). However since the GP in this case worked at the same practice as the one from case 10 it is reasonable to assume that the question may have been prompted by the same computerised system relating to the Quality Outcomes Framework.

This idea is given further credence since it is followed by a new line of questioning regarding alcohol. However, though it is tempting to assume that this is therefore a QOF question, it is not possible to establish whether or not this was the case since the GP did not confirm this during his post-consultation interview. Furthermore the fact that this GP does appear to relate the question back to the patient's health generally it would also be reasonable to assume that the questions did relate to the patients MUS in some way.

Patient

Having established that a similarly placed question regarding smoking in a simultaneous case had been prompted by a QOF indicator rather than being connected to the patient's MUS, the researcher raised the issue with the patient during her post-consultation interview. The researcher was interested to see how the question had been interpreted by the patient and whether or not she had connected the associated risks of smoking to her current MUS, as the researcher had hypothesised.

However somewhat unexpectedly the patient responded to this question by giving a detailed and passionate response, revealing that she had been agitated by this line of questioning, and that she felt it showed a lack of empathy from the GP for her suffering and for her situation. She also felt that given the relatively small number of cigarettes she was smoking (4 per day) it was unreasonable for the GP to have talked about her giving up completely, especially since this may be the only thing which is *"keeping her going"*. Interestingly she also felt that the GP was making a moral judgment of her as a smoker and even that he was *"totally disgusted"*. In response to this she expressed her defiance, declaring that she *"didn't really care"*.

Another very telling comment was made at the beginning of the extract where she states *"that was like a point where I just thought 'oh go away'"*. This would appear to indicate that the patient lost any feeling of rapport with the GP which may have been built during the course of the consultation; since there was no prior familiarity between the doctor and the patient this may well have led to the patient losing respect for this particular GP and might jeopardise any further successful consultations which result in positive health outcomes as we know this consultation had done from the example drawn from this case in the previous chapter (7.1 *"so it's sometimes nice not to be involved with the patient"*).

Reflections

Viewed in isolation the section of consultation pertaining to smoking from case 8 did not appear particularly significant and thus the issue was not raised with the GP in his post-consultation interview. However drawing on the knowledge gained from case 10 which took place simultaneously, the researcher had established that a similar question in a separate consultation at the same practice had been prompted by the computer and was related to QOF targets rather than being related to the patient's MUS.

The researcher had not been able to explore the issue with the patient from case 10 since she was unavailable for interview however the interview with the patient for this case (case 8) had been scheduled for later due to the patient being too busy for an immediate post-consultation interview.

Theorising that the question regarding smoking in case 8 may have been interpreted as significant by the patient and possibly relating to her MUS the researcher presented the issue using an open question, or in fact simply a reflection of what the patient said in response to the doctor's question, to see whether the patient had anything to say on this issue.

The researcher had, however, not anticipated that the patient would have perceived the question as a moral judgement, and this perhaps was because of her own (the researchers) status as a non-smoker coupled with her own lack of clinical knowledge and thus lack of familiarity with the health care milieu in terms of QOF and standard questions. It had not occurred to the researcher that such questions may be arbitrary and she had always assumed instead that they were a reflection on her own *'good faith efforts'* to remain well; she had, therefore, always perceived such questions in a positive light, seeing them as affirmation that she was a *'good patient'*.

The patient in this case, meanwhile, as a smoker, and in the absence of *'familiarity'* with the GP and also with the health care milieu in terms of standard questions prompted by the computer, perceives the question as a moral judgement and thus she is annoyed.

It is interesting to note here that the patient comments on the fact that, whilst smoking is obviously considered to be a negative health behaviour, it should be viewed in context of the patient's overall health trajectory and accepted. This again resonates with the literature regarding coping mechanisms amongst particular communities as mentioned in case 6.3 *("behavioural epidemiology as cultural inevitability")* (Maxwell, 2005) and in particular the literature around smoking as a coping mechanism (Graham, 1993a; Graham, 1993b; Graham, 1994; Graham, 2009; Robinson, 2008) since it actually relates to smoking and the patient even says: *"well good God maybe it's the only thing that's keeping her going"* which is a common theme throughout this literature.

With regards to *'non-familiarity'* and what this example demonstrates, it is reasonable to infer that, where a patient does not have a detailed, prior knowledge of the health care milieu and thus an understanding of the GP's role and why they might ask certain questions at certain times, the possibility arises for misinterpretation of intent which can have potentially disastrous consequences for the rapport and future relations between doctor and patient.

Furthermore, where the consultation is also characterised by a *'non-familiarity'* between a particular doctor and a particular patient, they are less likely to correctly interpret and pick up on certain interactional cues which have been demonstrated to be helpful, for instance in examples 5.2 (*"the three okays")* and 5.3 (*"the desire to talk about un-doctorable grief*) of this thesis.

This point is further emphasised by the remaining two cases in this chapter since they both mirror cases 5.2 (*"the three okays")* and 5.3 (*"the desire to talk about un-doctorable grief*), but with *misinterpretations* rather than correct interpretations of certain patient cues and responses.

Example 8.3 (Case 16) *"I'm not stressed"*: Contextual non-familiarity & the importance of terminology

An early career GP working at a large, multi-GP practice, reflects on a complex consultation for which *'non-familiarity'* was a feature and which was characterised by the presentation of several, seemingly unrelated, physical symptoms, but which the patient felt were related in some way.

The consultation lasts approximately 20minutes 20seconds, which is the allocated time for GPs at this stage in their career at this particular surgery. A turning point seems almost to be initiated at 18minutes 16seconds when the GP asks the open question *"how are you feeling otherwise in yourself"* and the patient appears to engage with this, responding positively to a line of questioning about being tired and reflecting on her work related pressures. However this positive interaction and rapport is called to an abrupt halt when the doctor asks the question *"would you say you're quite stressed"* as this appears to cause the patient to backpedal. There is a discernable change in the pitch of the patient's voice and she repeatedly refutes the possibility that she might be *'stressed'*, repeating and emphasising the word in the negative.

Reflecting on this extract and responding to a question regarding her thought processes in asking the open question at this point the GP reveals that she suspected that psychosocial issues may be at the heart of the presentation of physical symptoms. Of the patient's reluctance to engage with this turn in the conversation the GP comments that the patient probably felt it was an affront to her ability to cope, given that she is a pub landlady and that self-reliance is highly valued amongst this cohort of society.

From the outside it would be reasonable to assume that the GP is correct in her assumptions and has detected unvoiced agendas and the need for psychosocial support. However it does seem that the problem arose from the term *"stressed"* and it could be hypothesised that had the GP been familiar with the patient, as was the case in example 5.3 (*"un-doctorable grief"*), she might have been more attuned to the appropriate terminology for the cultural context of the patient, so as in example 5.3 the acceptable term was *"Fed up"*.

Summary:

The consultation extract, taken from near the end of the consultation, shows the doctor asking the open question regarding how the patient is feeling *'in herself'* and the patient's initial engagement with this, agreeing that she is constantly tired. However this rapport is broken when the GP pursues the psychosocial theme asking if the patient is *"stressed"*. This appears to cause a complete shut down by the patient who repeatedly asserts that she is not *"stressed"*.

The extract from the GP interview shows the GPs comments regarding the possibility that the patient is affected by psychosocial issues but does not feel able to address these due to her cultural context, including her employment.

It was not possible to interview the patient

Consultation:

547 GP: **how are you feeling otherwise in yourself**
548 Pa: hhhh
549 GP: are you feeling tired
550 Pa: dead tired (.) and I can't afford to cause I'm too busy in me [job]
551 GP: [Yeah]
552 Pa: you [know as I said]
553 GP: [been quite busy]
554 Pa: I do get loads of breaks now like with >having me place<
555 GP: mm
556 Pa: you know but I I could just sleep around the clock I ( ) up to come here before
557 GP: yeah
558 Pa: but I'm (usually) up anyway and I thought yeah (.) feel as though (.) dragging meself you know but (.)
559 very tired like
560 GP: mm (.) **would you say you're quite stressed**
561 Pa: sorry
562 GP: would you say you're quite stressed
563 Pa: **↑I'm not stressed no (.) I don't feel stressed at all**
564 GP: no
565 Pa: **>I've got nothing to be stressed about<** erm only worrying about ((name)) me son and whether he's
566 ok
567 GP: yeah
568 Pa: coz his results aren't back yet
569 GP: Mm
570 Pa: you know (.) bit worried about him but other than that **I'm not stressed (.) I've got no stress**

GP interview

GP:

I: ...then I thought there was sort of a turning point where you say erm ***"and how are you feeling otherwise and in Yourself"*** and I thought that was really interesting I was wondering can you remember what you were thinking about when you said that?

GP: Basically if she's got some problems like depression 'cause often people come in with some symptoms one symptom multiple symptoms but it's not actually what's bothering them...that actually what might be bothering them is actually feeling *"I'm just feeling horrible well over the past 4 months"* that you know she wants to just drive and not stop you know there... people do have a lot of sort of hell of a lot of anxiety and depression out there...outstanding we don't see it in the hospital obviously you know for obvious reasons but it's just seriously 8 of the 10 patients you can see in the day can be for anxiety or depression and a lot of people do come in with sort of physical symptoms that are a little bit vague and a little bit you know little bit of knee pain and then it's like we just you tend to sort of pick up on things you know and you just sort of ask them *"ok so how are you in yourself"* you know *"what's your knee been like...but you still sort of getting out? Are you sleeping ok you know"* and then you just **find it sort of opens the Pandora's box** you know just

I: Yeah

GP: Sort of *"no I've not being able to sleep being really depressed and um and ah"* and you do the HADS score which is like questionnaire depression thing you know you find out whether er really they're not ok you know

I: Yeah

GP: So often the physical can sort of be the presenting symptoms for something else that's going on and **she was a little bit even though she denied sort of being low in mood and being sort of particularly stressed at work even though she sort of alluded to stress earlier she**...sort of denied it when I ask her outright erm she did seem a little bit sort of there's just so much going on and it maybe both the health thing plus stuff going on with her son and um and ah her home situation I don't know but that's why I asked cause there just seemed to be a bit more going on

I: Yeah I thought this bit was really interesting because initially she starts saying yeah she's really tired she could sleep around the clock erm she's dragging herself around but as soon as you suggest that you know you say are you feeling stressed at all it does seem to like a barrier goes up

GP: Yeah

I: She says *"ooh gosh no no I'm not stressed I just need to get on with things"*

GP: **She's one of those copers though I'm sure she's one of those you know pub landlady coping can deal with everything you know when the idea of (.) some people are just so reticent to the idea of being stressed because it's like an affront to their ability to cope with life**...so you do find people that actually you find the opposite that people that just can't cope with anything and she's and asking for medication at every juncture so she may just be one of those you know

I: Mm does that make things more difficult then to sort of try and address the °difficulties°

GP: It does if that's her main problem...and you need to have a certain sense a certain amount of insight... a certain amount of you know the divide sort of help yourself so that we can help you so if you don't know the insight into sort of that being the main problem then how can you help you to to help to you know to get better eventually soI mean we can do it with the physical things the physical things were fine but if after that's all done and she's still stressed then she's going to have a problem

Patient:

It was not possible to interview the patient.

Consultation

The consultation was twice the average length of primary care consultations, however since the GP is early career and currently training, the allotted time for a consultation at this particular practice is 20 minutes and thus the consultation is, in this context, not particularly long.

Having been characterised for the first 18 minutes by sequential presentations for physical symptoms the consultation takes a turn when the GP asks an open question designed to elicit a psychosocial discussion. This is initially successful and the patient begins to discuss being tired and the nature of her work as a pub landlady, which does not allow time for her to feel tired.

This rapport is broken however when the GP ask the patient if she feels that she is *"stressed"* at which point the patient quite abruptly shuts down and begins asserting her self-reliance, keenly refuting any suggestion that she might be *"stressed"*, and interestingly repeating the word *"stressed"* throughout her explanations which are designed to emphasise the word in the negative and utterly refute any suggestion that she might be.

GP

Responding to the question of why she had asked this particular open question at this point, the GP confirms that she had suspected psychosocial issues and that it is common for people to present with multiple, physical symptoms when the underlying issue is depression or anxiety. The GP goes on to describe this consultation device as often eliciting the opening of *"Pandora's box"*.

Having reflected that the patient denied low mood or being stressed at work, despite alluding to stress earlier in the consultation, the GP makes some interesting comments regarding the patient's cultural context as a pub land lady and the possibility that the line of questioning may have appeared as an affront to her ability to cope. However the GP does not appear to feel that it is the word *"stressed"* that in itself that is significant or problematic here.

Reflections

It is interesting to note first of all that, despite the *'non-familiarity'* which characterises the example, the GP has obviously garnered a lot of information about the patient during the 20 minute consultation and has built up a picture of her and her cultural context which is probably reasonably accurate. She has established that she is a *'pub landlady'* and has drawn on her own knowledge of this cohort to make inferences as to why the patient may be reluctant to engage with any diagnosis of anxiety or depression.

This, in some senses, could be seen as contextual familiarity on the part of the GP and a case of exercising *'cultural competence'* (Fox, 2005), *except* for the fact that there is obviously a point at which the communication breaks down causing the patient to return to the *'safety'* of discussing physical symptoms. Furthermore this breakdown in communications appears to emanate from the terminology used and specifically through the rejection, by the patient, of a particular word used by the doctor: *"Stressed"*.

When viewed in context of case 5.3 (*"un-doctorable grief"*), whereby a similar presentation for *'doctorable'* physical symptoms is found to be a presentation for ongoing grief and the desire for psychosocial support, it is interesting to see how delicate the negotiation of such an interaction can be, resting, perhaps, on the careful selection of specific words and concepts which can be considered appropriate by members of that particular community. It seems that whilst the term *"fed-up"* is perfectly acceptable to the patient in case 5.3, the term *"stressed"* is not at all acceptable to the patient in this case (8.2).

Considering the previous example in this chapter (8.1 *"the standard question perceived as a moral judgement"*) and the potential for certain aspects of interaction to be misperceived and taken out of context, it is reasonable to assume here that the term *"stressed"* may mean something quite different to the patient than it does to the GP, perhaps alluding, in the patient's estimation, to an individual's inability to organise their lives in a manageable way; this seems particularly plausible give the patient's comments about *"I've got nothing to be stressed about"* and *"I've got no stress"*.

Furthermore there patient makes an interesting distinction between the concepts of being *'stressed'* and being *'worried'*, asserting that she is in fact *'worried'* about her son who is currently awaiting test results, but that she is most definitely not *'stressed'*. This emphasises the extent to which meaning and understanding can rest on the construction of particular elements of interaction, including the subjective use of each individual word (Wierzbicka, 1999).

This case therefore highlights the problems which can arise through *'non-familiarity'*, not only in terms of GPs and specific patients but also in terms of GPs and the particular community context within which their surgery operates (Maxwell, 2005) and thus the cultural context of the patient (Kirmayer & Young, 1998).

In terms of the importance of relationships between particular GPs and particular patients, this case resonates with the findings of Peters et al 2008, who concluded that one of the key ways to ensure the success of reattribution of medically unexplained symptoms was to establish a quality of relationship in which patients could perceive psychosocial enquiry as appropriate, whilst fostering an environment within which doctors can support patient self-management (Peters et al., 2009).

We have seen in the previous chapter, through case 7.2 *("I was expecting there to be more...so I was kind of waiting")* that it is possible for this kind of *'rapport'* to be built within a single consultation, even where *'non-familiarity'* is the defining characteristic in every respect (patient to GP, surgery and health care generally) and that in fact *'non-familiarity'* can even be beneficial in terms of lack of *'prior bias'* and thus positively affect GP interpretation and reaction to the presenting of additional somatic symptoms following initial explanation. However symptom presentations in cases where medically unexplained symptoms are present are often complex and difficult to unpick in a single consultation and may in fact, as in example 5.2 (The three *"okays"*), require several consultations with the same GP before their complexity ifs revealed and the GP is able to intervene in a medically meaningful way. Thus this case supports the widely held notion that *'familiarity'* often has a positive effect upon doctor-patient interaction and the primary care consultation and highlights the potential negative effects of *'non-familiarity'* in this context.

Example 8.4 (Case 19)

"And that's when I thought: "Oh pants I could have sorted this out much sooner"

A GP at a large, multi-GP practice reflects on a consultation with a patient who he saw through *'open-access'* and who was unfamiliar to him. Having been characterised by multiple, physical symptoms relating to kidney function and breathlessness, there comes a turn in the consultation when the GP asks an open question designed to elicit the patient's thought processes regarding her symptoms. It transpires that the patient's aunty is in hospital and that the patient has a variety of other psychosocial factors which are causing her to worry.

The GP states more than once in his post-consultation interview that he realised about 10 minutes into the consultation that the problems were probably more psychosocial in origin and that, had he have realised this sooner, he could have reached a more helpful resolution and made better use of the time. Furthermore he asserts his belief that a lack of familiarity with the patient in question was quite unhelpful in this case.

Summary:

The consultation extract shows the patient escalating symptoms following an attempt at normalisation by the GP and the GP's response with an open question. This does not immediately initiate a turn to psychosocial issues, since the patient begins reflecting on why her symptoms could not be explained by a virus, however this leads to a decision by the GP to order some blood tests and this prompts the patient to mention that her aunty is in the hospital. Subsequently the GP begins a line of questioning regarding stress and then begins reattribution. The patient seems wary at first but then engages with this and the GP says that, pending the results of the blood tests, he would like the patient to come back so that they can talk about psychosocial issues and the patient responds positively to this saying: *"Ok that'll be great"*.

Extract 1 of the GP interview shows the GP commenting on the fact that the psychosocial revelation did not emerge until halfway through the consultation and that ordinarily he would have brought the consultation to a close but that he was influenced by participation in the study and thus continued. In extract 2, reflecting on his use of the direct question, the GP comments that this a preferable technique in medicine but that this can take a long time and thus direct questions are often used; again he reflects that participation in the study caused him to continue here. In extract 3 the doctor is responding to a question about whether the patient's introduction of new symptoms makes things more difficult, which the GP refutes saying that, on the contrary, this confirmed his theory that psychosocial issues might be involved and he chides himself on not having realised this sooner rather than pursuing a *"biological route"*. In extract 4, responding to a question about whether he felt he could have done anything better, the GP again is self-critical, observing that not picking up the psychosocial cue sooner had a negative impact on time management.

Consultation:

GP: I think it's unlikely that antibiotics would make any difference at [all]
Pa: [yeah]
GP: With this (.) erm (..) so I think we just kind of (.) we want to see how things go
Pa: Yeah
GP: And it'll settle then completely
Pa: But I've been like this for weeks you know (.) it's only over the last 4 days when (.) erm I've actually been sick coughing (.) [but]
GP: [ok]
Pa: I've been like this for weeks where I'm waking up (.) and I'm in a lather of sweat
GP: Right
Pa: I'm mean rolling (.) down me legs and things
GP: Right (.) and why do you think that is
Pa: I don't know so I thought maybe cause to be honest at first I thought everyone's had that flu and [everything]
(Omitted text about the possibility that the symptoms are caused by flu and why the patient thinks it is unlikely)
GP: I suppose the other thing that might be worth us doing then (.) is if we're going to do the blood test for your kidney's anyway (.) we could also do erm some tests to get an idea of (.) if there is (.) what we call (inflammation) in the body which will [add]
Pa: [yeah]
GP: from infection or erm (.) and that would give us er (.) a clear idea about where
Pa: Whether I might have [an infection]
GP: [going to be] going (.) we can erm (.) °just let me sort that out ° (1 sec) the best way to get ( ) we can't do them in the afternoon unfortunately
Pa: That's ok [well I've]
GP: [but erm]
Pa: Got my auntie's in hospital and everything I know I'll get ( ) and ( )

GP: Sure (..) the best place probably if you going to ((hospital name)) the (placename) centre do you know where it is in the grounds of the ((hospital name))
(Omitted text about time, place and date of blood tests at the hospital)
GP: [Every week day] (..) erm (3 sec) **did you say your auntie's in the ((hospital name))**
Pa: [Yeah she had]
GP: Right
Pa: A bad car accident [last year]
GP: [Oh dear]
Pa: Someone 3 lads went into them (..) she went through the window screen and [everything]
GP: **A::h**
(7 sec)
GP: has that been playing on your mind much recently (.) or has that
Pa: No you know [cause I mean]
GP: [It's not (.) it's]
Pa: I mean worrying over me mum cause she's getting old now and
GP: Cause I'm just thinking again sometimes kind of stress can bring on
Pa: Mm
GP: Kind of that kind of (.) the sweats and [the]
Pa: [Yeah]
GP: The kind of particularly at night time funnily enough when (..) I'm just wondering if there's anything like that that might have been
Pa: **I have been pretty stressed though lately**
GP: Over what
Pa: Just over family things just being down and that
(Omitted text about use of illicit substances as a method of stress management)
GP: I'll leave that for another time (.) erm ok (.) so we'll check (.) as part of all of this (.) I'll just c- erm I'll check for these things called inflammatory markers (1 sec) see if there's (..) any sign that your body's fighting infection as well as checking your sugar levels (..) that's fine
Pa: **I'm dead tired as well all the time (.) you know I'm just (.) got no energy**
GP: No
Pa: Even when I am going to the gym I've got no energy
GP: Ok
(5 sec)
GP: ok (.) but I'll get these tests sorted alright but I'd you to come back and see me so that we can kind of (.) [start]
Pa:
[Yeah]
GP: Working out what's going on [cause I think]
Pa: [what's wrong]
GP: **Sometimes with this stuff (.) it's (.) it's impossible to kind of sort out on first (..) [first]**
Pa: [yeah]
GP: **Impression first meet- erm so we'll get the blood test to make sure there's nothing kind of physical going on (.) and maybe kind of next time we can concentrate a bit more about**
Pa: Yeah
GP: Perhaps kind of looking at some of the stresses and things [and]
Pa: [yeah]
GP: Seeing (.) what we (.) what might kind of (.) w- [how]
Pa: [yeah]
GP: To look at things in
Pa: If there's anything ( ) ( ) [then]
GP: [yeah] (.) is that alright
Pa: **Ok that'll be great**

GP:

Extract 1
GP: actually… for that particular woman I was kind of…**I think it was about 10 minutes in when we were talking about the sweats and and any kind of physical problems that er I kind of wondered if there may have been like a er an anxiety element to it and I** suspect that I probably would have let it lie… if we hadn't been doing this

I: If you hadn't have been oh I see hh

GP: Just because it was just… because it came… **because it took 10 minutes to kind of look at the (.) the physical side of things**…then that's you'd kind of think about rounding things off there

I: So you were actually you were affected by being recorded

GP: Yeah with that one (.) definitely

Extract 2

I: Er and then you say something that's really quite interesting you you say er in a sort of really different voice you sort of say *"and why do you think that is?"* erm and I was wondering whether you can remember what you were sort of thinking when you said that

GP: Well…I think erm it's it's I suppose that the different voice thing (moulds) the move from kind of physical illness to erm er I don't know whether you'd kind of call it counseling voice or whatever…you know that kind of you know er like erm **the open questioning you're supposed to use in medicine you're supposed to use open questioning** erm but it takes a long time to do open questions erm so you tend not to so you tend to ask direct questions erm well I do erm and I think a lot of GPs do so er so I suppose at that point we'd kind of pushed on a little bit by the fact that we had this microphone in front of us er looking at unexplained symptoms erm then er I thought it was probably reasonable to erm yeah to try and you know explain cause I'd looked at it as an unexplained symptom…

Extract 3

I: Right ok erm then she starts er actually she does start giving some other symptoms then she says that she's just really tired all the time and that she's got no energy (.) does that make it difficult when people (.) keep bringing new symptoms and during the consultation or

GP: **Well no because I think that… what was probably going through my mind at that point was: "oh pants why didn't I pick this up earlier"** because I think yeah because she'd said she come in for kidney problems and because she was talking about sweats yeah I don't think I was really thinking of and night sweats I don't really think of as er as a as a erm psychological symptom sort of thing I mean they're often kind of in my mind at least they are physical symptom so erm so I suppose **I probably went down the biological route a bit** more than I might have so at that point then you're thinking "oh pants" you know **"I could have probably sorted this out in 10 minutes"** erm if I'd kind of been a bit more kind of sensitive to the idea that this might be a sort of you know more a psychological kind of issue than a (.) physical one

I: So that sort of confirmed that in your mind that it was more

GP: well it kind of it **it backs it up doesn't it it kind of** you know because then because all that kind of erm I mean uh obviously kind of issue you've got a chronic infection going on then you have low energy and kind of and that can make you depressed and it can so it's not it's not straight forward but erm it it kind of moves you in given the rest of the story if you like the narrative erm **you kind of think yeah this is probably going to a bit of kind of stressing times pressured…**

Extract 4

I: And was there anything you felt you could have done better

GP: Erm I as always er the time management so it's kind **of getting to the nub of the problem straight away** and you know I think if you're very critical you could say well **if you'd asked that open question "what do you think's going on?" right at the beginning then you may have got kind of quicker answers erm**

I: yeah

GP: Which is what you're supposed to do you're supposed to ask open questions for the first couple of minutes

I: °Oh right °

GP: And that does yeah there's a load of kind of techniques that you're supposed to apply (depending) on if your lazy or (   ) erm but yeah they're there for a reason and so they the open questions are probably yeah

Patient:
It was not possible to interview the patient.

Consultation

The consultation begins with the patient giving a letter regarding her kidney function as a reason for presenting and the GP explains that it is actually a new and very sensitive test that the letter she has received pertains to and which ought not to be cause for alarm. However the consultation then progresses into a discussion of many different physical symptoms which the patient feels are connected to her reduced kidney function and she appears to remain un-assured by the GP's explanations.

Then, following an explanation by the GP regarding the lack of utility of antibiotics in this instance, the patient begins escalating her symptoms and this marks a turning point in the consultation as the GP asks the open question *"Why do you think that is"*. The patient initially responds that she doesn't know and begins exploring the possibility of flu and giving reasons why she does not believe that this is the reason for her symptoms. The GP then begins discussing a blood test which they could do in order to eliminate *"inflammation"* which would result if there was infection present.

It is at this point that the patient reveals that her auntie is ill and is in fact in the hospital where she will need to go for her own blood tests. The GP picks up on this, treating it as a psychosocial cue, and begins exploring whether or not having a family member in the hospital has been a source of stress. Whilst the patient refutes this idea she does then engage with the psychosocial turn and reveals that she is worried about her mother and that she has been stressed lately.

The GP then begins linking this to the symptoms described and begins reattribution and the patient does appear to engage with this to a degree. The GP then comments that they should get the aforementioned blood tests sorted out first and then he would like the patient to come back and see him to talk some more about the link between stress and symptoms and he comments that it can sometimes be difficult to deal with these issues on *"first impressions"*. The patient appears to verify that the physical risks will be explored first before moving to the psychosocial and then appears content and says *"Ok that'll be great"*.

GP

Reflecting on the consultation generally, the GP reveals that it wasn't until about 10 minutes into the consultation that he began to suspect that there may be *"an anxiety element"* but that because it had taken so long to discuss the physical symptoms he would ordinarily have left the exploration of psychosocial issues until another time, however he was influenced by his participation in the study to pursue the matter on this occasion.

Responding to the researcher's enquiry about his thought processes leading up the open question, the GP explains that this is what you are *"supposed to use in medicine"* but that, since this takes a long time he and (he suspected) other GPs tended to ask direct questions. Again the GP reflected that he had been influenced by the nature of the study and the fact that he was being recorded.

In the next extract the GP responds to a question about the fact that the patient introduces new symptoms following his explanation and whether or not it makes things difficult when patients do this; in response he replies that this was *not* the case and that in fact this was the moment when he thought: *"oh pants why didn't I pick this up earlier"*, reflecting that the nature of the symptoms hadn't immediately appeared as the kinds of symptoms he would associate with *"psychological symptom(s)"* and that he had thus gone down the *"biological route a bit more than I might have"*.

The GP further reflects that he *"could have probably sorted this out in 10 minutes"* if he had been *"a bit more kind of sensitive to the idea that this might be...more a psychological kind of issue than a physical one"*. Responding to a question as to whether the patient's introduction of the new symptoms actually confirmed his theory of psychosocial issues, the GP agrees that this does *"kind of backs it up"* and that *"you kind of think: yeah this is probably going to a bit of kind of stressing times pressured..."*.

In the final extract the GP is responding to the general interview question of whether he felt there was anything he could have done better (in the consultation) and he once again reflects on the time which might have been saved by asking the open question sooner, thus enabling him to get *"to the nub of the problem straight away"*.

Patient

The patient was not able to be interviewed for the second part of the study.

Reflections

The consultation was long (16minutes 25 seconds) and characterised for the first 10 minutes by the presentation of physical symptoms which the patient felt were connected to her kidney function, having received a letter from the surgery regarding a test she had recently which showed that her kidneys were *"not flushing properly"*. The GP attempts to reassure the patient that these test results are nothing to be alarmed about because the test from which they are produced is a new, very sensitive test. However the patient does not appear to be reassured by this and continues to present with physical symptoms.

The extract presented joins the consultation just as the GP is explaining to the patient why antibiotics would probably not be helpful for these symptoms and attempting to *'normalise'* and the patient responds by escalating her symptoms; this resonates with the literature surrounding *'normalisation'* which demonstrates that patients are often reluctant to accept these kinds of explanations and thus they escalate their symptoms in a bid to be taken seriously (Dowrick et al., 2004).

Whilst the open question does not appear to directly elicit the psychosocial turn in the discussions this turn in the conversation does come shortly after this and is initiated by the new information offered by the patient regarding her aunty being ill in the hospital. This fits with the well-documented theories regarding the utility of open questions in medical practice (Robinson, 2006)

The patient's initial response to the GP's *'reattribution'* is initially cautious, although she does engage, agreeing that she has been *"pretty stressed though lately"*. The patient does bring in the physical symptom of tiredness and having no energy, even when she goes to the gym, which might suggest that she is attempting to outline this tiredness as having a physical cause as distinct from being related to *'stress'*. However having established that the GP is going to first of all going to do blood tests and ensure that there is not physical problem present, the patient appears satisfied and says *"Ok that'll be great"* which is both a positive response and a signal that she has got what she came for since it is framed as a closing statement (West, 2006).

The extract here relating to *'reattribution'* seems to support the findings of Peters et al 2009 in the sense that the patient's acceptance of psychosocial factors is aided by an assurance that medical attention to these issues will not preclude vigilance to physical disease (Peters et al., 2009).

A key feature of this example is the fact that the GP is of the opinion that non-familiarity has had a negative impact on the consultation, as well as his own use of direct questioning rather than open questions, and his assumptions regarding the biological nature of the symptoms rather than considering earlier the possibility of psychosocial factors.

In many ways this example does share some similar features to the previous case in this chapter (8.2 *"I'm not stressed"*) particularly the fact that both are long consultations, initially characterised by the presentation of multiple, physical symptoms and the fact that the psychosocial element emerges at least halfway into the consultation. One interesting distinction however is the acceptability, or not, of the word *"stressed"*; whereas in example 8.2 the patient appears to find the word *"stressed"* to be an affront to her ability to cope, the patient in this example (8.3) not only engages with the idea but also mirrors the actual word, saying: *"I have been pretty stressed though lately"*.

An interesting comparison can also be drawn with example 7.2 *("I was expecting there to be more so I was kind of waiting")* in terms of the GPs comments regarding the use of open questions; whilst *'non-familiarity'* and initial presentation of physical symptoms are key features of both consultations, the GP in case 7.2 asks an open question quite early on as well as utilising the technique of *'waiting'* (Dowrick, 1997) and this brings forth the previously hidden anxieties the patient holds regarding his symptoms as *"warning signs"* for chronic heart disease, with a possible genetic component; the anxieties in turn appear to be linked to the symptoms themselves and thus the techniques used by the GP do in fact appear to *"get to the nub of the problem"* more or less straight away, despite the *'non-familiarity'* which defines the encounter.

There are comparable elements of the consultation with other examples in the thesis, for example the open question used in case 6.1 (*"How do you think the doctor's feeling"*), where the open question does elicit a psychosocial turn but this has to be reinforced and aggressively pursued due to the resistance of the patient. There are also interesting contrasts to be made with all the cases from chapter 6 on the positives of familiarity, which all pertain to accurate perception and detection of cues and agendas, which are aided by *'familiarity'*.

However the most striking comparison to be made is with example 5.3 (desire to talk about *'un-doctorable'* grief) since both consultations are characterised by the presentation of multiple, physical symptoms and a feeling by the GP that their attempts at exploration and normalisation are not engaging the patient in question and their own reflections after the fact that perhaps much time could have been saved by an earlier use of open questions and consideration that there may be a psychosocial component to the presentation.

Conversely however it may be that such early and perhaps obvious assignment of symptoms to psychosocial matters and their exploration may not be culturally acceptable to the patients in question who may prefer to establish a *'doctorable'* health complaint as the initial reason for presenting and may indeed need the reassurance that their physical health is in order, before psychosocial issues become and acceptable consideration. This again links back to the idea of assurances from the GP regarding rigorous exploration of physical symptoms before exploration of psychosocial issues being an important foundational step for *'reattribution'* to take place.

Finally it seems that this case is an illustrative example, particularly when viewed in context of the previous examples, of the complexity of GP work and thus the importance of flexibility and choice with regards to health care in the primary health care setting.

Part 4: Discussion and conclusions

Introduction

Part one of the thesis, comprising two chapters, was concerned with locating the field of enquiry. In chapter one the familiar arguments regarding the *'problems'* posed by *'Medically Unexplained Symptoms'* in primary care were introduced and then problematized in terms of the illness category itself and thus any subsequent extrapolations made regarding this cohort of patients.

Questions were also raised regarding the imprecision of the established concepts of *'sustained relationships'* and *'continuity of care'*, which are currently regarded as models of best practice for conducting primary care consultations, but are themselves subject to differing interpretation within the literature. The remainder of the chapter therefore set about addressing these emergent questions by exploring the literature surrounding these familiar yet problematic concepts, including: the wider field of contested illness and the emergent concept of *'familiarity'*.

In chapter 2 therefore, this concept of *'familiarity'* which also lacked robustness of definition, was used as a 'heuristic' to conduct a structured, critical review of the literature, and was subsequently developed for the purposes of the study and became the main focus of enquiry in terms of how it impinged upon consultations relating to Medically Unexplained Symptoms.

As highlighted in previous chapters, the concept of *'familiarity'* is distinct from the concepts of *'sustained relationships'* and *'continuity of care'* since it refers to a particular component which may exist *within* both of these concepts, but which can also exist independently and is not associated with the wider connotations of either.

For the purposes of this study the term *'familiarity'* refers to the varying degrees of prior knowledge doctors and patients hold about each other as individuals and/ or their life-worlds and the varying degrees of prior contact (if any) through which this has been obtained. Additionally this concept was built upon and the mirroring concept of *'non-familiarity'* proposed and explored.

The literature surrounding *'familiarity'* has suggested the possibility of negative as well as positive implications for doctor-patient communication and the primary care encounter generally (Broom, 2003), which is in contrast to the literature and widely held beliefs regarding *'sustained relationships'* (Balint, 2000) and *'continuity of care'* (Haggerty et al., 2003; Saultz, 2003b).

The exploration of the positive and negative effects of *'familiarity'* and *'non-familiarity'* was the main focus of the thesis, with specific emphasis on consultations pertaining to Medically Unexplained Symptoms, but with inferences also to be drawn in relations to the primary care encounter more generally.

Part two of the thesis was therefore concerned with the research strategy and, having set forth a theoretically informed framework of 'bricolage' for discussion in chapter three, an innovative methodology was formulated and a plan of action for data collection was presented in chapter four.

The resultant findings of the empirical research were presented in Part three of the thesis, comprising four discrete chapters:

- Chapter 5 – Positive aspects of familiarity
- Chapter 6 – Negative aspects of familiarity
- Chapter 7 – Positive aspects of non-familiarity
- Chapter 8 – Negative aspects of non-familiarity

Each of these empirical chapters offered carefully considered data extracts and analysis to elucidate the emergent concepts of *'familiarity'* and *'non-familiarity'* as they exist to varying degrees between the various actors of the health care milieu.

Part four of the thesis then, is given over to further examination and interpretation of the findings. In chapter nine the new and original contribution of the study is emphasised. Following this the strengths and limitations of the research process will then be discussed, including reflection on the innovative methodology developed and its particular utility in relation to this setting and this particular health concern.

The researcher's personal reflections will also be discussed in terms of 'conceptual baggage' and the potential impact of this upon the interpretation of the data and conclusions about meanings of the results. Some additional reflections on rigour in this qualitative research project will be discussed and the work will be situated within the more general concepts of 'confirmability' and 'transferability'.

The tenth and final chapter will then seek to draw conclusions and present possible implications of the research for the future with regards to research, practice and policy development within the field of contested illness and the primary care milieu more generally.

Chapter 9: Discussion

9.1 New and original contribution

In part one of the thesis the well-established concepts of *'sustained relationships'* and *'continuity of care'* were scrutinised and, following on from this, the nuanced conceptualisation of *'familiarity'* and mirroring concept of *'non-familiarity'* were developed, and an accompanying model proposed (figure 3). These concepts and their manifestations within the study will be explored further in this chapter since they represent significant development in terms of this field of enquiry and have implications for future research, practice and policy development (which will be emphasised in the concluding chapter of the thesis – chapter 10).

The main focus and thus primary new and original contribution of this study however is the fact that observable positive and negative effects were demonstrated with regards to doctor-patient interaction for both *'familiarity'* and *'non-familiarity'* within the primary care consultation. This deviates from the dominant thinking in the field of enquiry which regards *'familiarity'* as being the most auspicious milieu for doctor-patient interaction, and it supports the emerging literature proposing possible negative effects of *'familiarity'* as well as the better explored and recognised positives (Broom, 2003; Gabel et al., 1993). *'Non-familiarity'* meanwhile appears to be a little explored concept and thus our development and analysis greatly adds to this field of enquiry.

The exploration of the concepts of *'familiarity'* and *'non-familiarity'*, in terms of their positive and negative effects on interaction, has also revealed an inherent complexity, best demonstrated by the fact that in some cases both positive and negative effects were observed of each concept within certain cases as described above; thus any attempt to derive an ideal model upon which to base primary care practice, based on *'familiarity'* or *'non-familiarity'* as the deciding factor, would be inappropriate and flawed. The implications of this finding will be explored in the conclusions of this thesis.

Since the study focused on the cohort of patients which could be described as having *'Medically Unexplained Symptoms'*, and that the definitions and literature in relation to this cohort were found to lack precision, it was also an important part of the study to explore and develop a working definition of Medically Unexplained Symptoms.

Furthermore, since the empirical findings of the research were presented as case studies, with a triangulation of vignettes and accompanying commentary of the case as a whole, it is possible and appropriate to reflect on the nature of the MUS to which each case pertains, and in so doing solidify our working definition of Medically Unexplained Symptoms as understood from the literature. This deconstruction and exploration based on empirical findings will be useful to researchers concerned with the study of Medically Unexplained Symptoms and the wider context of contested illness, both in terms of definitions and the validity of extrapolations which can be made regarding this cohort; this in turn will have implications for practice and policy development and these will be explored in chapter 10.

Some particular phenomena also arose during the study of the data which offer a new and original contribution to the literature and may also present important considerations for policy within the primary care setting. In particular the concept of *'cylchdroi'* may prove useful to practitioners seeking to understand the puzzling presentations of some patients and help them to co-construct a management strategy to help them to move forward. This phenomenon was a dominant feature in at least two of the cases collected and appeared as a background feature in at least six others, thus further exploration of this topic would be worthwhile.

The finding that both doctors and patients may feel disempowered by *'familiarity'* in its various guises has important implications for the way in which the primary care milieu is conceptualised and organised; for example one aspect of current policy is to ensure that patients' appointments are scheduled with the same doctor each visit, even in large practices where the initial pairing may have been down to random chance and may not have proved to be a useful or satisfactory match. However this aspect of current policy is currently less emphasised than policies promoting *'rapid access'* where patients are allocated to any available practitioner. These policies naturally tend to minimise *'familiarity'*; thus the findings here could be drawn upon to argue that policies designed to promote rapid access may be less problematic than is commonly assumed.

Additionally, the finding regarding the possible disempowering effects of *'familiarity'* has important implications in terms of the idea of *'heartsink'* patients, particularly in relation to those with Medically Unexplained Symptoms (Rosendal et al., 2005), as enforced *'familiarity'* and ongoing contact may simply exacerbate this problem, leaving doctors feeling ever more disempowered and with patients also feeling disempowered, and perhaps developing a sense of the *'heartsink'* doctor.

The fact that in example 7.1, *So sometimes it's nice not to be involved with the patient*, the GP actually states that *'non-familiarity'* can sometimes be helpful, and then the fact that this does indeed appear to be evident from the extracts presented, with the outcome being the avoidance of unnecessary surgery and improved health status, is particularly compelling evidence of the potential utility of re-conceptualising the emphasis on this aspect of primary health care policy.

Meanwhile the findings of example 8.1, *"He was like totally disgusted"*, which show how a standard question can be perceived as a moral judgement, have implications beyond that of *'familiarity'* and *'non-familiarity'* since they reveal the potentially disruptive nature of other policies which impinge upon the primary health care encounter, here relating to questions which are asked as part of the Quality Outcomes Framework (Doran et al., 2006; Roland, 2004).

The concept of over-familiarity and possibly *'GP saturation'* which may occur as a consequence of unique circumstances, such as the amalgamation of a whole new, culturally distinct community, into the remit of a practice, with little or no additional support of resources to aid this transition, is proposed as a possible area for future enquiry.

Having explored the wider context of contested illness within which to understand and situate the concept of 'Medically Unexplained Symptoms', an idea emerged for the construction of a possible model to aid understanding of how the overlapping concepts within this field of enquiry might be viewed as a *'continuum of contested illness'* and this idea is briefly explored in terms of possible future research with a view to providing a fuller, more nuanced understanding of this illness category.

Finally, the 'epistemology of complexity' afforded by the 'bricolage' framework adopted (Denzin & Lincoln, 2005b; Kincheloe, 2005b) and the subsequently innovative, 'multimethodological' approach (Kincheloe, 2001) to the research process, resulted in a rich, 'multiperspective' data source which was then subjected to 'multiperspecival analysis'. This in turn presents an empirically grounded exploration of the concept of 'researcher-as-bricoleuse' and is, in itself, a contribution to conceptual development in this field of enquiry.

9.2 Conceptual development in relation to the literature: *'familiarity'* and *'non-familiarity'* & observable positive and negative impact

Since the concepts of *'continuity of care'* and *'sustained relationships'* were somewhat poorly defined and not considered to be helpful to our study, the concept of *'familiarity'* was drawn from the literature and further developed as a framework within which to study the doctor-patient interaction; a mirroring concept of *'non-familiarity'* was also developed and both proved useful and appropriate in examining the cases presented within the study. Both concepts were characterised by the level of knowledge participants had of each other as individuals and their wider context and also by degrees of distance.

Figure 3 demonstrates how *'familiarity'* and *'non-familiarity'* were perceived to exist in a variety of guises. For GPs this included *'familiarity'* and *'non-familiarity'* with specific patients only; specific patients and their family and/ or community context; and also with community/ cultural context (without knowledge of any particular individuals). Patients might be familiar (or unfamiliar) with a specific GP and therefore the practice as a whole. Conversely, in some larger practices, patients may be familiar with the practice but not with any particular doctor. Additionally, patients may have varying degrees of *'familiarity'* and *'non-familiarity'* with the healthcare milieu generally. Within the context of this study *'familiarity'* and *'non-familiarity'* were observed in these various guises and the ensuing positive and negative effects were explored.

In example 5.1, *the accurately perceived non-pressure to prescribe*, there is clearly a reciprocal sense of *'familiarity'* between doctor and patient which has the positive effect of enabling them to draw on shared knowledge and understanding regarding the presented symptoms which are a part of an ongoing problem. The need for lengthy discussions on the topic is thus greatly reduced and the possibility of misinterpretation is minimised. Whilst it is possible to speculate regarding the other forms of *'familiarity'* and *'non-familiarity'* which may or may not be present, this is neither demonstrable nor necessary to an understanding of the extract presented.

Example 5.2, *the three "okays"*, also clearly demonstrates a case where there is reciprocal *'familiarity'* between doctor and patient. This *'familiarity'* enables them to communicate on a level puzzling to the observer as they negotiate a discussion about difficult to raise issues with minimal obvious cues. Both participants comment on the shared *'familiarity'* in their interviews and frame what they say positively. The GP also makes comments during his interview which highlight a detailed knowledge, on his part, of the patient's family and cultural background, although this knowledge is drawn from discussions with the patient and also his cultural competence skills as a GP rather than personally acquired knowledge since the patient is a student and her family live in a different part of the country.

A similar level of reciprocal *'familiarity'* is also evident in example 5.3, *undoctorable grief*, but in this instance the GP has had close contact with the patient's spouse and retains detailed information regarding his illness and subsequent death, and also the relationship and life the patient and her husband shared; this gives the GP an insight into the grief suffered by the patient and an empathy with her position. In addition the patient is from the local area which is served by the practice and the GP demonstrates an understanding of the cultural context of the patient, particularly in terms of how this would shape the patient's beliefs and health seeking behaviour, for example considering the presentation of grief and or depression as *'undoctorable'*.

In example 5.4, *Cylchdroi*, there is clearly a high degree of shared knowledge regarding the patient's trajectory and both participants confirm during their interviews that this is due to the *'familiarity'* between them. Both discuss the *'familiarity'* positively, particularly with regards to the complexity of the patient's problem and the fact that their ongoing contact has enabled them to move forward, albeit slowly. However, interestingly the GP does make a comment in her interview that the patient tends to seek advice and information from a variety of sources before returning to the GP. This leaves the GP feeling undervalued next to the other sources to the extent that she feels like *"the last port of call"*. This example therefore demonstrates how *'familiarity'* can have positive and negative effects within the same case and consultation, thus highlighting the overall complexity of this issue in the primary care setting.

This paradoxical view of *'familiarity'* is also observable to some extent in example 6.1, *the disempowered doctor*, as the doctor discusses how *'familiarity'* with the patient, his family and community context enables him to decipher his presentation and formulate a way to best manage his over-reliance on the health care system. The patient also repeatedly expresses his satisfaction at having *'familiarity'* with this GP and also with the surgery and the health care system more generally.

However the overriding effect of the *'familiarity'* in this case as a whole appears to be the negative impact it has on the GP as he feels exasperated by what he perceives as the patient's lack of respect for his professional skill. Also the GP feels negatively about having repeated consultations during which there is a high degree of conflict regarding the patient's desire for somatic intervention and referral to secondary care, whilst the GP struggles to contain interventions to necessary ailments and appropriate levels.

In addition it would seem that the patient may be experiencing an *'over-familiarity'* with the health care milieu generally, developing perhaps a reliance on this setting for reassurance regarding his own health; he also appears to crave the contact with health professionals in this setting which may be explained by him having found solace in the relationships he built in the secondary care setting whilst attending as a carer for his parents, which he has not found a satisfactory replacement for outside of this setting.

In example 6.2, *the disempowered patient*, there is clearly a long standing *'familiarity'* between the doctor and the patient and both confirm in their post-consultation interviews that the *'familiarity'* has existed for many years, with the GP being the only GP at the practice and thus the only GP the patient has contact with; from this we can deduce that levels of shared knowledge about each other are high. Whilst both participants are polite about each other it is clear that there has been some disagreement and conflict over the years regarding the patient's health care and their own beliefs and perspectives. This has led them to formulate negative opinions regarding each other's attitudes and levels of knowledge and appears to perpetuate conflict at each consultation.

Example 6.3, *behavioural epidemiology as cultural inevitability*, demonstrates the circumstances under which a doctor may have contextual *'familiarity'* with the community and culture of the patient but not with the patient themselves. In this instance the negative effects observed relate possibly to the *'over-familiarity'* and maybe even *'GP saturation'* which the GP is feeling with regards to this particular community since there are so many overlapping, unique health and social difficulties, such as high levels of illiteracy, the sharing of medication, resistance to psychosocial discussion, and frequent presentation through emergency access (Personal communication, Reeve, 2011).

This complex array of factors may mean that the GP finds it difficult to intervene medically in a meaningful manner. Thus the GP's feelings of disempowerment and resignation regarding this particular community mean that she does not feel it is appropriate to explore the issue of anti-depressant use with the patient despite the fact that she has not previously experienced any difficulties exploring such issues with this particular patient. The subsequent psychosocial discussions which emerge following the requested prescription for sleeping tablets, and the patient's apparent willingness to engage with this, would appear to indicate that this particular patient may *not* completely follow the pattern of behaviour associated with her community, thus this could also be considered as a negative effect in that cultural competence led to assumed behaviours which were not present (although this is speculative and would need further investigation).

Whilst the GP in this instance shows a high degree of empathy with the patient, it might perhaps be the case that a different kind of *'cultural familiarity'* is needed here to bridge the gap which exists between the health beliefs and practices of a minority community such as the travellers in this area and the rest of the practice population. Perhaps a helpful model to draw on might be that of the Mexican American *'sobadores'* (folk manual therapists/ manual medical practitioners) who offer a form of non-mainstream healthcare, particularly in the treatment of musculoskeletal problems, which draws on cultural familiarity and offers convergent ethnophysiological discourse and pain validation (Hinojosa, 2008) or that of 'Kampo' in Japan, a traditional herbal medicine which is an integral part of the official Westernized medical system in Japan (Gepshtein et al., 2008).

Drawing on these models, perhaps some kind of specifically designed support mechanism for GPs engaged in delivering health care to this community could be formulated to work with the designated health visitor and support worker already in operation. These might involve community-specific services at the surgery, for example: designated practitioners with a specific interest and knowledge of traveller health; specific health interventions tailored to the needs of the community in the way that the managed zone programmes of Utrecht and Liverpool are with regards to prostitution (Clark et al., 2004).

A particular source of frustration for the GPs seems to hinge on the constant presentation of this community through emergency access rather than bookable appointments; however this may be the preferred form of presenting since high levels of illiteracy preclude the use of diaries and other appointment reminding paraphernalia. Thus some kind of community-based project working with the GPs at the surgery and the patients might find ways of addressing these issues, as well as challenging health beliefs, such as the normalisation of long term dependence on anti-depressants, and build an understanding of health practices which perpetuate these health behaviours, for example the pooling of medication for communal use.

Interestingly, this inappropriate use of resources, by the traveller community who were relatively new to the practice, resonates with the lack of understanding, underuse of services and thus limited treatment options in migrant populations discussed by Priebe et al in the review section of this thesis. Whilst the traveller community at this surgery have essentially been static for approximately 30 years, the unique prejudices towards this community and perhaps their fear of being detected and moved on, have possibly resulted in this community retaining some of the characteristics of the migrant communities discussed by Priebe et al. Approaching solutions, Priebe et al noted the reported success of the following interventions and/ or services which might also prove useful in addressing the needs of the traveller community in this setting: collaboration with social services, that would be able to assist in legal and/ or social issues, sharing information and liaising with families; engaging with community centres to contact migrant patients in the wider community; fostering positive relationships between staff and patients, including 'welcoming policies'; altering service delivery with modifications of routine practice (Priebe et al., 2011).

The GP feelings elicited in this scenario have a certain similarity with those identified in the concept of the *'heartsink patient'* (Mathers et al., 1995; Mathers & Gask, 1995; McDonald & Odowd, 1991; O'Dowd, 1988; Rosendal et al., 2005) even when the GP and patient are meeting for the first time, and thus the phenomena could perhaps be termed the *'heartsink community'*. However the feelings expressed by the GPs are not so much of despair, anger and frustration described in the literature surrounding the *'heartsink patient'* but rather one of resignation about certain health behaviours which seem inevitable and must be incorporated into the system of care.

There is also a notably high degree of empathy present and recognition that the complex and difficult presentations are a symptom of the unique pressures individuals face as members of this community, rather than of patients themselves being difficult; it is more a kind of *'cultural competence'* but in a passive sense, since they feel there is nothing which can be done but to accept and collude. This shares some similarity with that of the war-related syndromes and higher level of acceptance regarding psychosocial origins of symptoms given the respectably serious nature of the psychosocial distress experienced by veterans (discussed under point 1.2 of this thesis).

This high degree of empathy and interest in the context of the patient also helps to distinguish the concept of *'GP Saturation'* from that of the more popularly known *'burn out'*, for which Maslach defined 3 components: emotional exhaustion; depersonalisation of others; and lack of personal accomplishment (Kirwan & Armstrong, 1995). Far from displaying any tendency towards *'depersonalisation'* the GP in the study describes in detail the pressures facing the patient, comparing them with her own life and saying "so she would have my sympathy but I would also be at a loss as to how to help her" (Extract 3, GP interview, example 6.3, L2675-2678).

In addition, this is not a feeling limited to one particular GP but is a practice-wide phenomenon regarding one particular community, and even in this instance there is no evidence to support feelings of emotional exhaustion or lack of personal accomplishment. However this is not to say that this will not become the case if support mechanisms are not built into the current system in order to remove barriers to care and facilitate communication.

In order to be successful any intervention would need to be designed with the input of the GPs and the community since they are best placed to highlight the problems they face and what they feel would help; it is important to recognise the co-constructed nature of this relationship between community and primary care practice engaged in delivery of healthcare to them.

Example 6.4, *familiarity but disparity*, demonstrates the fragility of *'familiarity'* in terms of the way in which it is conceptualised between individuals. In this instance there is an asymmetry in the level of *'familiarity'* that the doctor and the patient feel exists between them and this is the root cause of the misunderstanding presented in the extract and, whilst not immediately disruptive, shows the potential for misinterpretation and talking at cross purposes which can occur when an undefined or asymmetrical level of *'familiarity'* can be said to exist.

As mentioned above, example 7.1, *"so it's sometimes nice not to be involved with the patient"*, is drawn from the same case (case 8) as example 8.1 *"he was like totally disgusted"* and again highlights the complexity of levels of knowledge and acquaintanceship for doctor-patient interaction since example 7.1 demonstrates a positive impact of *'non-familiarity'* whilst example 8.1 demonstrates the opposite. Seen together with example 5.4, *cylchdroi*, then, we can conclude that both *'familiarity'* and *'non-familiarity'* can have positive and negative effects within the same consultation.

In addition, we can see here the utility of differentiating between the different guises of *'familiarity'* and *'non-familiarity'* since the positive effects of familiarity in example 7.1 relate to the non-familiarity between doctor and patient and the objectivity this affords the diagnostic process, whilst the negative effects of example 8.1 relate, at least in part, to the patient's lack of familiarity with the health care milieu generally and thus her lack of awareness with regards to the computer-prompted standard health questions which are integrated into the primary care consultation.

Example 7.2, *"I was expecting there to be more so I was kind of waiting"*, could be said to represent *'non-familiarity'* in its purest form since the patient has no *'familiarity'* with the health care setting generally, having not even visited the primary care setting for at least 15 years, and thus, it follows, with the specific practice nor with the specific GP. The positive effects observed relate mainly to the *'non-familiarity'* which exists between the specific GP and the specific patient.

It is interesting to note that in example 8.2, *"I'm not stressed"*, the negative effects observed probably relate just as much to the *'non-familiarity'* the doctor has with the patient's community context as with the patient herself, further emphasising the importance of acknowledging the nuanced nature of *'familiarity'* and *'non-familiarity'*. It would appear in this case that *"stressed"* is not a culturally acceptable term for the patient and, whilst this knowledge could be garnered from the patient herself over time, it is also something which health practitioners working within their own community context would have perhaps instinctively known (Hinojosa, 2008).

The final example, 8.3 *And that's when I thought "Oh Pants I could have sorted this out much sooner"*, in some ways reflects this same problem since this particular practice serves a wide and varied community (or communities) and this may have made it difficult for the GP to draw inferences regarding what the patient would and would not find acceptable in terms of explanations and thus presentations. However the main form of *'non-familiarity'* under scrutiny here is that which exists between doctor and patient. Furthermore the doctor feels that, since he has now identified potential psychosocial explanations for the symptoms, he will be better able to make progress with this patient in the future.

9.3 Medically Unexplained Symptoms as a concept within the literature

As discussed in chapter 1, the literature surrounding the study of Medically Unexplained Symptoms is fractured and plagued by overlap, imprecision and terminology being inappropriately applied interchangeably (Nettleton, 2006; Peveler et al., 1997). The root of the problem is that the symptoms to which these illness categories pertain are categorised by the very fact that they evade diagnosis to any recognisable physical, organic pathology according to the current Western Biomedical Model. Being outside this model means that no standard, agreed diagnostic label has been ascribed and thus the literature describing the ensuing phenomena is characterised by competing definitions and labels. To gain a coherent understanding of the contextual background of this cohort of patients it is therefore helpful to consider the wider field of contested illness.

The current Western Biomedical Model proposes that disease can and should be classified and that such classification should be based on demonstrable cause or effect within the anatomical frame (Nettleton, 2006). Where both cause and effect are clearly observable, illnesses are certain and the patient is treated as legitimately ill and afforded all associated treatment, sympathies and benefits.

Where cause or effect is not satisfactorily understood a certain degree of uncertainty can be said to exist (Cooper & Geyer, 2007) and illnesses which fall within this category can then be divided into two main categories. The first category, where a cause or effect can be established for the illness in question, but not both, nevertheless retains some of the features of the certain illness category in that they are accepted as being legitimate. So for example, in the case of type 1 diabetes the exact cause is not known, however the effects of the illness – diminished production of insulin and subsequent rise in blood glucose levels, is clearly observable and indeed fatal unless treated (Cooper & Geyer, 2007; Spencer, 2009).

However the remaining illnesses are characterised by symptoms which cause patients to suffer but which are more difficult to pinpoint since they are *'felt'* and *'experienced'* rather than occurring in a tangible, observable way, for example: pain, fatigue and dizziness. This poses significant problems for the patients and the health professionals seeking to treat them. The absence of a legitimating diagnosis means that a degree of uncertainty remains regarding the nature and level of suffering of the patient and their status as legitimately *'ill'* or *'sick'* is itself contestable.

This lingering uncertainty is difficult to deal with and has led to an array of coping mechanisms and management strategies, which has included attempts by both doctors and patients to assign definitive diagnostic labels to certain clusters of symptoms. However these labels overlap and depend upon the ideas underpinning the explanations and beliefs held regarding the causes of symptoms (Barsky & Borus, 1999).

Explanations are subject to modification depending on the ever-changing landscape of medical knowledge and or new knowledge and perspective brought to bear in individual cases. All illnesses within this field however, regardless of label and explanation, are characterised by *'diagnostic limbo'* (Corbin & Strauss, 1985).

In some cases patients, and perhaps even the practitioners in charge of their care, believe that their symptoms are caused by organic pathology. This medicalisation may have arisen because the patients' trajectories through the health care system have brought them to one of the specialist fields within secondary care where clusters of symptoms are categorised and given a diagnostic label. However these named syndromes depend more upon the medical specialist making the diagnosis than on the particular combination of symptoms experienced and there is an inevitable degree of overlap between them (Barsky & Borus, 1999).

In other cases medicalisation can be seen as *'consumer-driven'* and the assigning of a disease label in this way perhaps highlights the growing influence of lay expertise in the context of medical uncertainty, with some patients organising themselves into social movements and drawing on their shared, embodied expertise to confirm the medical character of their problem and its remedy (Barker, 2008). In cases such as these any labels and explanations assigned are embodied by patients and are accepted, if not assigned and promoted, by the health professionals involved in their care. Patients identify themselves as being *'ill'* and the health professionals involved either concur or have had a hand in instigating this.

In contrast to this are patients of whom it is believed that their symptoms are psychosocial in origin. Explanations of physical symptoms here are based on the idea of somatisation and functional explanations of symptoms (Salmon et al., 1999). This is sometimes explained to patients by health practitioners and the patients may accept the rationalisation of their symptoms as having origins in anxiety or stress and thus begin a process of *'de-somatisation'* addressing underlying causes of anxiety and stress. In other cases the health practitioner may hold this view of the patient but may not address this with the patient overtly, or else attempts to do so but the patient rejects offers of psychosocial support and asserts their belief in organic pathology; nevertheless the practitioners view regarding somatisation may influence decisions regarding treatment and management.

In cases where the functional explanation is shared and accepted it could be said that the condition and the label are embodied to some degree by the patient. In cases where the practitioner holds the belief but does not address it with the patient (or else it is rejected by the patient), it could be said that a degree of *'secondary embodiment'* or *'embodiment-by-proxy'* potentially takes place, as the physician assigns characteristics of somatisation and functional explanations to the symptoms and labels, treats and manages them accordingly.

This theory is based upon the *'parental embodiment'* described by Spencer 2009 in relation to the required 'assumption of responsibility for the taken-for-granted secretion of insulin by the pancreas by the mind' which takes place following diagnosis of type 1 diabetes in adolescents. According to Spencer, since adolescents (depending on age and maturity) may not possess the cognitive capacity to self-manage their diabetes diagnosis, the requirement to *'embody'* the responsibility of insulin dosage and associated blood glucose levels falls to parents (Spencer, 2009). In the case of patients and practitioners, patients may not, for cognitive, cultural or other reasons, be able to accept a psychosocial explanation for their symptoms and thus responsibility falls to the practitioner.

In cases such as these, there is some degree of overlap with the field of mental health since somatisation explains physical symptoms as manifestations of psychological distress, and functional explanations draw on lay understandings of stress and the fight or flight response to explain the sensations and very real physical symptoms experienced; some patients may subsequently come to be diagnosed and treated for this underlying distress and thus pass through to the field of recognised mental illness or emotional distress (Dellaverson, 1997).

Between these two poles lie the more transient conditions and less defined suffering. For some patients their symptoms may be a temporary disturbance which has not caused them to identify themselves as *'ill'* nor even as a *'patient'*; they are simply experiencing some symptoms, for which they may or may not seek treatment and then return to their usual routine without much thought given to cause and effect. In these cases the *'condition'* remains unlabelled and may be un-embodied or only partially so.

Also occupying the middle ground are a few unique conditions, for example the war-related syndromes, which possess a mixture of organic and psychosocial explanations which are assigned and accepted to varying degrees. Interestingly, in spite of the psychosocial elements, a greater sense of legitimacy is generally felt with regards to these syndromes given the respectably serious nature of the potential psychosocial distress which gave rise to them (Kilshaw, 2004; Kirmayer et al., 2004).

In some cases, it may happen that over time symptoms do come to have an observable, organic cause or effect and that this has simply not yet been discovered. In such cases patients move into the field of legitimate, recognised, physical, organic pathology and may even be treated and cured of their ailment. As discussed in chapter 2, an example of this can be seen in the case of stomach ulcers and acid reflux, once previously attributed to psychosocial and functional issues, which have since come to be considered largely to be due to Helicobacter pylori bacteria, now treatable with antibiotics (Chey & Wong, 2007).

On the other hand it might be that symptoms are psychosocial in origin and that the partial or whole acceptance of this by the patient may lead to an improvement in the symptoms; a rejection of this kind of explanation may lead to the situation continuing. Patients whose illnesses are contested may have a label for their suffering or not and may have embodied this label and the explanation for their symptoms or not. Whilst they do not share a specific disorder, belief or pattern of behaviour, they are all in the same social and clinical predicament (Kirmayer et al., 2004).

All of the illnesses which fall within the field of *'contested illness'* do so because they remain beyond the conventional explanations offered by the current western biomedical model of illness. Medically Unexplained Symptoms is therefore a helpful categorisation for all of these illnesses since it neatly describes the fact that the symptoms in question are simply not explained by current *'medicine'*; this explanation also avoids any negative connotations regarding blame or lack of legitimacy and is therefore neutral and helpful for an exploration of this field of enquiry (Dowrick, 2005).

However within the literature the term Medically Unexplained Symptoms is applied with little consistency, with variations existing (including Medically Unexplained Physical Symptoms, persistent Medically Unexplained Symptoms and Unexplained Symptoms (Burton, 2003; Dowrick, 2005; Escobar et al., 2002; Ring et al., 2005; Salmon et al., 2004) and terms being used interchangeably with the named syndromes and the concept of somatisation.

At the beginning of the study therefore it was important to define what we meant by the term Medically Unexplained Symptoms, thus we adopted the criteria proposed by Peveler et al 1997 and created a three part checklist for doctors to use when deciding whether to include patients in the study or not (Peveler et al., 1997).

However this criteria was not rigidly enforced as it was interesting and important to reflect on how general practitioners perceived and categorised patients as having *'Medically Unexplained Symptoms'* or not. Each example included in the findings section will therefore now be considered in terms of their definition under the umbrella term of *'Medically Unexplained Symptoms'*.

9.4 Medically Unexplained Symptoms as observed in the study

There was great variety observed within the patient group allocated to the study by GPs according to the 3-part checklist. This variety was observable in different ways, for example whether a label had been assigned or adopted, or not. Equally, whether or not a tangible explanation had been formulated, and if so whether this explanation had been accepted and embodied by the patient – or indeed accepted by the practitioner, if the explanation had been proposed by the patient.

Obviously explanations varied in terms of whether or not they rested on an idea of organic pathology or psychosocial issues, or perhaps a mixture, and this had a bearing on the overall perceptions of the patient, by parties, as *'ill'* or not. Finally, since they were recruited in real-time in a sequential manner, patients were inevitably at different stages of their illness trajectory in terms of consulting and progress made in terms of receiving treatment for their symptoms and indeed thus whether or not their symptoms were being alleviated or even reversed. This variety reflects the clinical reality of this cohort of patients.

In example 5.1, *"the accurately perceived non-pressure to prescribe"*, the patient's symptoms are currently in the process of being explored and have not been assigned a label nor conceptualised as a specific illness; no specific explanations in terms of cause or effect have been ascribed and thus the symptoms have not been attributed to organic pathology or psychosocial issues. The symptoms are therefore transient and undefined.

The fluidity in terms of definitional boundaries are highlighted by example 5.2, the three *"okays"* because the patient originally presented with somatic symptoms of fatigue, hair loss and an uncomfortable, lumpy tongue. The patient believed the symptoms to be related to organic pathology, sighting anaemia resulting from her vegetarian diet as a possible cause. However following testing for this the patient made a new presentation with the symptom of headaches and this prompted the GP to begin exploring possible psychosocial causes for the symptoms.

Over a period of time it became apparent that the patient had long standing, deeply entrenched problems with anxiety and the doctor helped her to make connections between this and her physical symptoms. As a result the patient's symptoms improved and she began treatment for anxiety.

Example 5.3, "*undoctorable grief*", is very interesting indeed in terms of its definition as MUS, as the patient presents with physical symptoms but which the GP realises are actually not the reason for the visit but are rather a *'doctorable'* and legitimating explanation to enable the patient to gain access to the psychosocial support she seeks from the GP but which she perceives as an unsatisfactory reason with which to present with.

In example 5.4, *cylchdroi*, the GP included the patient in the study because she had symptoms which remained unexplained due to the patient's presenting style rather than because of a lack of available explanation through the western biomedical model. The patient is fearful that test results might show that she is infertile, perhaps due to a genetic syndrome, and thus unable to fulfil her dream of becoming a mother; she is therefore caught in a quandary of indecision and is thus *cylchdroi* between unfavourable options and consequently evading medical explanation for her symptoms (figure 3). This avoidance of any explanation in the healthcare setting means that the patient is not assigned a label or a cause for her unexplained symptoms and thus she remains in a transient and undefined state, which could be seen as the purest form of *'diagnostic limbo'* (Corbin & Strauss, 1985).

A similar behaviour resulting in the same kind of outcome was observed in a case (not included in the findings) where a road traffic accident had left a patient in pain and with reduced mobility relating to his knees. However whilst there was an operation which could improve the functioning of his knees the patient was reticent regarding setting a date for the operation as he feared there was a risk it would not work or might possibly even make things worse. However the current situation left him feeling depressed and thus he returned to the GP to discuss his options. This case was not included in the study due to lack of space but may be published as part of a forthcoming paper on the phenomena of *cylchdroi.*

Example 6.1, *the disempowered doctor*, is fascinating as it seems that the patient has a limitless supply of symptoms for which he seeks explanations grounded in organic pathology and yet he acknowledges an awareness of how some of his physical symptoms may in part be explained by psychosocial issues including anxiety. The most striking feature of this example however is the fact that each symptom presented appears to be designed to elicit somatic responses including prescriptions and referrals to see specialists in secondary care.

As the case unfolds the underlying reasons for this appear to be a complex mixture of heightened health awareness due to the death of his mother from a simple chest infection which he feels could have been treated by antibiotics which she refused, and perhaps a dependency on the secondary care sector, of which he has fond memories from having been a carer for his mother and father when they were ill (Semple et al., 2005).

The patient appears to seek out labels for his symptoms, though usually drawn from uncontested illness spheres, and he fully embodies the idea of being a *'patient'* and being *'ill'*. Interestingly, despite feelings of disempowerment and frustration, the GP appears to feel a high degree of responsibility for the patient's ongoing care and thus could be seen as demonstrating *'secondary embodiment'* (Spencer, 2009) of somatisation on behalf of the patient.

In example 6.2, *the disempowered patient*, there is a clear divide between the ideas of the doctor and the patient as to what causes a variety of her symptoms and overall health trajectory. The doctor believes very strongly that her ongoing symptoms of migraine and new symptoms of dizziness are psychosocial in origin. The patient meanwhile wonders if the symptoms may be explained by organic pathology and would like to explore options, but the GP is keen to confine consultations to symptoms for which a definite and serious organic pathology exists. In the patient's view therefore, her symptoms remain *'medically unexplained'* because they remain *'medically unexplored'* at least on to any satisfactory level. Meanwhile in the GP's view the patient's symptoms are explainable by the concept of somatisation and/ or functional illness.

Example 6.3, *behavioural epidemiology as cultural inevitability*, presents a complex array of symptoms, some of which it is perceivable that she may believe can be explained by organic pathology. However it is the intermittent use of anti-depressants and request for sleeping pills that reveals an undercurrent of psychosocial issues present. Additionally the patient's culturally shaped perception and normalisation of depression and desired treatment through medication, against the unique behavioural epidemiology of her specific community, in the GP's view, which renders some of her symptoms unexplained. The plethora of explanations regarding her numerous symptoms and the mixing of organic pathology and psychosocial issues mean that her suffering is currently transient and undefined.

The consultation of example 6.4, *familiarity but disparity*, is also characterised by multiple symptom presentation, some of which are definable in terms of organic pathology and others which are currently medically unexplained. The patient actually alludes to the fact that some of her problems may be psychosocial in origin given that she is currently under stress related to her mother's illness and she does not appear to seek further exploration or somatic treatment for many of the physical symptoms she presents; this is similar to the presentation in example 5.3, *undoctorable grief*, and may therefore also be seen as a way of eliciting psychosocial support, which she might otherwise feel uncomfortable seeking.

Examples 7.1, *So it's sometimes nice not to be involved with the patient*, and 8.1, *He was like totally disgusted*, are drawn from the same case (case 8) and demonstrate a phenomena which is not often referred to in the literature or conferences pertaining to medically unexplained symptoms: where patients, and perhaps some of the health professionals involved in their care, believe that the symptoms have a specific, organic pathology and thus appropriate tests, investigations and even surgery are arranged. Subsequently however a doctor with a fresh perspective on the matter makes a counter diagnosis which is also rooted in organic pathology and prescribes medication for this ailment; the outcome is that the patient's symptoms are much improved thus apparently confirming the new diagnosis, rooted in alternative explanations regarding organic pathology – in this case pertaining to bowel function rather than gynaecological disease. This case began with the idea that the unexplained symptoms were explainable by organic pathology and resulted in organic pathology being identified, although not the originally suspected organic pathology; the patient subsequently passes through to the field of explainable illness and perhaps even restored health.

In example 7.2, *"I was expecting there to be more so I was kind of waiting"*, the patient enters the consultation with the concern that his current symptom of problematic bowel function may be caused by organic pathology and may also be a *"warning sign"* indicating underlying, congenital heart disease. The doctor however offers a functional explanation for the symptoms which the patient finds convincing. The patient makes some changes to his diet and also makes an effort to *"think differently"* and address mounting levels of anxiety regarding the issue; subsequently the patient finds his symptoms to be much improved. In this instance the patient begins with the perspective that his symptoms may be rooted in organic pathology but, having engaged fully with the psychosocial explanation provided and having found this to be helpful, leaves with the notion that they may be psychosocial in origin. Subsequently this explanation appears to aid reversal of the underlying cause of the illness and the patient's health appears much improved.

In example 8.2, *"I'm not stressed"* the patient presents a plethora of physical symptoms and also alludes to the fact that she is finding these difficult to manage because of her work as a pub landlady, which in itself may be seen as partly an acknowledgement of psychosocial issues. However exploration of this is cut short by her negative reaction to the doctor's use of the word *"stressed"* and subsequent shutting down of the presentation. It may be that the patient is herself unclear about whether or not she feels that her symptoms are rooted in organic pathology or psychosocial issues, or a mixture – it may be that she has not given *cause* much thought at all. No label or specific explanation is assigned by either party and the patient's suffering remains undefined.

The final example, 8.3 *and that's when I thought "Oh pants I could have sorted this out much sooner"*, nicely demonstrates the juxtaposition of opposing views held by the GP and the patient. The patient has presented because she received a letter seemingly stating that a recent test showed that she had reduced kidney function – thus demonstrable, organic pathology, confirmed by the biomedical model. She appears to retain this belief throughout the consultation, whilst the GP begins by attempting to allay the patient's concerns, explaining that the test is oversensitive and does not necessarily demonstrate organic pathology.

However faced with an escalating presentation and elaborated symptoms the GP initially explores possible organic pathology with the patient before unveiling some psychosocial issues which the patient apparently feels are unrelated to her somatic symptoms. By the end of the consultation the doctor believes quite strongly that the symptoms are at least in part psychosocial in origin and has gained some agreement from the patient regarding an exploration of these at a future date.

In this example no definite explanation or label has been assigned but from the patient's perspective, the likely explanation for the symptoms is underlying organic pathology, whilst the GP is more inclined to assign them to underlying psychosocial issues.

9.5 Additional findings and conceptual development

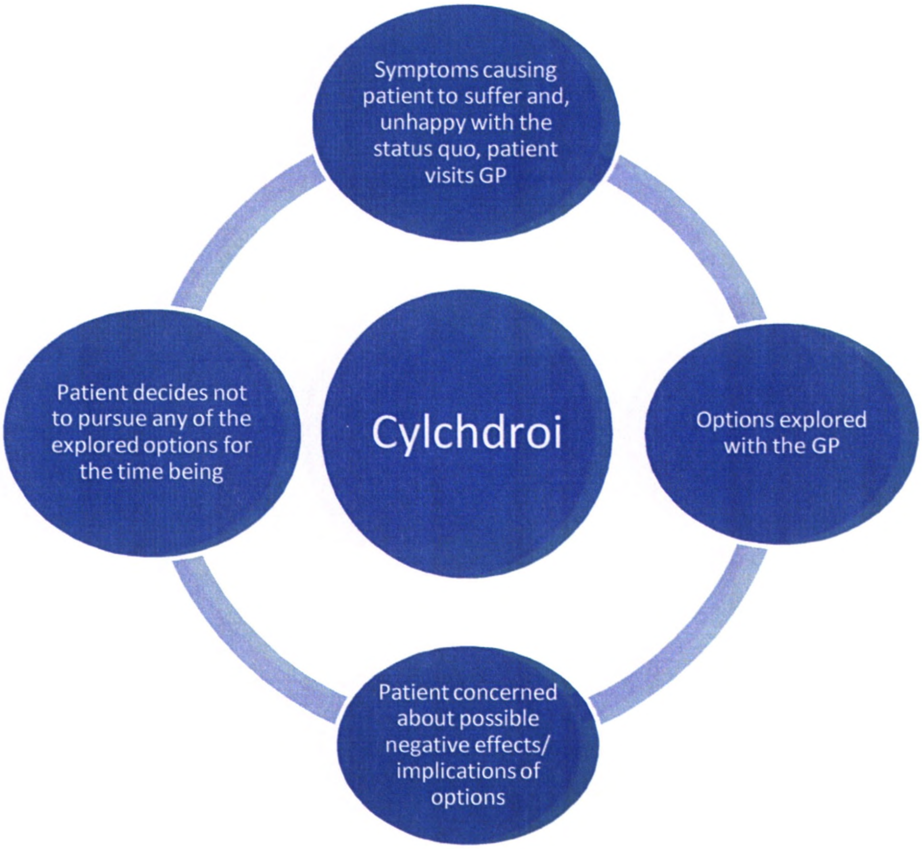
9.5.1 'Cylchdroi'

The behavioural phenomenon of *'cylchdroi'* was observed in the data and was first drawn from case 4 (used in example 5.4), before subsequently being noticed and explored in several other cases in the study, confirming its applicability in this field of enquiry. In some cases the behavioural phenomenon was actually discussed by the participants as part of the consultation, with the GP and patient in case 15 using the term *'stuck'* to highlight the concept.

However the term *'stuck'* implies not moving or changing, remaining in the same position, whilst the behaviour observed was one of continually turning in a circle and being unable to stay in one place since no favourable option appeared to present itself.

Following discussions of possible terminology (in the English language), none of which seemed to describe the observed phenomenon in a way that matched the Welsh word that the researcher found useful, it was decided that the Welsh language term *'cylchdroi'* would be used to coin this specific phenomenon. This word literally translated as *'circle'* (cylch) *'turn'* (droi) and thus is an accurate and helpful description of the observed phenomenon. The following model was developed to illustrate the concept:

Figure 3: Cylchdroi



9.5.2 The disempowered patient and the heartsink doctor

Whilst there is some existing literature regarding the negative impact of *'familiarity'* and the idea of the *'disempowered doctor'* (Chew-Graham et al., 2004), no equivalent concept appears to have been shaped regarding the *'disempowered patient'*, although of course there are examples in the literature of patients criticising the health care setting and attitudes of GPs generally particularly with regards to unexplained symptoms (Nettleton, 2006).

Much has been written in the literature regarding the *'heartsink patient'*. O'Dowd describes how such patients cause practitioners' hearts to sink each time they consult, evoking feelings of exasperation, defeat and even disgust (O'Dowd, 1988).

Mathers et al highlighted the need to consider the doctor's own contributions in the difficulties experienced with the *'heartsink'* patient and identified four explanatory variables associated with the number of *'heartsink'* patients identified by GPs: greater perceived workload; lower job satisfaction; lack of training in counselling and/ or communication skills; and lack of appropriate postgraduate qualifications (Mathers et al., 1995).

Furthermore, in a study where a pilot workshop was designed to help doctors achieve a greater understanding of and ability to cope with *'heartsink'* patients, Mathers and Gask do discuss the fact that their approach was necessarily *'doctor-centred'*, with no contact or feedback from the patients themselves (patients discussed within the workshops) suggesting perhaps that there are two sides to every story and that patient views on these cases may have been useful (Mathers & Gask, 1995).

The importance of considering the co-constructed nature of the encounter and ongoing care of *'difficult patients'* were explored by Hodgson et al, who found that disparity of opinions, poor doctor-patient communication leading to *'dysfunctional relationships'*, and perceived mismanagement of symptoms were all factors within cases of frequent attending, which often resulted in a sense of mutual frustration and a lack of reciprocity (Hodgson et al., 2005).

Meanwhile, other studies have reported elsewhere on patients' views regarding difficulties in communicating with doctors, for example: Zickmund et al 2006 reporting on perceived conflict with their GPs, held by patients experiencing congestive heart failure, found a number of common complaints regarding sources of conflict, including: poor interpersonal skills of physicians; concern regarding perceived lack of medical competence of physicians; dissatisfaction in terms of ease with which they (the patients) could obtain medical information; non-tertiary care specific complaints regarding lack of competence of physicians; and specific problems arising as a result of the complex and confusing organizational structure of hospitals or clinics, namely the impact this had on doctor-to-doctor communication (Zickmund et al., 2006).

However nothing could be found within the academic literature regarding the formal conceptualisation of the *'heartsink doctor'* which, from the empirical findings of this study, seems just as likely a phenomenon. Having conducted a wider internet search, using the search engine *'Google'* rather than the search engines used to review the academic literature, the researcher found a handful of references to the 'heartsink doctor', including: a posting on the BMJ careers website, stating that "There are no heartsink patients, only heartsink doctors' as part of a 'dos and don'ts' list for 'Dealing with the 'heartsink' patient' (Coales, 2004). There have been some allusions to this idea on personal *'blogs'* and the phrase has already been coined by some *'disempowered patients'*: http://hypercryptical.blogspot.com/2011/01/heartsink-doctors-revisited.html and associated responses from a doctor on his own blog: http://drphilyerboots.wordpress.com/2011/02/17/heartsink-patients-and-heartsink-doctors-revisited/

However this definitely appears to be an area which merits further investigation and conceptual development.

9.5.3 The potentially disruptive effects of questions relating to the Quality Outcomes Framework (QOF)

One of the more striking findings with regards to the positive and negative impacts of *'familiarity'* and *'non-familiarity'* was the fact that a computer-generated question, emanating from the target-driven, quality outcomes framework (QOF) had the potential to be misinterpreted as a moral judgement and subsequently to detrimentally effect the rapport between doctor and patient during a consultation which had otherwise been quite successful.

Further reflections on the data produced by the study revealed some further negative feelings held by GPs with regards to QOF. The first mention on QOF in this study appears to be a short statement made by GP05 from case 2 (data from which was used in example 6.1, *the disempowered doctor*). Whilst reviewing the consultation recording the GP makes the following comment regarding the research process and the requested activity of tape-assisted recall:

"Mm very interesting...beats QOF!" (GP05)

Whilst this comment is very short and is not a specific consideration of the quality outcomes framework (QOF) it does suggest a certain distain on the part of the GP towards the application of QOF since he is suggesting that the research process of this study is more *'interesting'*.

However a much stronger example of negative feeling towards QOF can be gleaned from comments made by GP11, case 10 which was the case where the origin of the seemingly strangely placed smoking questions was revealed. Having been asked what had prompted the question regarding smoking the GP revealed that it had been generated by the computer rather than being related to the consultation and appears critical of the introduction of such unrelated questions within the consultation:

"yesterday there was also a question of smoking status that was on there so that triggers me to just ask so ***it comes out of the blue*** *it's completely unrelated to the consultation it is completely my agenda generated by the computer" (GP11)*

Furthermore, following a discussion regarding the reasons behind asking such questions the GP responds:

"Oh it's the QOF is the erm it's the GP contract...hhh...bane of our lives" (GP11)

Here the doctor appears openly critical of QOF and this supports the emerging idea that QOF is perhaps unpopular amongst GPs. Following the uncovering of this theme the researcher incorporated a line of questioning regarding QOF into the interview schedule designed to elicit further responses regarding the inclusion of QOF related questions.

Many of the remaining GPs in the study revealed that they had not incorporated any of the QOF questions into the consultations since the complexity of the consultation or level of distress of the patient had meant that it would not have been appropriate.

This finding regarding the perception amongst GPs that incorporating QOF related activity into the consultation is problematic and may even interfere with the application of their own practical wisdom and clinical judgment, or 'phronesis' (Hilton, 2008) resonates with the ideas presented by Dowrick et al 2009 regarding similar misgivings of GPs concerned with the application of standardised measures of severity of depression (Dowrick et al., 2009).

Furthermore, whilst Dowrick and colleagues found that patients who experienced QOF depression scales as part of the consultation process were generally positive and encouraged by them, the findings of this study demonstrate the potentially disruptive nature of QOF questions relating to health behaviours such as smoking. Here the difficulty has arisen due to the patient's lack of familiarity with the health care setting generally and thus the lack of knowledge with regards to computer generated questions. Thus it may be that the negative impact of the smoking related question is due to the embedded, almost covert nature of the question, rather than the open application of external health indicators, which may, it seems, have credence amongst patients (Dowrick et al., 2009).

9.5.4 GP saturation

Example 6.3, *behavioural epidemiology as cultural inevitability*, uncovered a community-specific phenomenon at one of the practices in that a whole traveller community had been integrated into the remit of the practice following its recent *'discovery'* by the local council whilst exploring sites for possible regeneration within the city (circa 2005). It seemed that the community had settled in a disused area of the city and had remained there, undiscovered, for almost 30 years, meaning that some of the current generation of young people had been born at the site.

The council took the decision that the community should be allowed to stay and began interventions to enable the community to access various facilities, one of which was healthcare. However in practical terms this had meant far more than simply an increased number of patients for the practice since there were so many specific health and social care challenges presented by this community, including high levels of illiteracy, cultural ideals around health, specific behavioural epidemiology and patterns of presenting.

All of this it seems had resulted in *'GP saturation'* with GPs feeling generally overwhelmed by the task of catering for this community. Consequently GPs felt increasingly disempowered in terms of their ability to intervene in a medically meaningful way and felt resigned on certain issues. In addition this may or may not have led, in this instance, to missed cues regarding psychosocial support.

As discussed earlier in the chapter, whilst this phenomenon may seem to share some characteristics with the established concepts of *'heart sink'* and *'burn out'* there are some important distinctions, namely that: in relation to the former, the GP is expressing feeling of resignation regarding external factors, rather than despair, anger and frustration at the patient in particular; in relation to the latter, the GP expresses high levels of empathy and interest in the context of the patient, which is diametrically opposed to the kind of 'depersonalisation of others' which is a key characteristic of 'burn out' (Kirwan & Armstrong, 1995).

9.5.5 A 'continuum of contested illness': a potential model to aid conceptualisation of the field

The literature review highlighted the need for a robust definition of Medically Unexplained Symptoms and an understanding of this in terms of the wider context of the field of contested illness. During the course of the research the idea of conceptualising the field as a continuum (with accompanying model to aid understanding) was considered and the idea appeared to have some merit when viewed in terms of the empirical findings of the study.

However to produce a sufficiently robust and nuanced model, and an appropriate level of development of this as a useful concept, would require a lengthy and detailed critique of the extensive literature on medical nosology and diagnostic classifications.

This task was therefore beyond the scope of this study but is a consideration for further development at a later time. Such conceptual development and model may prove useful to those working in the research field of contested illness and medically unexplained symptoms, particularly in terms of providing a shared point of reference for this complex illness category.

9.6 Strengths and limitations of the research process

9.6.1 The use of qualitative methods

As outlined in the research strategy section of this thesis, a qualitative approach can often reveal subtle nuances and provide explanations regarding observable phenomena which may otherwise appear puzzling or else be misunderstood or overlooked if studied using quantitative methods.

For instance in the first example of the study, *the accurately perceived non-pressure to prescribe*, if a quantitative approach had been applied this might have been categorised as *'pressure to prescribe'* (Britten, 1995), however the post-consultation interviews revealed that this was not how it was perceived by either of the participants during the encounter.

Many of the subsequent examples, including 5.2, *the three "okays"*, 5.3 *undoctorable grief*, and 5.4 *cylchdroi*, might also have gone unnoticed or else been considered puzzling or insignificant when in reality they are central to the outcome of the consultation and the ongoing health trajectories of the patients concerned.

Example 6.1, *the disempowered doctor*, and 6.3, *behavioural epidemiology as cultural inevitability*, may simply have been categorised according to the well documented phenomena of somatic responses by doctors who felt a 'pressure to prescribe' (Britten, 1995; Wileman et al., 2002) rather than a specific management strategy and a complex case of cultural competence and *'GP saturation'*.

Example 6.2, *the disempowered patient*, may also have gone virtually undetected or else have been recorded as *'slight dissatisfaction'*, had the methods of the study been confined, for example, to survey methods, since the patient seems reluctant, even within her interview, to openly criticise the doctor, despite clearly feeling quite strongly on the issue.

The innovative methodology constructed for this study maximised this qualitative potential for exploration since phenomena observed in the consultations could be explored with both parties separately in order to gain as full an understanding as possible of what they understood to be going on, or at least what they chose to present to the researcher as an explanation.

However on a practical level the method of recruitment of patients meant that, whilst many were willing to have their consultation recorded and for the data to be used in the study, some subsequently were often too busy or unwilling to have a post consultation interview within the required timeframe and thus of the 23 cases collected, 11 are full and the remaining 12 consist of the consultation and post-consultation GP interview only.

9.6.2 Tape-assisted recall (TAR)

The use of Tape-assisted recall (TAR) proved very useful, particularly in helping to shape the narrative of post-consultation interviews and for remaining focussed on the doctor-patient interaction rather than general health trajectory for patients and general commentary regarding the health care setting on the part of the GPs.

TAR was also of course useful in helping GPs to remember the patient in question (since they saw several in each session and several more prior to the interview) and in helping both participants to recall the detail of the consultation, including, for example, how they felt at specific points and why they may have said certain things.

As the research progressed however the full utility of the method became clear as it enabled the exploration of seemingly minor elements of the interaction, including the questions regarding smoking which revealed so much about how the patient in example 8.1 was feeling but not saying during the consultation in question.

The main weaknesses which can be highlighted in terms of the use of TAR are simply practical ones, including the fact that some people were not keen to hear a recording of their voices and the fact that listening to the recording inevitably could be quite time-consuming, depending on the length of the consultation in question.

Whilst time was not generally too much of an issue for patients, since they were usually quite happy to talk at length about their health and problems they had encountered in seeking diagnosis, GPs are increasingly busy health professionals, who have between 10 and 20 minutes allocated per consultation, thus asking them to record consultations with their patients, use a checklist to identify relevant patients for the study, and then to take part in an interview where they would listen to and comment upon an entire consultation, was asking for a fairly significant commitment.

In spite of this many GPs willingly took part, with some commenting that this was a familiar activity for them as it was a technique often used in their training. In addition, many of the GPs who took part commented that they had found it a useful exercise.

There were some instances where a GP would find more than one patient who met the criteria, with one GP finding four patients in one session. Where such instances occurred particular elements of the consultations were identified by the researcher for discussion and in some cases the recording extracts pertaining to these were cut using *'audacity'* software[17] in order to save time and facilitate the research process.

9.6.3 A notation system developed from the Jefferson system

The development and application of a notation system, based on those used in the field of conversation analysis, proved very useful in terms of identifying subtle cues and patterns of speech. For instance, in example 5.2, the *"three okays"*, the fact that there are three *"okays"* in a row is enough to attract attention, however the fact that the third *"okay"* is said in a noticeably quieter voice further indicates that there is perhaps something more afoot.

A more striking instance is apparent in example 6.1, *the disempowered doctor*, since the GP comments in his post-consultation interview on the way that the patient *"talks through your word all the time and doesn't even let you finish a sentence" (L100-104)*. The use of a notation system to transcribe the consultation clearly shows this overlapping speech to which the doctor is referring and further demonstrates the utility of triangulating between the data sources.

Example 6.4, *familiarity but disparity*, also highlights the utility of being able to record *how* things were said as well as *what* was said, with the consultation extract being characterised by short sentences, pauses and sighs and the opening line being uttered notably quieter than the proceeding speech.

One of the best examples in the study of the utility of the notation system is case 8, from which examples 7.1, *so sometimes it's nice not to be involved with the patient*, and 8.1, *he was like totally disgusted*, are drawn. Here the conflict during the consultation is as clear from the notation as it is from the words themselves with sections of speech emphasised by both participants, the frequent occurrence of overlapping speech and an instance in 7.1 (extract 5, line 400) where the patient raises her voice and says with emphasis *"WELL I HAVEN'T GOT A CLUE"* following a particularly persistent line of questioning from the GP. This is also a feature in example 8.1 when the same patient raises her voice and says with emphasis *"NOT-A-BIT"*. Whilst perhaps initially this might appear trivial, its significance is revealed when the patient comments on this extract during her post-consultation interview, revealing that she had, at this moment, been quite annoyed with the GP for what she perceived as his moral judgement of her as a smoker.

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[17] A free, open source software for recording and editing sounds (http://audacity.sourceforge.net/) often used by those recording and editing their own music

Finally, a full appreciation of example 8.3, *"I'm not stressed"*, can surely only be gained when consideration is given to the change in pitch of the patient's voice and the emphasis she repeatedly places on the word *"stressed"*. The use of a notation system here enables the reader to *'hear'* the discomfort and distain the patient exhibits at being potentially labelled as *"stressed"*.

The notation was quite time consuming and required the researcher to develop an understanding of this field of research, including the development of an abridged notation system appropriate for the study (Appendix 6) and an appreciation of how notation systems are applied and interpreted. Additionally, as discussed in the research strategy section of the thesis, the formatting of the notation system caused some compatibility issues with the data analysis package NVIVO. However, since the use of this package was subsequently deemed unhelpful and unnecessary for this project, this was not a significant problem – but would be worth bearing in mind for future work where the use of an analysis package may be useful.

Overall the notation system provided excellent insights, was an interesting aspect of the researcher's development and was a very useful and worthwhile aspect of the research strategy.

9.6.4 Recruitment and other practical considerations relating to fieldwork

On a practical level, recruitment for the study proved difficult at times. Access to practices had to be negotiated through practice managers, who were often very busy, and then the research was presented to the GPs of the practice and consent gained. Following this the researcher was required to organise to work with one GP at a time, for one *"session"*. The researcher would then recruit patients in the waiting area, an activity which varied in nature and degree of difficulty from practice to practice.

For example in some practices the patient list for each doctor was specified at the beginning of the session and patients booked in at reception, thus the reception staff were able to hand a leaflet to each patient which, as well as giving information to the patients, also served as an indicator to the researcher that the patients could potentially take part in the study.

In other practices however this system was complicated by automatic self check-in systems (using a touch screen) and others which were *'open access'* or included an online system for booking appointments which appeared to continue even whilst the surgery was in session. Subsequently the list from the beginning of the session often held little or no resemblance to the patients who were actually seen by the GP.

In such situations an improvised approach to recruitment was necessary, which included watching carefully at reception, where possible, to see which GP a patient was assigned to, and, in the case of surgeries operating a self check-in system, approaching all patients in the waiting room and asking them which doctor they were seeing.

Once recruited, patients signed consent forms and took one copy (from the 3-sheet carbon copy) through to the GP. This indicated to the GP that the patient had agreed to take part and the GP would record the consultation. This part of the research proved unproblematic since the recording devices were simple to use, small enough to be unobtrusive and produced good quality recordings.

This process meant that a maximum of 23 patients could be recruited on any given day, with the figure usually being closer to 8. Of these patients the researcher had to identify them during the very small window of opportunity afforded by the interim between them arriving, checking in and being called through to see the GP.

Of these patients who were approached and who agreed to take part, the number was reduced further by the three-part checklist administered by GPs (provided by the research team) to denote whether or not the patient was relevant to the study. Thus numerous visits to surgeries and numerous patients were recruited in order to elicit the resultant number of 23 cases.

Nevertheless, plenty of cases were recruited and so much data collected that not all cases have been included in the thesis due to lack of space; these cases will however be utilised in the formulation of future papers relating to the research. Whilst the recruitment process was somewhat arduous, the fact that the patients were recruited in the way that they were and thus spontaneous, uncontrived talk-in-action collected, adds a certain real quality to the findings.

Post-consultation interviews were organised with the GPs, with one taking place immediately following surgery, but with most being arranged within ten days of the consultation. These were often difficult to organise as GPs are generally very busy and the time frame was quite finite. However this, again, did not prove impossible and many GPs were willing to take part and help out with the research which they felt was making a valuable contribution to the field of enquiry regarding this problematic cohort and aspect of primary care medicine.

Post-consultation interviews with patients were obviously subject to similar constraints to those of the GPs but were generally easier to organise, provided the patients were able and willing to participate.

9.6.5 The role of the researcher

9.6.5.1 Professional status

An important reflection within any research employing qualitative methods is the knowledge, position and contribution of the researcher in shaping the narrative and direction of the study. Since the field of enquiry is that of health care and the setting for the study is the primary health care milieu, a possible criticism might be made of the fact that the researcher was not clinically trained. A clinical background might have afforded early recognition and greater understanding of certain issues and perhaps better communication with the health practitioners.

Contrary to this view however, in this study it would seem that certain themes may have been seen as common place or insignificant and thus remained unexplored if they had been observed by a clinician with inside knowledge and understanding of them, for example the integration of QOF questions during the consultation.

The very fact that the researcher was unfamiliar with the context from which these questions arose meant that they appeared odd and out of place and thus they were questioned; this led to some important discoveries within the data. The researcher's status as a '*non-GP*' could also be seen as having benefitted the interviews with GPs since no prior understanding of issues was assumed and therefore perceptions and phenomena where explained in detail, thus offering insight and also recordable vignettes with which to illustrate the findings.

Finally on this point, since the methodology involved an exploration of the consultation as a co-constructed event, and included interviews with both GPs and their patients, it may have been an advantage that the researcher was not perceived by the patients as a being a clinician and thus *'part of the system'*, which may have reduced frankness on their part, particularly in terms of criticising the delivery of health care in any way.

Furthermore the researcher's perceivable status as closer to being a *'patient'* than being a *'clinician'*, and also the researcher's personal circumstances as having herself experiencing MUS, may have elicited feelings of shared understanding, camaraderie and greater frankness on the part of some patients.

9.6.5.2 Personal reflections and 'conceptual baggage'

Conceptual baggage was a term used by Kirby and McKenna (1989) to refer to the process of recording initial personal assumptions, thoughts and ideas about the topic and the research process, and also ongoing reflections throughout the research process (Kirby & McKenna, 1989, pages 32, 102). Meanwhile in a later, revised edition of this text, Kirby, Greaves and Reid (2006) chose the term 'field notes' to refer to this process, noting that "field notes are for candid and overt reflection, for the demonstration of and accounting for existing biases, and for the ongoing reflection on content and analysis" (Kirby et al., 2005, page 68).

Existing biases might take the form of stereotypical assumptions, opinions and prejudices regarding a topic, which may perhaps have been formed as a result of previous research or reading of the subject area, or else relate to the influence of the theoretical framework upon knowledge production, or else reflect the personal biography of the researcher. In considering her own conceptual baggage, the researcher can offer the following reflections on the research process:

The first data source collected in each 'case' within the findings was the recording of the consultation, which was naturally-occurring speech. Whilst it could be argued that research participants, both practitioner and patient, may have been influenced to some extent by the knowledge that they were being recorded, the researcher herself did not have any influence over the course of the consultations. However the second and third data sources in each case, the separate interviews with participants, had the potential to be influenced by the researcher. During the course of the fieldwork therefore the researcher carefully reflected after each data collection exercise on how her own actions may have influenced and shaped the knowledge produced.

The first interview in the study (example 6.2 'The disempowered patient: "*It's rather...a bit destroying really*"' was unique in that the researcher had not listened to the recording prior to the interview with the GP since the interview took place immediately following the end of the GP's surgery. The interview was conducted by playing the recording from beginning to end, giving the GP freedom to comment wherever he felt appropriate and with scarce input or prompting from the researcher. The impact therefore of any 'conceptual baggage' on the part of the researcher was minimal in terms of shaping the narrative during this interview.

However the interview with the patient took place a few days later and the researcher had listened to the recording and formulated questions prior to the interview. At this point it is fair to say that the researcher had some reservations regarding the tape-assisted research method and was unsure of what kinds of questions to ask in relation to the recording; it was perhaps therefore the case that the researcher overcompensated by drawing too heavily on her own experiences as a patient with medically unexplained symptoms – at one point even talking across the interviewee whilst making certain points or relaying personal anecdotes regarding her own experiences.

In spite of this however, the interviewee made some unprompted revelations, particularly regarding her prior contact with the GP and how some of this interaction had left her feeling, for example: *"neglected"* and that the experience was *"a bit destroying really"*. This was not something which the researcher had foreseen, predicted or prompted, but was expressed freely by the patient and was mirrored by the GP in his interview when he expressed his own frustrations regarding prior contact with the patient.

Another pertinent example of the impact of 'conceptual baggage' during the fieldwork, this time in terms of the kinds of questions asked, can clearly be seen in the 6th case collected (example 5.1 The accurately perceived *'non-pressure to prescribe'*). In this example the researcher's efforts to read around the subject and to draw on this knowledge are the problem as they seemingly work against her – prejudicing her interpretation of the interaction.

The researcher had noted from her reading that some GPs attribute disproportionate prescriptions in this cohort, despite a lack of demonstrable physical pathology, to feeling a *'pressure to prescribe'* from the patients (Britten, 1995). Therefore, upon listening to the consultation recording in this case, the researcher picked up the point that the patient's opening line in the consultation appears to be a request for a prescription. This lead the researcher to ask questions which could be perceived as 'leading', particularly in the case of the patient: *"I was wondering was it actually specifically you were hoping he could give you something or maybe whether he could explore and find out"*. However in this case, since the answers given by both participants is so similar, and that they refute the idea of *'pressure to prescribe'*, it could be argued that the researcher's 'conceptual baggage' has been instrumental in illuminating this unexpected, shared perception on the part of the participants, which might otherwise have remained hidden.

Whilst the 'conceptual baggage' of the researcher undoubtedly had some impact on the production of knowledge from the empirical research, including the formation of questions, the researcher made every effort to reduce this as she became more experienced in conducting interviews – particularly after the revealing findings from the *'non-pressure to prescribe'* case.

By case 8, for example, the researcher had refined questioning to making observations such as: *"Okay the doctor asks er if you smoke at all...and you say you don't feel that you could give up at this moment"*. So by this case, rather than asking a direct question which the participant may have then felt obliged to answer (as in example 5.1 *'non-pressure to prescribe'*), the researcher is opening up the extract of naturally-occurring talk for discussion and allowing the participants to make their own decisions regarding the direction they wish to take the interview. In this case it led to the surprising discussion regarding the possibility that the GP was making a moral judgement of the patient as a smoker, and then to the further revelation, by a GP at the same surgery, that such questions were prompted by the computer and were actually standard questions relating to the quality outcomes framework rather than any agenda held by the GP.

In addition, viewing the pattern of questioning by the researcher over the course of the fieldwork reveals a shift towards open-ended questions, for example: *"what was in your mind when you said that/ they said that?"* This kind of questioning was initiated on the advice of the supervisors and seemed to work particularly well with the GPs within the study since they themselves were trained in this kind of questioning and were therefore comfortable in answering them.

Interpretation of the data and conclusion about the meaning of the findings was greatly aided by the triangulation between the two or three data sources collected as themes emerged from the naturally-occurring talk and were confirmed or refuted (as in case 5.1 *'non-pressure to prescribe'*) by the very participants who are being observed from data source one – the naturally-occurring speech.

9.6.5.3 The concept of rigour in qualitative research & situating the research within the general concepts of 'confirmability' & 'transferability'

As discussed in chapter 3 (pages 70-71) of the thesis, qualitative researchers are under constant pressure, particularly within the field of healthcare, to demonstrate that their research processes are 'scientifically rigorous' in a way which is comparable with that of research conducted within quantitative, experimental methods.

The researcher noted that measures of 'validity' and 'rigour' which apply criteria drawn from the quantitative, often positivistic, fields of enquiry, risk undermining the research process by placing too much emphasis on methods and checklists, rather than on the knowledge production itself. However, concepts and methods do exist for addressing 'rigour' in qualitative research, including the four 'parallel criteria' for addressing 'trustworthiness' and 'goodness/ quality' proposed by Guba and Lincoln in their seminal text: Fourth Generation Evaluation; the term 'parallel criteria was used because they were intended to "parallel the rigour criteria which have been used within the conventional paradigm for many years" (Guba & Lincoln, 1989, page 233) (with 'conventional' here referring to 'positivism').

Confirmability was conceptualised to parallel the conventional criterion of 'objectivity'. Both are concerned with assuring that "data, and interpretations of inquiries are rooted in contexts and persons apart from the evaluator" (researcher). However, whilst 'objectivity' seeks to achieve this through process-driven methods which are considered to be "divorced from the values, motives, biases, or political persuasions of the inquirer", 'confirmability' demonstrates integrity of the findings in the data themselves; data can be tracked to their sources and the logic used to assemble the interpretations is structurally coherent. Essentially, the data and the process can be inspected and confirmed by outside reviewers of the study (Guba & Lincoln, 1989, 242-243).

In this study, 'confirmability' was achieved throughout data collection by a constant dialogue between the researcher and the supervisors and also with colleagues and fellow research students at the data analysis sessions and departmental presentations. As quoted earlier in the thesis (pages 70-71), 'triangulating' in this manner adds rigour, breadth, complexity, richness, and depth to the enquiry (Flick 2002), particularly when the data is discussed with colleagues from other disciplinary backgrounds as this can provide new insights and interpretations (Ziebland & McPherson, 2006).

Through this process some of the preconceptions held by the researcher, which might otherwise have biased interpretation of the data, could be addressed and discussed. For example, since the researcher did not have a clinical background, it was often easier for her to identify with the perspective of the patient rather than the GP, particularly given that the researcher herself had medically unexplained symptoms and had experienced similar consulting patterns as the cohort in question. However one of the supervisors was a GP and the other a practicing Clinical Psychologist and therefore they were able to reflect on the recordings from a different perspective, helping the researcher to see that some of her responses to GP actions may in part be due to emotional responses on her part elicited by her identification with the patient.

Additionally, the postgraduate group at the University of Liverpool was drawn from the different departments within the faculty of medicine and thus a variety of practitioners attended the data analysis sessions and reflected on the transcripts bringing an insight in terms of policies, frameworks and training which shape the work of GPs in primary care, such as the behavioural health questions and reattribution – which the researcher may otherwise have interpreted as being confusing or even patronising.

Transferability corresponds to the idea of 'external validity' or 'generalisability' and is concerned with the degree to which the findings of qualitative research can be generalised or transferred to other contexts or settings. The main technique for establishing the degree of transferability is to produce a 'thick description', providing an extensive and careful description of the time, the place, the context, and cultural setting in which the findings were produced. Thus rather than providing 'confidence limits' of the study, the researcher provides as complete a data base as humanly possible in order to facilitate transferability judgements on the part of others who may wish to apply the study to their own situation (or situations in which they have an interest) (Guba & Lincoln, 1989, pages 241-242).

The findings of the thesis are presented as case studies, with a rich description of context given. The triangulation or 'crystallisation' between the talk-in-action of the consultation, together with the two tape-assisted, post-consultation interviews, helps to build a multi-dimensional perspective of the encounter, which is then analysed within 'case', and compared with other 'cases' within the study. Additionally, throughout the findings, discussion and conclusion of the thesis, due consideration is given to the utility and implications of the findings for clinical practice and research. The thesis therefore presents as complete a data base as possible, with the potential advantage of presenting a more holistic picture than that observed by either of the research participants (since it involves the perspective of both of them on their encounter).

Overall the study was successful in gaining appropriate numbers of participants and collecting sufficient data upon which to base satisfactorily new and original findings. The implications of these findings, in terms of future research, practice and policy development will be discussed in the final and concluding chapter of this thesis.

Chapter 10: Conclusions

10.1 Implications of conceptual and definitional developments

In chapter 9 conceptual developments relating to the current literature on 'familiarity', arising from the analysis of the empirical findings of the study, were discussed with reference to the model developed in part 1 of the thesis to aid understanding (figure 3, page 36), including: 'Familiarity' and 'non-familiarity' and potential positive and negative impact.

In addition, phenomena derived specifically from the findings of this study were developed and conceptualised, including: the concept of *cylchdroi* (figure 4, page 159); the disempowered patient and the heartsink doctor; the potentially disruptive effects of questions relating to the Quality Outcomes Framework (QOF); the concepts of *'GP saturation'*; and the idea of conceptualising the field of enquiry as a *'continuum of contested illness'* with accompanying model.

These findings have important implications for future research in this field, for primary healthcare policy and for practitioners working with this cohort of patients within the primary health care setting. This chapter will therefore explore these implications and propose areas which warrant further study.

Some reflections on the contributions of the study to methodological innovation, including the utility of 'bricolage' as a theoretical framework, will also be considered and some final study conclusions will close the chapter and the thesis.

10.1.1 *'Familiarity'* and *'non-familiarity'* and the observable positive and negative effects

The literature review highlighted the lack of precision of the concepts of *'sustained relationships'* and *'continuity of care'*, and identified the potential for a robust and nuanced definition of *'familiarity'* and a mirroring concept of *'non-familiarity'*. The conceptual development and accompanying model (figure 3, page 36) provided by this study will undoubtedly be useful to others interested in researching ideas relating to levels of prior knowledge and contact in the primary care setting, as well as the wider health care sphere and possibly beyond.

The main findings of the research, namely that there are positive and negative implications of both *'familiarity'* and *'non-familiarity'*, support the emerging idea in the literature that, contrary to long-held beliefs in this field, *'familiarity'* may not necessarily always be the best, nor even desired, situation within which to conduct primary care consultations, and that doctors and patients sometimes find *'non-familiarity'* just as useful and satisfying. This has potential in terms of widening the debate and providing a shared point of reference, where previously discussions were hampered by confusion caused by different kinds of *'familiarity'* being envisaged, described and alluded to using a plethora of terminology interchangeably.

These findings have implications for practice and policy in the primary care setting in terms of the automatic allocation of patients to certain doctors within practices, with an emphasis on seeing the same GP being prioritised rather than patient choice and, by extension, GP choice and professional judgement of what would be best for each situation.

Further research relating to this finding would be useful, particularly in terms of highlighting how policy development based on these findings might provide demonstrable improvement in terms of management and outcomes. Some key research questions on this topic might include: "Do GPs and patients value *'familiarity'* in primary care? Does this vary depending on factors such as: illness to which consultation pertains; issues regarding attachment style; particular demographic location and practice characteristics?

10.1.2 Medically unexplained symptoms

The literature review also highlighted the need for a robust definition of Medically Unexplained Symptoms and an understanding of this in terms of the wider context of the field of contested illness. This conceptualisation was thus explored with reference to the examples presented within the empirical findings. These explorations may prove useful to those working in the field of research relating to contested illness and medically unexplained symptoms, particularly in terms of providing a shared point of reference of this complex illness category.

Additionally these explorations may help to clarify the fact that a variety of factors underpin the social and clinical predicament of this cohort, and also help in the future to avoid the confusion, overlap and inappropriate assumptions which often characterise discussions, for example: that all Medically Unexplained Symptoms are psychosocial in origin, or that some or all labels and categorisations relating to this field are interchangeable.

This in turn has implications in terms of interpreting the related literature in this field, particularly with regards to epidemiological figures of prevalence and associated problems presented by Medically Unexplained Symptoms, for example: frequent attending and the burden on health care. For example: the integrity of prevalence rates which relate to a cohort of patients around which there is considerable imprecision in terms of definition; is the burden definitely unnecessary and based on frequent attending which is unnecessary, or might it be a valid pursuit of a diagnosis based on organic pathology which is eventually identified (as in example 7.1 *"so it's sometimes nice not to be involved with the patient"*); and is the frequent attending and lack of progress attributable to something other than the somatic focus and agenda of the patient, for example the *'cylchdroi'* pattern of presenting.

These findings also have practical application in terms of facilitating the management and treatment of patients considered to be presenting with Medically Unexplained Symptoms and associated policy development in this area.

10.1.3 Cylchdroi

This phenomenon was observed whilst specifically observing patients presenting with Medically Unexplained Symptoms, and indeed would appear to emanate from the inherent uncertainties which characterise the predicament of this cohort of patients.

However it is possible that the concept of *'cylchdroi'* may have wider applicability in the field of uncertain illness and also within the wider sphere of medically *explained* illness at the intersection where some uncertainty may exist regarding outcomes of certain tests, treatment or surgery, particularly where there is a degree of patient autonomy and choice regarding timing or style of treatment.

Additionally, since *'cylchdroi'* describes a specific behavioural phenomenon, it is not necessarily confined to the field of health care research and may find applicability in the broader framework of social science research with regards to uncertainty and behavioural patterns, for example: studies regarding reasons for procrastination and *'writers block'* in students. The applicability of the model is in the understanding of the complex behaviour patterns which otherwise seems counterintuitive.

For example, in terms of implications for practice, *'cylchdroi'* may prove to be a useful model to health professionals engaged in the management of illnesses of uncertainty with regards to the paradoxical nature of some decisions made by patients regarding health choices offered and/ or seeming reluctance to accept interventions which at face value represent the best chance for regained health.

Following on from this, *'cylchdroi'* has implications for policy development in health care since it highlights that the decision making process regarding interventions is inherently more complex than is often acknowledged and may be used to highlight specific training priorities for GPs in helping patients to rationalise their thought processes. In this setting it may be useful for all kinds of illnesses rather than being confined specifically to illnesses of uncertainty.

10.1.4 Disempowered patients and the 'heartsink doctor'

These concepts which mirror two of the more well-established concepts within the literature are virtually unexplored and have not been formally conceptualised within the academic literature. The idea that patients can also find enforced *'familiarity'* disempowering, to the point that they perceive some doctors as *'heartsink'* polarises the argument for the re-evaluation of primary care policy regarding the automatic assigning of patients to the same doctor where possible, without any other variables being taken into consideration.

There is significant scope for further development of these concepts and thus a demonstrable need for further research in this area. Possible research questions might include: To what extent are the feelings of the doctor mirrored by their 'heartsink patients'? Do patients and their practitioners both experience feelings of disempowerment and if so, who do they attribute this to? What are the difficulties at the heart of the *'difficult consultation'* and how might these be addressed from the perspective of both participants?

Given that the previous concepts of disempowered GPs and the 'heartsink patient' arose from studies which focussed primarily on the perspective of only one of the participants, it would seem sensible that a similar approach to the one taken in this study, that of observing the event and then consulting both participants individually and triangulating between resulting explanations, would make an excellent approach by which to address the questions posed regarding these concepts.

10.1.5 Quality Outcomes Framework

The findings relating to the negative perspective on QOF held by many GPs, together with the potential for misinterpretation on the part of the patient and thus disruption of the consultation, of course have implications in terms of the way in which such QOF questions are managed and introduced into a consultation.

However, these findings may also perhaps go further to suggest that questions which are not directly linked in some way to a patient's presentation, and which are not likely to be followed through beyond establishing what is needed in order to meet the target, for example: whether or not a patient smokes, are unhelpful and perhaps even inappropriate in this setting.

Interestingly, a comment by the GP in question, in relating to another case, further illustrate this fact since he refers to the *"Craft work"* involved in general practice, such as picking up on certain cues; the primary care encounter it seems is a highly sophisticated and complex interaction, made more so by finite time pressures, thus target-driven practices may be simply incompatible with the work of the GP. This again resonates with the feelings of GPs in the study by Dowrick et al on depression scales, in which it was suggested that *'phronesis'* may be compromised by the application of external health indicators (Dowrick et al., 2009).

The fact that the study findings on this matter support this emerging idea within the literature relating to QOF indicates that focussed, further research on this topic is warranted. Relevant research questions might include: To what extent are patients aware that certain questions asked during their primary care encounter are general health questions generated by the computer, rather than being specific to their health trajectory? Does the covert nature of some QOF-generated questions raise the potential for misunderstandings and conflict between practitioners and their patients? Do GPs find it difficult to incorporate QOF-related questions into the primary care encounter (and if so, what coping mechanisms have they developed to assist them in this task)? How are QOF-related questions presented during primary care encounters by GPs?

All of the questions above would benefit from the collection of some talk-in-action data, for example recordings of the consultation, so that the questions might be observed as they were actually presented. Interviews with one or both participants would then serve to further illuminate the perceptions of the participants involved. Alternatively, structured or semi-structured questionnaires may serve as a cheaper and less-time consuming means of data collection, although less detail would be garnered and would have limited utility amongst patients who may not be aware of the Quality Outcomes Framework.

10.1.6 GP Saturation

Very little has been written regarding the observed, specific travelling community at this site in the city, with just a few council reports making reference to them but in a perfunctory manner. Also, somewhat surprisingly, very little research appears to exist with regards to the health care needs of the traveller community generally.

It would seem therefore that the empirical research of this study has uncovered a pressing need for research in the area of traveller health generally and also in relation to this specific community, particularly with regards to the unique pressures faced by the practitioners engaged in providing their care.

It may be that the permanency of this particular traveller community provides the perfect opportunity for research in this area with the additional opportunity for studying such a community as it evolves and adapts to the changes in opportunity and environment (a new generation of young people at the site are beginning to see the benefits of education, with some 16 year olds observed by the researcher to be preparing for A-levels, whilst the older age bracket of 27+ being illiterate).

It is possible that an ethnographic study of this community would be beneficial if access could be negotiated, and certainly a small qualitative study involving the GPs at the practice, with a specific focus on traveller-care, would be likely to reveal some very useful and interesting insights applicable to the study of traveller-health more generally.

10.1.7 A 'continuum of contested illness'

The study of Medically Unexplained Symptoms and related phenomena within the field of contested illness is hampered by a lack of precision in definition and distinction (Peveler et al., 1997) which has resulted in differing labels being applied interchangeably.

Whilst attempts have been made in recent years to produce a satisfactory, categorical criteria drawing together some of the other, previous definitions, and to use these to produce information such as prevalence (Peveler et al., 1997), the problem of highly variable, overlapping definitions persists, resulting in highly variable, and perhaps questionable, prevalence rates (Swanson et al., 2010).

Additionally, many of the current definitions of MUS are highly problematic for a variety of reasons, including: the fact that most definitions assume an 'underlying illness behaviour problem' and/ or psychiatric disorder, which may not necessarily be the case; and the inclusion of complaints that might remain unexplained simply because they are self-limiting and benign (Swanson et al., 2010).

A recent article exploring the discursive construction of *'medically unexplained symptoms'* in the medical literature, highlighted a number of problems including: the paradoxical nature of creating a catch-all diagnostic category within which to place the unexplained, as well as the diagnostic status and subsequent ramifications of framing this group as having a shared problem which can be approached epidemiologically; and the different ways in which this terminology is applied (Jutel, 2010).

Whilst Swanson 2010 highlights the fact that an array of definitions and interpretations relating to these definitions are currently applied interchangeably in the field of research, their primary focus was on characterising physician' estimates of MUS prevalence rather than offering conceptual development regarding definition (Swanson et al., 2010). Meanwhile, Jutel's observations focussed solely on articles obtained using the intentionally explicit term *'medically unexplained symptoms'* in order to consider the linguistic configuration and use made of the term by authors, rather than associate it with alternate terminology such as: *'somatisation'* and *'functional somatic syndromes'* (Jutel, 2010).

Thus the problem of a fractured field 'dogged by terminological confusion' (Peveler et al., 1997) persists to this day, perhaps because each terminology has its own literature and it remains unclear where these literatures overlap and/ or connect to each other.

The development then of a model demonstrating how many of the conceptualised phenomena fit together would provide a shared terminology and understanding, and thus greatly aid coherence in this field of research. This in turn would have further ramifications in terms of the interpretation of epidemiological figures and other extrapolations which are currently made regarding this cohort of patients, for example prevalence ratings (Swanson et al., 2010).

It would seem then that further research is required in order to take this idea forward. Possible starting points for addressing the issue might involve: a structured framework for systematic reviews in each terminologically defined field of study, followed by a mapping exercise, possibly involving elements of meta-analysis techniques and exploration of discursive construction like the one offered by (Jutel, 2010)

10.2 Methodological innovation

10.2.1 Researcher-as-bricoleuse

As discussed in part 2 of the thesis an innovative methodology was designed specifically for this study and was primarily shaped by the nature of the questions it sought to address and the setting of the interaction it wished to observe, rather than by one specific school of thought or overriding epistemology.

However the concept of researcher as *'bricoleuse'* was drawn upon to guide the design and development of a theoretically informed framework. This proved to be a good choice, particularly in view of the fact that the conceptual development element of the research, in terms of *'familiarity'* and *'non-familiarity'* are similar in focus and scope to those in similar fields, such as the emerging field of acquaintanceship proposed by Morgan 2009, which also found *'bricolage'* to be a useful framework within which to frame conceptual development (Morgan, 2009).

Useful aspects of the *'bricolage'* approach included: the fact that it enabled the researcher to employ methodological strategies as they were needed in the unfolding context of the research situation, adopting an active rather than passive view of research methods to be utilised (Kincheloe & Berry, 2004); drawing on the whole of the research team's research expertise, rather than feeling the need to constrain aspects of the research process, such as analysis, so that it would fit nicely within a particular school of thought.

In terms of the researcher's development, drawing on *'bricolage'* approach has been rewarding and challenging, allowing for creativity and opportunity for knowledge gain, but in essence without the kind of 'how to guide' afforded by many other, neatly packaged perspectives. The adoption of this framework then, for the purposes of this empirically grounded research, represents some development in terms of 'bricolage' as an approach for qualitative research, and further contribution could be made through the production of reflexive journal articles based on the experiences of the researcher in the production of the thesis.

10.2.2 Specific methods

In terms of specific methods, the use of Tape-assisted recall, a method which originates from psychotherapy, to study phenomena within the primary care encounter, is relatively sparse, although there are a growing number of studies which appear to have recognised its utility and as a technique it is not dissimilar to that which has been used for many years by GPs as part of their training.

In this study it proved to be very useful and greatly facilitated the triangulation between the three data sources: consultation and separate, post-consultation interviews with each participant. Thus thematic analysis was possible, with the themes emerging from the data.

The use of a notation system, particularly for transcribing the consultation extracts, was found to be very useful (as noted in the previous chapter) and is definitely worthy of consideration in any future research conducted on this topic and the wider field of enquiry involving the primary care consultation.

10.3 Study conclusions

The field of enquiry surrounding contested illness and medically unexplained symptoms is marred by imprecision and overlapping terminology which leads to inappropriate concepts being used interchangeably. This study provides a discussion, illustrated by examples from the empirical data, of how Medically Unexplained Symptoms are currently defined by GPs in the field. This has the potential to aid clarity and understanding in this sphere. This problematisation of the cohort also has implications for the interpretation of any evidence relating to this field.

The concepts surrounding *'familiarity'* in healthcare also lacked definition thus this nuanced concept was developed and a mirroring concept of *'non-familiarity'* added. These concepts were then utilised to explore the positive and negative effects of knowledge and prior contact in health care and whilst some evidence was found which supported the dominant belief that *'familiarity'* is the most auspicious milieu within which to conduct the primary care encounter, contrary evidence was also uncovered which supports the growing body of evidence which suggests that familiarity can sometimes be detrimental.

In addition, the proposal of the concept of *'non-familiarity'*, with its own positive and negative effects, is a significant addition to the field of enquiry.

This study also advances models and concepts for understanding specific behaviour as well as mirroring concepts of *'the disempowered patient'* and *'the heartsink doctor'* to those already established in the academic literature (*'the disempowered doctor'* and the *'heartsink' patient*).

The increased medicalisation of patients who find themselves in the social and clinical predicament of living without a diagnosis has been attributed to the paradoxical phenomenon that increased medical advancement has led to a reduced ability within society for the tolerance of clinical uncertainties (Fox, 1980). Furthermore it has been argued that the very acts of trying to gain control of disorder through the proposal of classifications and categories serves to generate more disorder and chaos (Bauman, 1991). However perhaps conceptualising the field in its widest sense, as a continuum with room for fluidity of movement and the incorporation of new information is a helpful approach which enables the acceptance of *'uncertainty'*, *'ambivalence'* (Bauman, 1991) and *'embodied doubt'* (Shilling, 2003), which may be beneficial to management in the primary care setting.

Postmodern society is increasingly characterised by micromanagement and a target-driven, tick box approach, however whilst this produces measurable, demonstrable outcomes it is widely regarded as being restrictive and reducing creativity. Given the observably nuanced and highly creative *"craftwork"* of general practice, it is unsurprising that imposed target-driven policies such as the Quality Outcomes Framework appear highly problematic if not incompatible. To some extent this is also true of the long-standing belief in sustaining pairings between specific patients and GPs without any particular consideration given to other factors affecting the consultation – it is too reductive to be particularly helpful, especially given the changing nature of primary care surgeries, with a greater scope for choice within multiple-practitioner surgeries.

Finally, this thesis examined a particular aspect of GP work, relating to a particular cohort of patients. It has highlighted the complexities inherent in this setting and within the patient group in question and has proposed some ideas for making sense of the uncertainties in this field of enquiry. A new and original contribution is therefore demonstrable.

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Appendix 1: Ethical Approval (LREC)

NHS
Sefton Local Research Ethics Committee
1 Arthouse Square
61 - 69 Seel Street
Liverpool
L1 4AZ

Telephone: 0151 296 7537
Facsimile: 0151 296 7536

RB: 06/Q1501/92-2
(Please quote our reference in reply)

04 July 2006

Miss Sara Edwards
PhD Studentship
Liverpool University
Division of Primary Care
School of Population, Community & Behavioural Sciences
Whelan Building, Quadrangle
Brownlow Hill
Liverpool L69 3GB

Dear Miss Edwards

Full title of study: The impact of doctors' perceptions and emotional responses during consultations with patients who present medically unexplained symptoms in primary care.
REC.' reference number: 06/Q1501/92-2

The Research Ethics Committee reviewed the above application at the meeting held on 28 June 2006. Thank you for attending to discuss the study.

Ethical opinion

- The standard wording regarding indemnity should be in all participant information sheets. Please insert the following paragraph:

  'If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you.'

- Item 6 on the Consent form mentions storing records and transcripts for future research. This should be mentioned in the Participant Information Sheets.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, provided the above points are taken into consideration.

Ethical review of research sites

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA). There is no need to complete Part C of the application form or to inform

Local Research Ethics Committees (LRECs) about the research. The favourable opinion for the study applies to all sites involved in the research.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Application		15 May 2006
Investigator CV	1	15 May 2006
Protocol	1	15 May 2006
Summary/Synopsis	1	15 May 2006
Letter from Sponsor		25 April 2006
Participant Information Sheet: Focus Group	Final version to be submitted	15 May 2006
Participant Information Sheet: leaflet format	Final version to be submitted	15 May 2006
Participant Information Sheet: GP	Final version to be submitted	15 May 2006
Participant Information Sheet: Patients	Final version to be submitted	15 May 2006
Participant Consent Form: focus group		15 May 2006
Participant Consent Form: patient		15 May 2006
Participant Consent Form: GP	1	15 May 2006
Expression of interest form	1	15 May 2006
CV (Prof C Dowrick)		15 May 2006
Patient Topic Guide	1	15 May 2006
GP Topic guide	1	15 May 2006
C.V (Prof P Salmon)	1	15 May 2006

Research governance approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final research governance approval from the R&D Department for the relevant NHS care organisation.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/Q1501/92	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Peter Owen

Dr Peter Owen
Chair

Email: Rebecca.Beckwith@centralliverpoolpct.nhs.uk

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments
Standard approval conditions (SL-AC2J

Copy to:

University of Liverpool
Research and Business Services
The Foresight Centre
3 Brownlow Street
Liverpool L69 3GL

Appendix 2:

North Liverpool
Primary Care Trust

Research Governance
Liverpool & Sefton PCTs
Latham Court
Bridgemere Close
Liverpool
L7 0LS
Tel: 0151 285 4881
Fax: 0151 285 4889

e-mail: gabrielle.marr@northliverpoolpct.nhs.uk

Monday, 03 July 2006

Dear Sara

Re: The Impact of Doctors' Perceptions and Emotional Responses During Consultations with Patients who Present Medically Unexplained Symptoms in Primary Care

Subject to a final favourable ethical opinion of your research by the REC, I am pleased to inform you that your request to carry out the above research has been given management approval by the
Liverpool & Sefton PCTs Research Management and Governance Collaborative.

I should be grateful if you would forward me a copy of the formal REC approval letter for our records on receipt.

As a non NHS researcher you will require an honorary contract before you may start work on this project as discussed via our telephone conversation. A copy of your CRB clearance has been forwarded to the Human Resource Department, to request an honorary Contract. If you have any queries or delays in receiving your Honorary Contract please telephone Jo Crossland on 0151 300 8055.

The RM&G approval group felt it important that time commitments associated with the project are highlighted to the practices prior to agreeing to take part in the project.

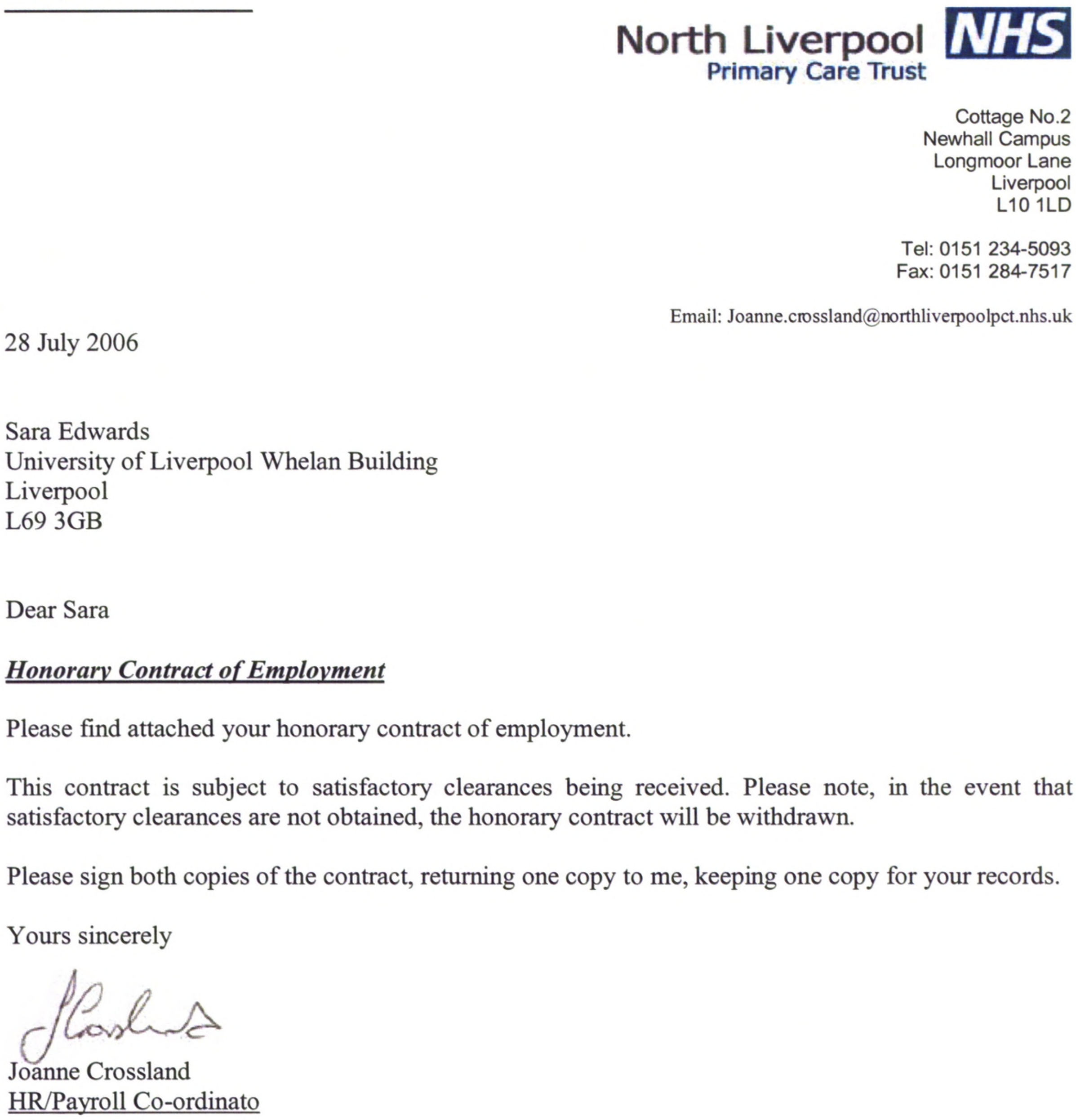
I should be grateful if you would sign and return the enclosed investigator's agreement prior to starting your research. If you have any queries regarding this please feel free to give me a call.

I look forward to receiving a copy of your final report.

Yours sincerely

Gabrielle Marr
On behalf of the
Liverpool & Sefton PCTs
Research Management &
Governance Collaborative
Encl (1)

Appendix 3:



North Liverpool NHS
Primary Care Trust

Cottage No.2
Newhall Campus
Longmoor Lane
Liverpool
L10 1LD

Tel: 0151 234-5093
Fax: 0151 284-7517

Email: Joanne.crossland@northliverpoolpct.nhs.uk

28 July 2006

Sara Edwards
University of Liverpool Whelan Building
Liverpool
L69 3GB

Dear Sara

Honorary Contract of Employment

Please find attached your honorary contract of employment.

This contract is subject to satisfactory clearances being received. Please note, in the event that satisfactory clearances are not obtained, the honorary contract will be withdrawn.

Please sign both copies of the contract, returning one copy to me, keeping one copy for your records.

Yours sincerely

Joanne Crossland
HR/Payroll Co-ordinato

Liverpool & Sefton PCTs

Research Management & Governance Collaborative

HONORARY CONTRACT OF EMPLOYMENT

Name:	**Sara Edwards**
Capacity:	To undertake agreed research at University of Liverpool
Date of Commencement:	July 2006
Name of Study:	The Impact of Doctors' Perceptions and Emotional Responses During Consultations with Patients who Present Medically Unexplained Symptoms in Primary Care

Your honorary appointment commences with effect from 03/07/2006 and will run until 01/03/2009. Extensions should be agreed with your Clinical Supervisor / Research Governance Steering Group. Should ethical approval for your research expire this honorary contract becomes invalid.

Your appointment is regarded as honorary.

Location:

Your place of work for the duration of this honorary appointment will be those locations where the business of the Trust is carried out.

Duties:

You will undertake such duties as outlined within your research project.
If this involves clinical or administrative duties connected with patient care you are granted access to the associated records. Please refer to the section on confidentiality.

Confidentiality:

You must be aware of your responsibilities under the Data Protection Act 1998 and only use such information for a registered purpose. This should not be disclosed to any unauthorised person.

You must not either during your employment or afterwards disclose to any unauthorised person information concerning the Trusts business, the patients in its care or the staff.

If, as an honorary contract holder you handle identifiable patient or staff related information stored on computers you must ensure that it remains on Trust owned computers and it is not transferred to computers owned by other organisations including those of your substantive employer without appropriate authorisation.

You should make yourself familiar with relevant Trust policies.

Hours of Work:

You are expected to work as many hours as are necessary for the full performance of your duties in agreement with your Clinical Supervisor/Substantive Employer.

Research Governance:

As an honorary employee you must comply with all reporting and monitoring systems as outlined in the Research Governance Framework (1) and agree to accept the responsibilities associated with your role that are outlined within it.

Intellectual Property:

You and University of Liverpool recognise the Trust's right to benefit from intellectual property arising from work undertaken under this honorary contract in accordance with the Health and Social Care Act 2001.

In circumstances where there is potential intellectual property you are required to notify the Trust's Research Management & Governance Steering Group. Specific intellectual property agreements will be negotiated on an individual case by case basis.

Salary:

As an honorary appointment, this post is unpaid.

Policies and Procedures:

You are required to observe the policies and procedures of the Liverpool & Sefton Primary Care Trusts in so far as they apply to this appointment and observe all NHS policies and procedures in respect of clinical and research activities.
You are responsible for familiarising yourself with the Trust's policies and procedures, copies are available from the Human Resources Department and on the Trust's intranet site. The Trust reserves the right to terminate this honorary contract where your conduct is inconsistent with the high standards of work and behaviour expected in your continued honorary placement with the Trust. Please be aware that the management of any disciplinary procedure will be the responsibility of your substantive employer, however this will be with the co-operation of the Trust. The Trust will be entitled to bring any cause for concern to the attention of your substantive employer at any time.

Fraud and Probity:

You should at no time act in a manner that places, or may place you in a position where your personal interests conflict with those of the Trust.

The Trust has in place a procedure for concerns about patient care or matters of business probity / conduct. (See Policies and Procedures above)

Pre-Employment Checks:

The Trust reserves the right to carry out certain pre-employment checks deemed appropriate e.g. Criminal Records, Medical Health, References, Work permit. This honorary contract will be subject to satisfactory completion of such checks.

NHS organisations are exempt from the provision of the Rehabilitation of Offenders Act 1974. Therefore if asked, you are not entitled to withhold information requested by the Trust about any previous convictions you may have even if under other circumstances they would have been regarded as `spent' under the Act.

Health and Safety:

You are required to follow all applicable rules and procedures relating to Health and Safety, and take all reasonable precautions to avoid accidents. A copy of the Trust's Health and Safety policy is available in the Human Resources Department and on the intranet.

In the event of sickness or unavoidable absence, you must notify the relevant person acting in a line manager capacity.

You must report any accident or injury however trivial, arising from or in the course of your duties to the Risk Manager in the PCT in which you are working, making appropriate records and statements as required.

You will need to arrange an identification card. Please contact Angela Trubshaw on 234-5095 to arrange an appointment, and take with you a copy of this contract as proof of a contractual relationship with the Trust. Until you have your own identification card it will be necessary to sign in as a visitor in each PCT building.

Liability:

Whilst undertaking officially sanctioned NHS duties, you are covered by the NHS indemnity against claims for negligence. In other circumstances, e.g. when providing services for which you receive a separate fee, or if undertaking research that has not received Trust approval, you are not covered by the indemnity. If you intend to treat priyate patients on Trust premises you must have a valid indemnity. Medical practitioners are advised to maintain membership of a medical defence organisation and submit a copy of current membership to the Human Resources Department.

Registration:
Professionals must be registered with a professional body for the tenure of this appointment. This honorary contract will be terminated should you cease to be registered with the appropriate body.

You should forward a copy of your current registration certificate to your Clinical Supervisor/Research Governance Support Manager.

If you agree to accept this Honorary Contract on the terms specified above, please sign the form of acceptance at the foot of this page and return it to Joanne Crossland, HR/Payroll Co-ordinator, Cottage 7, Newhall Campus, Fazakerley, Liverpool L10 1LD. A second copy of this letter is attached which you should also sign and keep for your own reference.

Signed:

Date: 2/8/06

On behalf of Research Management & Governance, Liverpool & Sefton PCTs

PLEASE DO NOT DETACH

Form of Acceptance

I have read and agreed to the above conditions and enclose a copy of my current professional registration certificate (if applicable).

Signed: Sara Edwards **Name:** SARA LOUISE ELLIOTT EDWARDS

Address: University of Liverpool, Division of Primary Care,
School of Population, Community & Behavioural Sciences,
Whelan Building (2nd floor) Brownlow Hill, Liverpool, L69 3GB

Date: 08|08|06

(1) Department of Health (2001) The Research Governance Framework for Health and Social Care

http://www.doh.gov.uk/research/rd3/nhsrandd/rghonorary contracts.htm

Appendix 4:

THE UNIVERSITY
of LIVERPOOL

I M Carter, BSc, PhD, CEng, MIEE,
MCMI
Director of Research

Research and Business Services

The Foresight Centre
3 Brownlow Street
Liverpool L69 3GL

Telephone: 0151 794 8723
Facsimile : 0151 794 8728
Email: i.carter@liv.ac.uk

Ref: SP000153

Faculty Ref: UOL000136

04th May 2006

Professor C Dowrick
School of Population, Community & Behavioural Sciences

Dear Professor Dowrick,

I am pleased to confirm that, the University will act as Sponsor under the DoH Research Governance Framework for Health and Social Care for your study entitled "The impact of doctors' perceptions and emotional responses during consultations with patients who present medically unexplained symptoms in primary care". In accepting this role the University expects you, as Principal Investigator, to conduct the project in full compliance with the requirements of the Framework so that it is able to meet its obligations as Sponsor.

Having consulted the insurance broker, I also confirm that the University professional indemnity and clinical trials insurances will apply to the project as appropriate. However, I would point out that the University does not provide cover for non- negligent harm and that this must be made clear to prospective participants in the work.

I trust that this statement will enable you to proceed with your application for ethics approval. Please let me know if I can be of any further assistance in this matter.

Yours sincerely,

Cc Head, School of Population. Community and Behavioural Sciences.
Mrs L Carter, Research Administrator, Faculty of Medicine Office

University Switchboard
Telephone: 0151 794 2000
Facsimile: 0151 708 6602

THE UNIVERSITY OF LIVERPOOL FACULTY OF MEDICINE

FACSIMILE TRANSMITTAL SHEET

TO: **Sara Edwards**	FROM: **SARAH FLETCHER**
COMPANY:	DATE: **24-May-06**
FAX NUMBER:	TOTAL NUMBER OF PAGES, INCLUDING COVER:
PHONE NUMBER	SENDER'S REFERENCE NUMBER:
RE:	YOUR REFERENCE NUMBER:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

Sara

Please find your approval letter attached

Best Wishes
Sarah

Appendix 5:

MERSEY PRIMARY CARE R & D CONSORTIUM
www.merseyprimarycare.org

University of Liverpool
Department of Primary Care
Whelan Building (2nd Floor)
Brownlow Hill
Liverpool L69 3GB
Tel: (0151) 794 4552
Fax: (0151) 794 5613

27 July 2006
Prof Chris Dowrick
Health of School of Population, Community and Behavioural Sciences
Whelan Building
University of Liverpool
L69 3GB

Dear Chris,

Re: Impact of doctor's perceptions and emotional responses during consultations with patients who present medically unexplained symptoms in primary care

I am pleased to inform you that the executive committee has agreed for practices within the Consortium to be approached to take part in this study. It is essential that the practices are aware of the time commitment that may be involved.

Sara has provided us with copies of ethical and RMG approval and I understand that the process of obtaining an honorary contract is underway. Depending on time lines, it may be necessary to follow up with the PCT as to when this may be issued.

With best wishes

Mark Gabbay MD FRCGP
Consortium Director

Appendix 6: Key to transcription symbols

Code	**Description**
[**[**	Indicates a point of overlap onset, whether at the start of an utterance or later.
] **]**	Indicates a point at which two overlapping utterances both end, where one ends while the other continues, or simultaneous moments in overlaps which continue.
(.)	An interval of a tenth of a second or less in the stream of talk
(0.2)	Timed pause represented in seconds
WORD	Loud speech relative to the surrounding speech
°Word°	Passage of talk which is quieter or softer than the surrounding speech
( )	Indicates transcriber's inability to hear what was said
(Word)	Probable hearing of unclear speech
((Word))	Transcriber's description of event's rather than actual transcription, for example: ((telephone rings)), ((sniffs)), ((coughs)) etc.
Word	Partial or full underlining indicates emphasis
?	Rising intonation (not necessarily a question)
!	Animated tone (not necessarily an exclamation)
:	Prolonged or stretch of the sound just preceding them (the more colons the longer the stretching).
.	Indicates a falling, or final, intonation contour (not necessarily the end of a sentence)
↑↓	Sharper rises or falls of pitch than would be indicated by combinations of colons and underlining. Arrows appear immediately *prior* to rise or fall.
Hhh	Discernable aspiration or laughter (the more hs the longer the aspiration/ laughter)
(Ha(h)ppy	If aspiration/ laughter occurs inside the boundaries of a word, it may be enclosed in parentheses in order to set it apart from the sounds of the word
"Word"	Reported conversations/ quotations
…	Speech trailing off or beginning, depending on if it's in front or behind
> <	Indicates compressed or rushed speech between the symbols
< >	Indicates a stretch of talk that is markedly slowed down or drawn out