

Report:

When doctors and patients talk: making sense of the consultation

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Identify Innovate Demonstrate Encourage

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This project and report was originally commissioned in 2009 by the Health Foundation in order to develop its thinking and understanding of the topic. In 2012, the Health Foundation edited the report for publication to allow wider use and discussion of its findings.

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Health Foundation commentary

The Health Foundation commissioned this work to explore the complex issues around the clinician–patient interaction – and suggest ways that it could be improved. The research has informed our work and we hope it will provide stimulus for others.

We believe that people taking an active role in their care is not a choice they can enact alone. Rather, it is a factor and consequence of the dynamic created by the way care is provided. For people to be more active in their care, we need clinicians, managers, services and systems that invite and enable this active role.

Increasingly, as our improvement programmes support people to take an active role in their care – whether managing a long term condition or making decisions about treatment choices – we are finding that, to bring about change, we need a deeper understanding of the nature of the relationship between clinicians and patients. The analysis in this report speaks directly to this issue.

The research – bringing together insights from two quite distinct disciplines, complex adaptive social systems and discourse analysis – makes the very simple point that it is the relationship between doctors and patients that is at the heart of our health system. If we want a different health system, we need a different type of relationship.

The authors describe a dynamic that, whether or not it was fit for a bygone age, does not meet the needs of a health system in an economically developed, politically democratic, technologically sophisticated country. Partly due to the success of medical intervention, the hospital has become a place for the very ill and the community has become a place in which people live with long-term conditions.

Recognising that we are stuck in relationships that do not meet current needs and which disadvantage patient and doctor alike is not easy. As the authors say:

‘In the early stages of transformation the dominant powers and logic of any system may not even see the problems or recognise them as significant. Often even those who are disadvantaged by the clinician–patient dynamic do not recognise it.’

The report offers a powerful analysis of the current relationship – from recognition of the mutual fears that drive doctors and patients, to the invisible structures that are natural to the doctor but hidden from the patient – and describes a more nuanced model for the consultation.

The authors' observations on the fragmented nature of conversations, point-in-time encounters in which the patient is the only person to join up the narrative, give another angle on the current relationship between patient and service – specific encounters with the health service may be only one in a series; encounters which themselves are brief touching points on the journey of the patient's life.

This report sits alongside other work by the Health Foundation, and by others, exploring the challenges and opportunities of building new relationships between people and health services. Our improvement programmes – such as Co-creating Health, Year of Care, MAGIC, Closing the Gap through Changing Relationships and Shine (see www.health.org.uk/programmes) – address many of the recommendations for quality interventions set out in this report and are helping us understand these challenges and opportunities in practice. Our recent evidence reviews, *Helping people help themselves* and *Helping people share decision making*, provide insights into what works in changing relationships, as well as highlighting the gaps in our knowledge.

Taken together this body of work reveals that what often gets in the way of patients taking a more active role in their healthcare are the beliefs that each party holds about themselves – and about each other – and how these beliefs become reflected in patient, clinical and managerial behaviours.

The Health Foundation is therefore doing more work to get under the skin of these beliefs. There is little open exploration of the current relationships between doctors and patients and their implications. The Health Foundation is seeking to address this gap, initially by creating opportunities for doctors to explore these issues. We are publishing this report now as we think it makes an important contribution to these conversations. It would be too easy to focus on the technical and more tangible solutions, important as they may be, and shy away from the challenges of transforming the philosophies, cultures and behaviours of the NHS.

As well as supporting conversations for change amongst doctors, we are also standing back and asking what philosophies may provide alternatives to the current dominant approaches, helping us frame the relationship around people's capabilities and in the context of their relationships outside of the health encounter.

We hope this report will provide valuable insights and provoke fresh thinking. The analysis it offers, along with the wider evidence from our related work, emphasises the need to encourage a different type of consultation and relationship between doctors and patients. For this to be possible, we believe that:

- educators need to keep improving the curriculum, moving beyond communications skills training
- professional bodies must provide leadership and set standards
- policy makers and regulators should encourage new practices and send out the right signals
- commissioners and providers need to embed programmes that support people to improve their health literacy and develop the confidence and skills to be more actively involved in their care
- boards and other leaders have to help create contexts that support new ways of working
- individual clinicians and patients need to experiment with new behaviours and reflect on how they can best contribute.

This is a radical agenda, about changing deep-rooted ways of being. However, we believe it can be taken forward, incrementally, by people reflecting and challenging how things are usually done.

Adrian Sieff
Assistant Director
The Health Foundation

Chapter 1

Introduction

Some familiar scenarios

The patient

I'm sitting in my GP's waiting room, feeling a little anxious, aware of all the other people around me. Eventually I go in... I tell him about the first reason I've come. The doctor asks me questions which I try to answer, though I feel a bit tongue-tied. I'm quite a confident person at work and home but strangely, in front of my doctor I don't feel able to speak. He listens and types things on his computer. I'm just getting to the point where I'm going to mention the thing that's really been bothering me, that other thing which is a bit harder to talk about, when he's writing a prescription and clearly my time is up. I leave with no intention of filling the prescription and I think maybe the other thing isn't anything to worry about anyway. Or perhaps I'll try one of the other doctors next time.

The hospital doctor

I'm an acute care doctor in clinic... yet another busy clinic. The next patient comes in, clearly upset and angry. It turns out he's been waiting for more than two hours after his appointment time and is worried about losing his job if he's late back to work again. I know they book multiple patients at the same time, but what can I do about that? Anyway, I feel sorry for the guy but really don't have time to deal with all this; I've got to deal with the clinical issues in front of me. His notes have gone missing too so I have to take a full history again. The patient seems sullen and uncooperative and I think he's unlikely to comply with what I'm telling him he needs to do.

The nurse

I'm a nurse in a day surgery unit. In the morning the patient will be there and the doctor's saying 'Okay you're coming in today for your surgery, you're having your GA, we're going to be doing this, we're going to be doing this, we're going to repair your hernia' and all this sort of thing and the patient's going, 'yeah, right' and they sign their consent form. And he'll say, 'Any questions you want to ask me, anything about the surgery?', and nine times out of 10 they will say 'no'. In the doctor's head he's saying, 'Everything's going fine, I've had my consultation with the patient, I've got my consent form signed' and he's all happy.

Now what's going on in the patient's head is this: 'What's a GA? What am I having done? When can I go back to work? When can I do this, when can I do that? I haven't got a clue ... when will I have my next appointment?' As soon as the doctor leaves and goes away, you're left with a patient, as a nurse, to pick up the pieces a bit and they start asking you questions. But it's okay, you can come in afterwards and explain it to them in simple language and maybe give the patient time to digest. You don't have to give them everything at that point; you can come back to them. When you're doing something for them, that's often when you can say, 'are you feeling okay about everything?'

Are you surprised?

The vignettes in the box above should be recognisable from everyday life. They are real stories told to us during this research, but they are not extreme cases, although we do have some extreme versions within the project data.

They are here because we want to ground our themes and conclusions in recognisable scenarios which are unlikely to surprise many readers; these are the kinds of familiar situations and experiences within UK healthcare which the analysis aims to unpack.

These should be familiar kinds of situations with nothing outrageous or surprising about them. Except – as one of our workshop participants pointed out – perhaps these things should be surprising, and maybe they should outrage us:

‘I think there’s a risk of being complicit in these systems, being complacent about not being able to change them and therefore all becoming victims, whether we’re the patient or the manager or the clinician, we are a victim of the system which exists. And the question for me is, I just wonder about if we each had a very strong sense of surprise each time we came across this and a sense of outrage, whether that would impact upon our drive, and sense of responsibility, and sense of empowerment to be able to affect what’s around us.’

So one of the things we want to do in this report is to make the familiar strange and perhaps unacceptable, setting what we all see and experience every day in the UK health service in the context of our five themes.

‘You do not understand what you see, you see what you understand’

It is worth reminding ourselves that similarly to the quality agenda (or sexism/racism agenda), in the early stages of transformation the dominant powers and logic of any system may not even see the problems or recognise them as significant. Often even those who are disadvantaged by the clinician–patient dynamic do not recognise it.

We would expect a mix of resistance to and underestimation of the significance of the problem and the possibility of change. Others may say they are already working to make things better. This may be true, but we saw very little evidence of it in our (limited) observations or the literature.

While there is rich learning to be had from leading-edge practice in the NHS, as with those claiming to do ‘quality improvement’, it is important to look quite closely for evidence to support their claims.

We believe the current dynamic no longer serves either clinicians or patients well, and the degree to which it has shaped the way the NHS operates is to everyone’s disadvantage.

Study outline

This work is best described as research-based consulting. As such it involved data collection and analysis but also drew on the collective experience and interpretative ability of ourselves, Fischer Associates, as consultants and of the Health Foundation as experts in this field.

The approach we took was qualitative, eclectic and pragmatic; thus the work was systematic and based in data but was also interpretative, drawing on two distinct theoretical frameworks and on the experience of the authors.

We carried out some initial expert interviews with people deeply informed on the issues around the clinician–patient interaction, and carried out a scan of literature in this area (see appendix 2 for details of this literature scan). These informed our design and approach to a series of workshops with patients, doctors, nurses and allied health professionals. Sometimes we ran groups containing a mix of patients and health professionals, sometimes we kept them separate; some workshops were multi-disciplinary; some had only doctors participating. Some were segmented by age, for example including patients and clinicians all aged under 35. Extracts from these interviews and workshops are included throughout this report. See appendix 1 for full details of the composition of the workshops.

We filtered this data – and the Health Foundation’s own reframing of the issue – through a set of frameworks based on two different but complementary theoretical backgrounds: complex adaptive social systems and discourse analysis. Both these theoretical approaches operate at macro and micro level, connecting the two and seeing a reflection of large structures in small details – of organisations, conversations and relationships. We used our theories eclectically and pragmatically because our major objective – the core of the brief we took – was to create fresh perspectives on familiar issues and scenarios.

Our initial analysis was then informed and refined by a series of informal workshops with experts in the area of change at both individual and organisational level, and by a group of policy experts drawn from across the system. We are very grateful to all those who helped us at any point in this process.

Key findings

This report covers five major themes that emerged from this work:

- making sense of ‘the consultation’ (Chapter 2)
- fear as driver of the dynamic (Chapter 3)
- invisible structures (Chapter 4)
- fragmented conversations (Chapter 5)
- system dynamics (Chapter 6).

What we mean by themes are ways of thinking differently about the patient–clinician relationship, which might lead to different thinking about how to act. The work is focused on thinking differently in order to improve healthcare quality. We aim to improve quality through two streams: through better individual interactions (which we might expect to increase efficiency and effectiveness and ensure a better patient experience) and through taking a systems perspective on quality (changing underlying core elements that, through repeated and emergent interactions across the system over time, will create better quality across the whole).

It is important to note, too, that we are talking about implications across many quality domains. We are not just talking about improving patient centredness, but about ensuring better quality overall.

We finish the report, in Chapter 7, by suggesting possibilities of what future quality improvement interventions might look like following consideration of these themes.

Chapter 2

Making sense of 'the consultation'

We began this project trying to talk to people not about 'consultations' but about 'interactions' and 'conversations' between clinicians and patients. However, over the course of the work we gravitated back to the notion of the consultation – specifically the doctor–patient consultation – as the defining interactive form. Later we will discuss in more detail why this was so. But for now, we want to question the usefulness of current ideas around the consultation and suggest that to radically improve quality we need a more complex model.

What is 'the consultation'?

It was evident from this work that although the consultation is a single category, in practice it carries multiple purposes and multiple meanings. It can be and is organised around multiple different driving principles, or unstated notions of what those involved think they are doing. What we do and what it means to us changes according to our higher purpose or identity. In wiping a toddler's face are you (as an au pair) delivering a task, (as a nursery nurse) engaging in your professional practice or (as a parent) engaged in the huge and complex undertaking called parenting?

We suggest doctor–patient consultations will look, mean and feel differently according to their organising principle or 'higher' purpose. They might be (and often are), for example, organised around the achievement of a diagnosis, a transaction involving the transfer of knowledge (symptoms given to doctor by patient; diagnosis given to patient by doctor). Another kind of consultation organises around the development of a complex shared understanding: the creation of

new knowledge for both participants, unique to that patient; doctor and patient exploring together what it means for that person individually in their life to have diabetes, and to live with diabetes. There are many other kinds of identities or organising principles that might be reflected in a consultation: in practice it can be a site of the exertion of power; it can be a legitimising and validating ritual for both patient and doctor – and so on.

The important thing is that, in our observation, the methods and resources available to clinicians to vary the consultation are not as complex as the potential variation in the consultation itself. It was noticeable how many clinicians used binary oppositions to categorise patients along simple lines:

'But also it depends on the patient's expectations; some people want all the information and some people don't, so you have to tailor that to each person.'

(Workshop 7)

'People come in to see me; I ask them what's wrong. Some people want to talk and some people don't.'

(Workshop 7)

'I think as a clinician we feel how our patients are with us; if someone is talkative and very open, I am very open back, if someone is very reserved, I'm reserved back so I do feed off my patients and how they are with me.'

(Workshop 7)

Most of the change of clinician style that we were told about involves a change of timing or ‘depth,’ flexing around essentially the same model (take history, apply diagnostic algorithms, deliver diagnosis and so on). Clinicians say they vary how long they spend at a particular stage – the history stage or the intervention stage – and how deep they go. And certainly they reported themselves as varying in interactive terms, being chattier or not according to how sociable or socially close the patient is. Patients only reported variations in sociability. It seemed to us, though, that clinicians do not have a very broad range of approaches available to them in order to develop a range of consulting styles that would be truly fit for multiple purposes.

A new consultation model

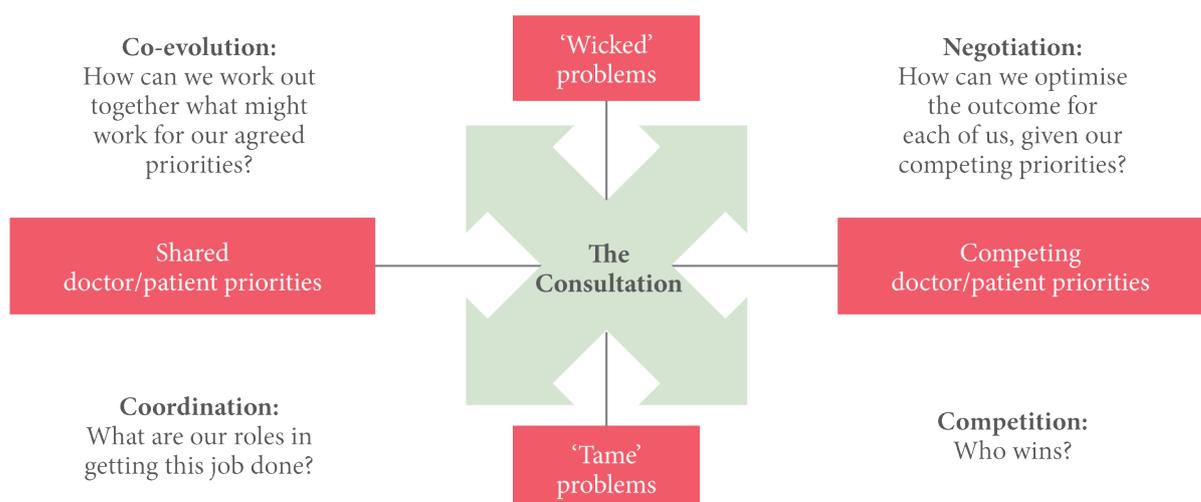
We suggest therefore that we need a more complex model; the consultation seems inadequate as a category, given the complexity and variety of possible medical problems and the existence of genuinely different priorities across clinicians and patients. Our work here suggests two candidate dimensions around which to begin to develop a more complex model (Figure 1).

The first dimension is that of priorities – specifically how far priorities are shared or not shared between the doctor and the patient. We know that in many cases doctors and patients share priorities: it is clear to both what the desired outcomes are and they agree how to prioritise those outcomes. In other situations it is less clear: the medical priority might suggest one course of action but the patient has a whole set of other priorities with which that medical one needs to fit or compete.

Our second candidate dimension concerns the difference between ‘tame’ versus ‘wicked’ problems.

A tame problem is one which is definable and solvable, and where environmental factors and parameters are static. It could be a very complicated problem but it is tame. Building the Channel Tunnel was a tame problem: clearly it was not an easy problem but the task was definable and solvable, given the right technology. The environment (physical in this case) was stable, the definition of success was shared and measurable (tunnels started in France and England meet), and the methodology (tunnelling machines to make a hole, concrete to line it) was known and deliverable. Some medical problems will fit into this category.

Figure 1: Hypothesis – we need a more complex model of ‘the consultation’



Adapted from: Pratt J, Plamping D and Gordon P. *Partnership: Fit for Purpose*. Kings Fund, 1998.

A wicked problem is one where there are multiple and often competing definitions of the problem itself and where any solutions are likely to have unknowable and possibly unintended consequences. Bringing up a child is an example of a wicked problem: for many of the decisions a parent makes, they have no idea what the consequences will be. And a parent simply interacting with a child changes the environment. There will be multiple (competing) definitions of success which will change over time. Many medical problems will fit into this category.

These two dimensions suggest four possible 'principles' around which a consultation might be organised, and therefore (at least) four ways we might think about what work must be done by the consultation and what tasks need to be accomplished within it.

- '**Competition**' occurs where we have tame problems but competing priorities, for example where a patient enters the consultation determined to leave with an antibiotic for a viral infection. The task – frustrating for both – is somehow to decide who will 'win'. Or the doctor's task in this case is perhaps to work on aligning the patient's priorities with their own, so turning it into a 'coordination' task. (Note the implications this has for definitions of and operationalising 'patient centredness'.)

'There's no point in you saying, "well here's what I think is important" because they'll go back to their real life and deal with what they think is important.'

(Workshop 19)

- Where again the medical issue is tame but this time the patient and the doctor have shared priorities, the consultation might most usefully focus on how they will together get the job done and what role they will each take. We might call this consulting purpose or organising principle '**coordination**'.
- A rather different kind of conversation would be needed – perhaps we would call this '**negotiation**' – where the patient's issue is a wicked problem and where they and the doctor have different priorities, but both sides recognise the other has something to offer. The work of

the consultation would be to figure out how everyone gets the best possible result in their own terms, given that one party's preferred outcome alone is neither possible nor desirable.

'I've just thought sometimes [doctors have] lost touch with reality. I had a holiday and I came back and I was unwell – I'd just had two and a half weeks off work and then I was unwell. I went to the doctor's and they said "take more time off", I thought "I've just had two and a half weeks off, I don't care what's wrong with me, I've got to get back to work" [...] He wanted to write me a note. [I said] "No I can't have more time off work" and he was very much, "you should take it" and was very flippant about it, like my job didn't matter.'

(Workshop 11)

'Yeah, they're like "go for a blood test", no problem, "go for an x-ray", no problem. You do have other things going on ...'

(Workshop 11)

- Finally, where doctor and patient have the same priorities but the problem itself is new, novel, shifting, or difficult to grapple with – very wicked – the task of consultation would be joint exploration and '**co-evolution**' of a course of action – how together the patient and doctor might work out what best to do.

Implications for healthcare quality

The consultation therefore needs to expand as a construct to accommodate the complexities we know are involved in delivering healthcare today. Looking at a number of 'quality domains', some implications for quality in healthcare are suggested immediately.

- **Efficiency:** doctor time might be used to better effect if it is clearer to both doctor and patient what kind of conversation is needed, what they are together trying to achieve.
- **Effectiveness:** reframing the consultation as focused on behaviour, not the application of expertise, focuses attention on practical achievement of better health outcomes.

- **Patient-centredness:** a more sophisticated model of the consultation is more likely to genuinely reflect patient **and** clinician priorities in different circumstances. Sometimes this might mean the doctor providing something different from what they thought the patient wanted:

‘I’m very frequently surprised by how easy it is to reassure people sometimes, there are some people who just need a bit of time, a good explanation and not even lots of tests. I kind of always feel happier if people have had tests but actually sometimes patients don’t want tests, they just want to see someone who’s got time to talk to them and explain what their symptoms are and say, “you know what, I actually don’t think that there’s anything seriously wrong here” [...] I feel like doctors or the type of medicine I practise is with medications and with tests and actually it’s often a surprise to find out that you can be the therapeutic intervention and that a lot of people are very satisfied with a good explanation and time.’

(Workshop 15)

Doctors are different

We noted earlier that we reverted (having begun with the intention of looking at clinicians as a broad category) to the notion of the doctor–patient consultation as the defining dynamic form. It is as though all of us – doctors, other clinicians, patients, managers and others – collude in upholding a clear ‘ring’ round doctoring. Doctors are just different.

Linguistic socialisation

So, what do we mean by the practical and symbolic function of the doctor–patient consultation? Many linguistic forms reflect the distinct discourse of medicine; the distinct separation of the language of medicine from the language of everyday life. This parallels the separation of the thinking, concepts and logical structures of medicine from those of the lay world. As in all professions, induction into that language is an important part of the socialisation and training process for doctors. While much of this involves technical discourse, linguistic

socialisation extends beyond technical terms into learning specific tribal uses of otherwise everyday terms – marking the inner circle of a discourse community. For example, doctors tend to use the terms ‘sick’ or ‘poorly’ to refer to those patients who are critically ill – not, as in everyday life, to those who are just a little bit ill:

‘I think patients do like to be unwell when they’re in hospital whereas our patients are not poorly and trying to get that across to them is very difficult. You’re not poorly after one of our [orthopaedic] operations, you can eat and drink, you can shave yourself [...] if you’re [critically ill] on a hospital bed you put your hand up in the air and go “right, look after me”. Whereas our patients are not like that, we don’t provide that level, they’re not poorly.’

(Workshop 16)

‘Each patient, they think they are the most important – well every patient is very important to us but sometimes you have to prioritise a very sick patient, you need to go yourself and see them, [...] but sometimes [the outpatient] won’t appreciate that and they think you have abandoned them and that makes it very awkward to restart [the consultation] with that patient again. But it’s out of our hands when you get distracted by someone poorly.’

(Workshop 15)

Formalised interactions

Thinking specifically about interaction, doctors’ interactions with patients are embedded in quite formalised events, terms and practices. We heard people talking about certain kinds of interactions as if they were capitalised: ‘The Consultation’, ‘The Round’, ‘The Assessment’ and so on. Interaction within doctoring is typically bounded in space and time – in contrast with nursing where interaction is much more fluid. As the nurse in our vignette said, ‘We can go backwards and forwards, we can talk to them while we’re doing things.’ Doctors’ interactions tend to be codified and named (as in the list above). There are subcategories too: ‘Taking the History’, ‘Giving the Diagnosis’, and so on.

‘Listen to the story first. Listen to their story, then take the history. (Q: And the difference is?) Their agenda, why they’re there. Why they think they’re here, and it might not be what the GP sent them in for.’
 (Workshop 3)

These interactive activities are named and have a certain status as key events and rituals – interestingly they seem to have been joined more recently by similar subcategories related to patient centredness: ‘achieving a shared understanding’, ‘incorporating the patient’s illness framework’ and so on (Calgary-Cambridge Framework).

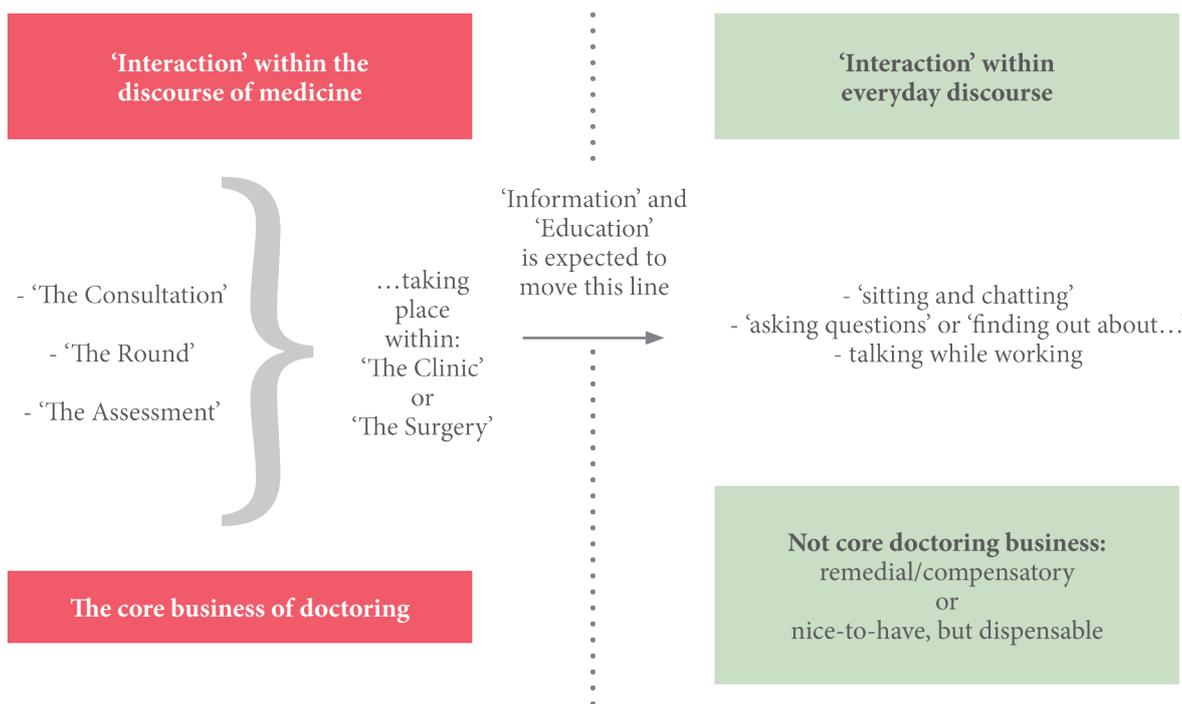
But there is a challenge: the consultation plays a crucial symbolic role.

In contrast, patients live and express their problems in a different kind of discourse, an everyday or lay discourse. Interaction in nursing is framed in terms much closer to that of the everyday world and this is arguably a more appropriate discourse within which to think and talk about many patient problems.

‘A doctor will come in and say, “okay, you’ve broken your hip, we’ll give you a hip replacement” blah, blah, blah and then walk out, whereas with [nurse’s name], she’ll actually have the time to sit down because the woman’s frightened, “oh my God, will it go wrong, will I get MRSA, will I get all this?”, whereas while you’re doing that dressing, while you’re doing blood or something, you can actually say, “well you know, I know you’re really scared, but my nan had it and she was fine and she’s going salsa dancing” or whatever.’
 (Workshop 19)

A lot of the work of nursing as we know it operates in that way – it is very effective but also of lower status within the medical hierarchy. We noticed in our workshops, for example, how doctors would tend to dismiss informal interaction as ‘just’ something: ‘just sitting and chatting’, ‘I haven’t got time to just sit and chat’, ‘all the nurses do that chatting stuff’.

Figure 2: Different constructions of ‘interaction’



'It's very interesting, we would always see the patients ourselves, the consultants first and then with new patients then they would often go through and see the nurse specialists and they will often talk about more personal, emotion type of things with the nurse specialist than they would raise with us. Not always, but some patients, so that can be quite a difference and of course the nurse specialist they'd see, they have more time to sit and chat with them and say I didn't want to bother the doctor about that.'

(Workshop 16)

'The emotional is done by our nurse, not by me, so the discussions are very simple.'

(Workshop 7)

There is an acknowledgement that this kind of interaction has a function but also a sense in which it is pushed to one side and away from doctoring. Those named, formalised, bounded interactions are constructed as the business of doctoring, while the informal lay discourse 'stuff' is either remedial – making up for the fact that the patient does not really understand or is particularly upset about something – or it is a dispensable nice-to-have. This extends to the separation – voiced by at least some patients – of 'good' doctoring from interpersonal skill.

'You have to differentiate between who's an excellent doctor but maybe hasn't got great interpersonal skills, and someone who's a wonderful person and actually [inaudible] but as a patient you're not able to judge.'

'You just know that the doctor is being very nice so you end up feeling good but you may not be being treated.'

(Workshop 7)

'Yes, but it would be quite nice for a bit of eye to eye contact, I don't know, but then again if he fixes my arm, who cares? I'm not out to be his friend, we want them to be good at a job.'

(Workshop 9)

'I didn't like my first doctor, but I couldn't make a complaint about him because I didn't want my name to be blacklisted as "she's complained about her doctor". Unless it was negligence, I wouldn't make a complaint about mannerism or [...]'

(Workshop 7)

We also noted a consistent disconnection of the consultation and the doctor's sense of responsibility from the rest of the system:

'I guess from a clinician's point of view, [...] if a patient's come in, is very aggressive, not necessarily with you but with the situation of whatever's happened (before), obviously yes there is a tendency to be defensive. Because you're in that system and okay, you don't know what's happened and you can't say ... I think sometimes the natural instinct is you become defensive. But then as it progresses, sometimes you think why are you apologising, it's not as if you've done anything. In a hospital if the receptionist is being rude or if the ward clerk is not bringing in the notes [...] you are irritated at them but you kind of think "I'm also frustrated, why should I be the one apologising?". You're apologetic at what's happened and you don't want the patient to feel like that, but you also feel like it's not me who should be apologising.'

(Workshop 9)

Cultural and professional distinction

We would also suggest the particular organisation and coding of doctor–patient interaction into discrete, named moments or events is part of a very wide and deep encoding of the idea of a doctor as a distinct cultural and professional figure.

'I see my GP, I don't want to hear he's made mistakes [laughter], I'm not assuming he makes mistakes, I'm assuming he's got everything right because I'm not going to go to someone who's unsure of what he's doing. And doesn't

matter how old he is, young or old, as far as I'm concerned he's a genius to be a doctor [laughs] and he knows everything, about everything.'

(Workshop 7)

'I mean certainly the old way of looking at doctors, they were on this pedestal ... you just sort of thought everything they said was right. They were treated a bit like, well you know the saying, like God. I think that's changed slightly because of how much information a lot of patients can get now for themselves from the internet and everything, so they come in bombarding with questions. But I think you just, I think this still will always be, because they're the ones in charge aren't they?'

(Workshop 19)

'We've gained [today] in that we're wiser and we can challenge and when something's wrong, we can take it further, etc., etc. But what we've lost is that permission for it not to be all on our shoulders, "doctor says, therefore it must be correct". Now everything's on our shoulders, which is good, but bad.'

(Workshop 9)

'I've changed my personal practice recently ... I always used to introduce myself as [first name] to the patients, first name terms, keep it fairly informal, people are nervous enough when they're coming in for operations. And actually one of my friends said to me, he worked at [a hospital] where they do cardiac transplants and somebody used to come in, swagger in, a really bolshie big fella and used to go, "Hello, my name's Dr Rar Rar and I'm a consultant cardiac anaesthetist" and the patients used to love it, these little old dears used to love it. There's this big name, he's really authoritative and he obviously knows what he's talking about, so they feed off

your own aura. I think since I heard that, I think maybe patients do prefer it, I did start introducing myself as Dr [name] instead of [first name].'

(Workshop 7)

The taken-for-grantedness of this relationship was underlined by how noticeable it was when the occasional participant was not in awe of doctors:

'I actually work around doctors and consultants who get paid probably a lot more than my GP. If I go to see my GP it's very much ... it's almost peer to peer, I'm not affected by them in any way, I say "right this is the problem, this is what I want" and they generally do it. [...] Whereas I guess before I started working in the hospital I could relate more to that because they're almost an enigma to a certain extent.'

(Workshop 13)

'In terms of asking questions and challenging them, I do ask questions, I do challenge. I didn't always do it but I started doing it at a relatively early stage. When I first started my studies and I met some doctors, I was going out with some doctors and I thought "wait a minute" [laughs], "you're not a magician"! So I do ask the questions and I do challenge and I always, always ask, "why are we doing it this way and we're not doing it another way?"'

(Workshop 11)

Interestingly too, while an asymmetry of power and status clearly underpinned much of this discussion (and our analysis of the dynamic), when we brought this overtly into the conversation, all parties sought to deny it:

'Is respect the right word? Well I don't know ... or is it trust and confidence? Yeah, that's a better way. Yeah. I mean I think that's what patients need, they need to be able to trust you and have confidence in your abilities.'

(Workshop 17)

'It's like being back at school [some agree] or going to a lawyer or something. (Q: What's that parallel, what's the similarity?) They're big and you're small [some agree], they have authority. And they must know what's wrong or ... they know the fixes. Know more than you. [...] It's the way they're treated though by everyone around them isn't it? Their assistants, nurses'

(Workshop 7)

From our perspective, information and education – the need for which was a constant refrain from doctors in some of the workshops – is hearable as a desire among medical professionals to change the interaction and to move the dotted line across (see Figure 2), to pull more of the patient's life, thinking and language into medicine. So patients are asked to become self-doctoring, or more compliant subjects, because they will be able to express, understand and manage their problems in terms of the language, logic and constructs of medicine.

Chapter 3

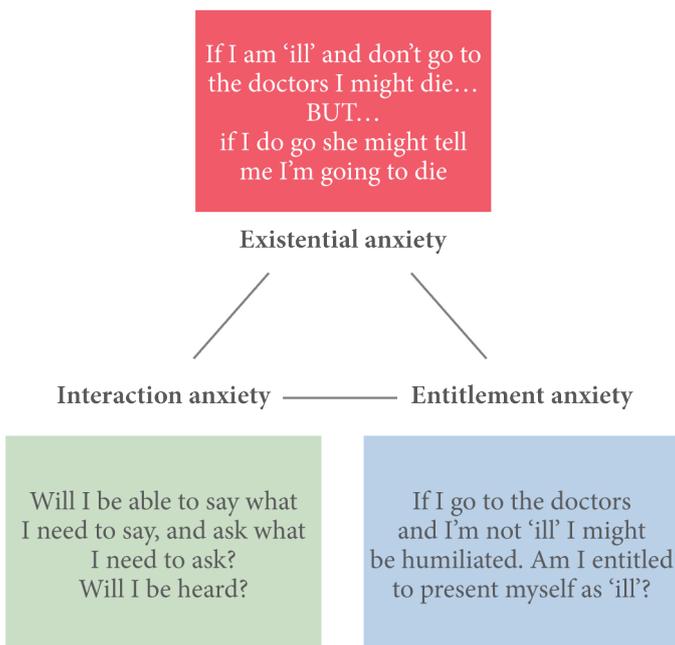
Fear as driver of the dynamic

Our second major conclusion from this work is that the primary driver of the doctor–patient dynamic is fear. This applies both to patients and to doctors.

The patient's fear

We will talk first about the patient's fear; we have traced three kinds of fear that form and inform the interaction dynamic. We should be clear that these are not at the surface all the time, but we have clear indications of the role of each in the patient's experience, and in accounts of their behaviour and decision-making around the consultation.

Figure 3: The patient's fear



Existential anxiety

First, there is what we might call existential anxiety: essentially 'If I'm worried about something and I don't go to the doctor, I might die ... but if I do go, she might tell me I'm going to die.'

'At the same time I'm thinking, "I hope they don't think I'm being paranoid when I mention prostate cancer" and all that sort of thing.'

(Workshop 11)

Interaction anxiety

Second, there is what we came to call interaction anxiety. Patients worry at a conscious or semi-conscious level as they go in: 'Will I be able to say what I need to say? Will I be able to ask what I need to ask? And will I be heard?'

'When I go to the GP, I always forget what I've gone for, sometimes I have to take [overtalking] ... you know the GP's got so many patients that day and you know you've got, is it ten minutes or five minutes?'

(Workshop 7; a clinician talking about being a patient)

'I usually feel quite worried and apprehensive when I'm in the doctor's, so if the doctor puts me at ease I'm more likely to tell them what's wrong with me. Sometimes I've gone out of the surgery and

thought [I haven't] necessarily told them everything I should have done. I'd have thought it's probably a good idea to write down the things that you want to say to the doctor, but then I don't actually do it when I go in, I think I'm going to tell them something but if they're not ... if they don't put me at ease then [I don't]. So I think for me it's very important to be put at ease to start with.'

(Workshop 7)

Entitlement anxiety

Then we identified a third kind of fear and came to call this entitlement anxiety. Note 'entitlement' within the current discourse of the health service means something quite different – a kind of demanding, consumerist approach to healthcare. Here we mean anxiety about entitlement: 'If I go to the doctor and I'm not ill by his definition, I might feel humiliated or even be actively humiliated by him ... so am I really entitled to present myself as ill for this reason, at this time?'

'For me, when I'm in the waiting room, I'm always assessing whether I have got more of a problem than anybody else and whether I deserved to have got the appointment that I got. Because it's very difficult to get an appointment at my surgery so if I've managed to get an emergency appointment, I feel guilty. And if I'm there I feel like there might be somebody who is perhaps close to dying waiting as well or little children or something. I'm always thinking, do these people look more ill than me, are they more ill than me. So I'm thinking about that when I go in [...] Because I have had a doctor say to me once I shouldn't have had the emergency appointment, I'm always now really worried that I'm going to be told off for getting an appointment that I shouldn't have had. Which is a really difficult situation then to come in and talk about the health problem that you've got. He gave me something for one

of the problems, like a nasal spray for an allergy thing which wasn't what I was really bothered about; I wanted to talk about my headaches, but he didn't want to talk about them.'

(Workshop 13)

'I'm very conscious of the fact that doctors are very, very busy and ... it's nice to have a little "how are you?" but that's it and I go in with a list, very short list but nevertheless ... and you make a joke of it and they can see it's only got two or three things ... (Q: Why do you make a joke of it?) Because you don't want to be perceived to be that you've come in with this really long list ... (Q: Why?) Because I feel that the doctors are very busy, there's a whole queue of people behind and again, touch wood, because none have been terrible reasons to go, I can be light-hearted. If I went in with something that was really serious then of course, I wouldn't be so [inaudible]. (Q: What are you concerned that the list might say to them about you?) I'm scared they'll think "how long is this bloody list?" so you want to make a joke that it's only got two or three things in. But what it's saying is I'm efficient, I want this to be a really effective meeting and let's be quick, that's my job, my job is about efficiency and effectiveness and I've just carried that on in life.'

(Workshop 9)

'[Bubble exercise: the patient is thinking] "What else do I need to tell the doctor?" and "How do I put this across so it doesn't seem like I'm making it up or I'm a hypochondriac?" Because sometimes you feel that you really have to justify your need to see the doctor, I'm talking as a patient here, why you're there and why you're taking up that appointment time and how serious it is, before you go in to the doctor.'

(Workshop 7)

We suggest, therefore, that patients enter the consultation with multiple potential anxieties, only some of which might be recognised across the table by doctors. Certainly we heard little recognition of patients' interaction or entitlement anxiety from the clinicians we spoke to. (The same is true in reverse – patients recognise doctors' actual or latent fears even less than doctors do theirs.)

We want to particularly highlight entitlement anxiety; something like it is referred to in some of the sociological literature but is far less evident in the policy and mainstream literature we reviewed.

Entitlement anxiety comprises these kinds of questions: 'Am I really sick enough to call myself 'ill'? Can I justify taking this doctor's time today? Am I really ill enough for the doctor to agree to call me 'ill'?' For some patients this might also surface as anxiety about using NHS resources, though this is quite a high level, rationalised concern. The shared worry – overt or implied in our conversations with patients – is that the doctor might send them away and/or tell them off, saying 'You're not really ill, you're wasting my time.'

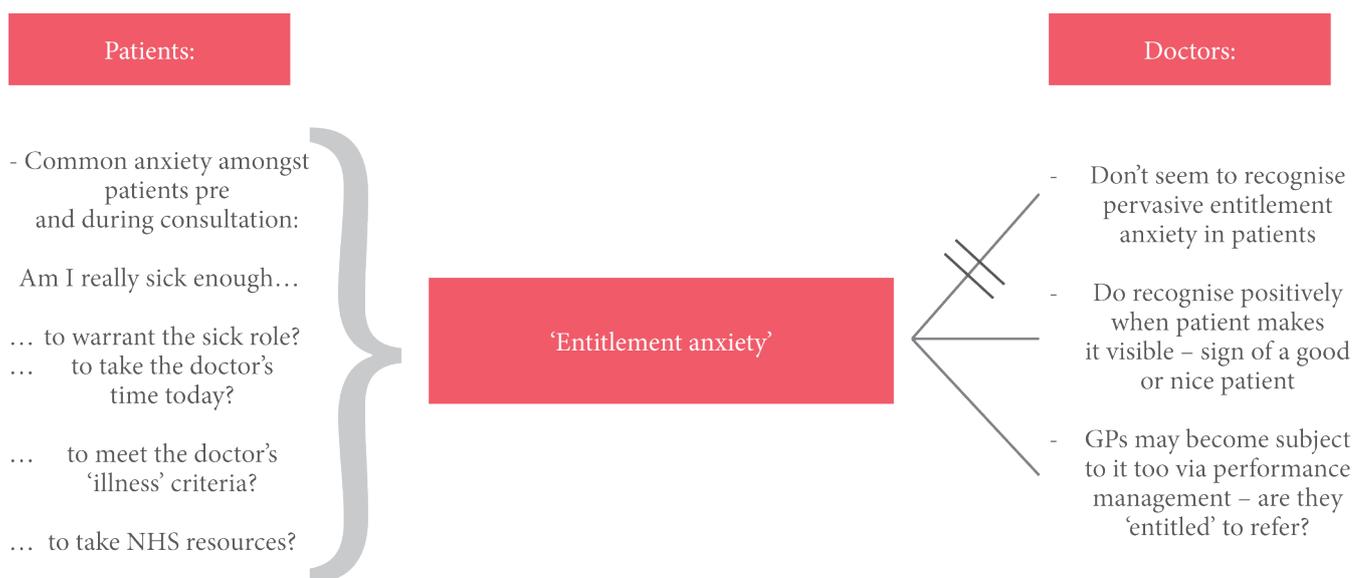
'I've been in a situation where I've been made to feel as though I'm being a hypochondriac, even though I know full well that I'm not, I think sometimes there is the authoritarian doctor approach that says "time waster" and it does come across like that anyway. No, I don't think that's their starting position, I've just been in situations before ... a couple of times where I've felt really awkward about being there, using their time, sort of guilty about "should I be here? should I have just stayed at home?'

(Workshop 7)

'I think if a doctor, if you go in and they're very abrupt you feel as if you're wasting their time and think "oh dear, can't keep them because they're so busy".'

(Workshop 7)

Figure 4: Entitlement anxiety: a hidden context for patients



“I hope you don’t think I’m wasting your time, doctor” – I’ve had that feeling. So I rush through what I’ve got to say as well because I know how busy they are.’

(Workshop 13)

‘I just said I’m worried about cervical cancer, I know that Jade Goody has had it and she’s quite young. I’m scared that I might have some of the symptoms and I’m more aware of it in younger people and told him about my mum [who had abnormal cervical cells]. And he said “you won’t have it, it’s silly to worry at your age, we can’t give you it regarding your mother, we can do it when you hit 24 or 25”. [...] I thought he was thinking “she’s only come here because of the stuff in the celebrity magazines, which is paranoia and it’s the fifteenth time this week that it’s happened” and he was just like “I just want to go on lunch break, I’m sick of this, I’ve had a million and one young girls come in to try and tell me about this” ... he kind of let his feelings show a bit too much, he was obviously really pissed off that I would ask for it. And I was like “okay I’ll just go then”. But it still hasn’t been resolved now just because I don’t want that again, I don’t want to go. (Q: So it’s had a big effect potentially, like that tiny conversation had potentially a really big effect on what you do?) Yeah, [he said I had to be] 25, so that means I won’t go back for another six years now until I can actually have one. Because I just don’t want to go through that, plus I must drum up the courage [...] that’s the basic thing that happened, I was just too embarrassed to go back.’

(Workshop 13)

Interestingly, the doctors we spoke to rarely recognised the possible pervasiveness of entitlement anxiety. Sometimes a patient makes it very visible, saying ‘I’m really sorry to trouble you doctor, I know you’re terribly busy’ – and that is read as a sign of a ‘good’ or a ‘nice’ patient.

‘They say “I really shouldn’t be here doctor, there’s nothing wrong with me” or “I am wasting your time” and actually that endears me to them a little bit, if they’re conscious of the fact that they’re one person out of 20 that you’re going to see that morning, they’ve maybe not told you what they want to tell you because they’re very conscious that they’re wasting your time, I feel a little bit more endeared and listen to their stories of their cat.’

(Workshop 15)

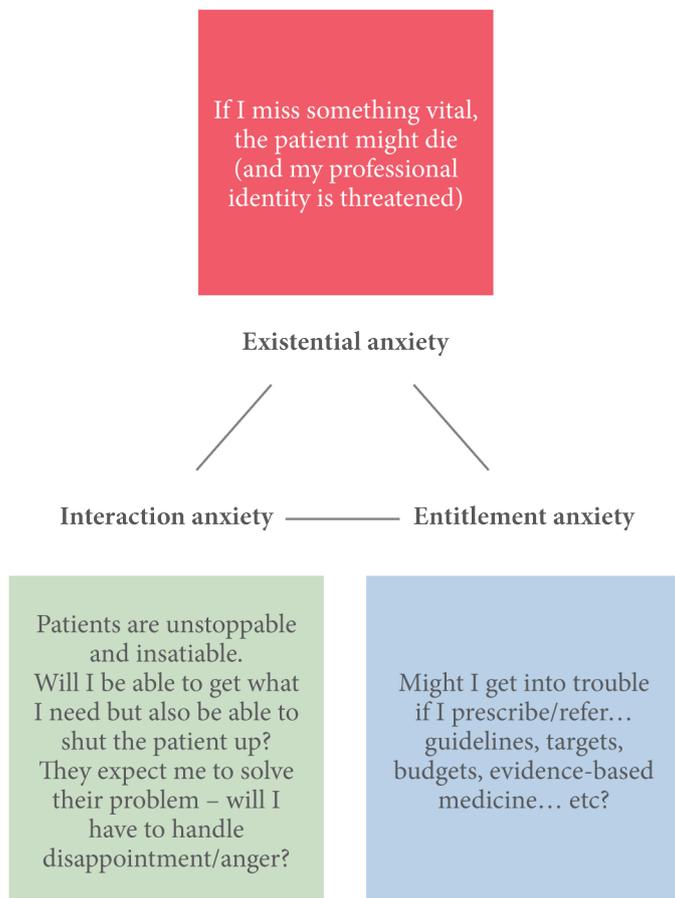
‘Yes, I’ve had things checked before and it’s turned out to be nothing and then afterwards you think what was the point in going in the first place? But it’s when they say “you were right to come in, you were right to have a concern, you were right to be worried, if this happens, if it gets any worse, and if it changes like this please do come back” ... when they say you were right to come in, even though it was nothing and you feel ... you weren’t wasting their time and you weren’t one of those people who ... on the posters in the waiting room it says, got flu symptoms, go away, sort of thing. You don’t want to be one of them.’

(Workshop 13)

The doctor's fear

In parallel, we suggest the same three categories of fear or anxiety on the doctor's side also inform and shape the dynamic.

Figure 5: The doctor's fear



Existential anxiety

So the existential anxiety in medicine is: 'I might miss a serious diagnosis and therefore allow the patient to die or suffer.' This possibility deeply threatens not only the doctor's humanity but also their professional identity.

'When you're dealing with people's lives ... it's not a normal job where every mistake you make, you lose a bit of money or cause an error. We're working in the healthcare profession, if you do make a mistake you're dealing with people's lives.'

(Workshop 7)

Interaction anxiety

We saw evidence of interaction anxiety being commonly expressed. It was striking and interesting how often patients were spoken about as 'unstoppable' and 'insatiable'. Often too this was expressed in terms of the 'trivia' that doctors claim patients unreasonably bring to the interaction.

'There are other patients who [...] are prepared when they come with a great big book full of questions to ask you.'

(Workshop 16)

'I think if the hospital sends out in the information that you can bring a list, but it can only have three items on it, we'd feel more comfortable with it. But our expectation generally with people with lists is there are a lot more than three things on it. So if I encounter a patient with a list, I will inevitably think "this is going to take quite a long time" and it will just depend on what else is going on around me, what else I've got to do as to how I'll respond to the list. It might be that we'll take the top six or whatever things on there.'

(Workshop 15)

'You have to have some way of coping with the wall of work so the classic is the [ward] round where by patient 17 of 20, the last thing you want is an internet handout and a list and a worried relative, that would be my full house of disaster at that point.'

(Workshop 15)

'I think [...] you cannot [give] each patient how much time they want. It becomes a nightmare for the staff, the doctors, for the patients, everybody and in the end, the end result will be we will not be able to cope with the demand. The demand will be so much in the end.'

(Workshop 17)

'They say "my baby's not breastfeeding very well", "my bed isn't very comfortable, is there any chance of it being changed?"... this whole drawn-out conversation and [...] you're trying to escape to do other things because it's not very medical any more. So it's not about the medical care that they're receiving, that I get irritated with, it's things like they go "can you go and get me a glass of water", "the baby's socks don't match", things that are totally irrelevant to their care and they ask you to go and do all these bits and pieces.'

(Workshop 7)

'When you've introduced yourself as Dr So and So and you're going to take them down to theatre ... I usually say who I am, what I've come to see them for as the first thing, "I've come to you about your pain, how is it?" And then they go "can you go and get me a glass of water?". Well yes, you could do that but you also have 70 patients to see on an average weekend's ward round and if everyone said go and get a glass of water, it takes 30 seconds, times that by ... it sets a precedent as well, the other patients think ...'

(Workshop 7)

Occasionally a doctor would share their experience, or quote studies, claiming that, 'I've discovered if you just let them talk, they do stop'. The amazement (and unspoken disbelief) with which this was greeted by their colleagues was also striking.

'Isn't it only about 90 seconds that patients will actually go on for if you don't stop them? There's something that on average, if you just let them carry on, they stop within two minutes or something ... might feel like an hour and a half but ... I can't remember exactly how long it is but I know when I was at medical school they said it's actually a surprisingly short amount of time, that most people will carry on for.'

(Workshop 15)

'If you change the system (so you have) one patient of five minutes, one over 10 minutes, one over 20 minutes then when the people come to know that they can make (appointments for) 20 minutes, everybody will want 20 minutes and the number of consultations will be very few.'

(Workshop 17)

It is worth noting here that unstopability and insatiability were themes of which we saw traces right through the system, right up to policy level: a sense in which there is no stopping the demand on this system. So the interaction anxiety for the doctor could be expressed as 'How can I get what I need from the patient to make sure I don't miss something, but also contain this unstoppable or insatiable force?' There was also a kind of sadness or anxiety around the interaction; 'Is this patient going to be disappointed or angry because I can't always give them what they need, especially in the 10 minutes that I've got with them?'

'Another thing I recognise is disappointment at the end of consultations, that could be a legacy. Because about 50% of the patients I see I probably can do something for that might make them better, and about 50% I probably can't. And the 50% who you can't make better or you think you can't [...] leave with disappointment. Because of course they've been referred some time before, they get the date through the post, they've been waiting and waiting, build-up, they come and they sit in the waiting area, next week, tomorrow, it's today. Then they have to wait say an hour because the clinic is running behind, the appointment is all over in 10 minutes in many cases, and they've been told ... that's right. So disappointment I think can be quite a common legacy in the short term.'

(Workshop 16)

‘There’s no harm in them talking and allowing them to, but I wonder if there’s some kind of inner kind of fear that they sometimes would ask about things that you can’t solve, or you can’t do anything about ... financial/house things, yeah. I can’t solve some kind of social issue in a consultation anyway, or I can’t save the cat for you ... or even their other medical problems sometimes.’

(Workshop 15)

‘He’s had some painkillers and he’s come in [...] they want something doing. They don’t want to be told that they’re overweight and this, that and the other. And I’m sat on the other side of the table trying to make sure that there’s nothing there serious really, I’ve not missed anything, you know the red flag signs or anything. [I’m] probably sitting on the other side of the room and just making some intuitive interpretation of what their pain threshold is, about what impact on their life and looking at what are the next steps for the patient and how I’m going to sell that to the patient. (Q Sell it to them?) Yeah. In terms of whether they will accept another dose of ice or whether I’ll have to send them for physio or some other form of investigations. And I think there would be a negotiation between what the patient wants or his expectations and I think in some degree [...] maybe it’s another condition that I can’t influence an awful lot that led to a lot of back pain.’

(Workshop 17)

evidence-based medicine stops an older physician from prescribing a placebo or a tonic that they might once have done, which they might argue and believe would be appropriate and therapeutic but which would fail an evidence-based test.

We are not suggesting these fears are necessarily voiced or made fully conscious in this form, but we have consistent indication of their influence on the patient–doctor dynamic throughout the conversations that we had.

The conventional form of the consultation has, we propose, been organised precisely to manage and reduce the doctor’s fear; this fear is not experienced as such because its management is routine and normalised for the doctor.

Doctor’s fear and patient’s fear

So the consultation is a conversation going on with two sets of potential anxieties in the room, each party having only partial visibility, across a chasm, of the other’s predicament.

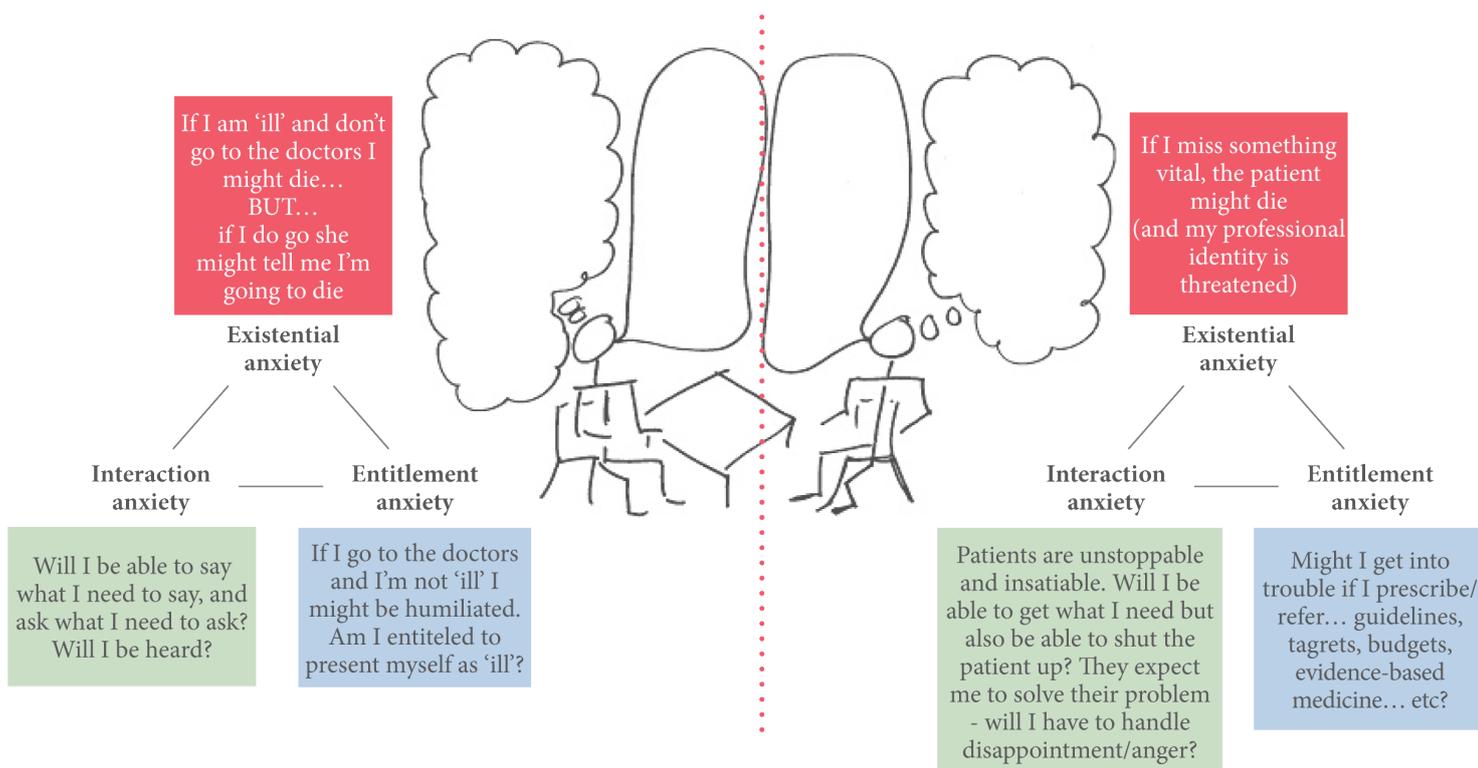
So what might happen in a consultation, if this is what is present in the room? For familiar reasons to do with status, it is the doctor who has the power to control the interaction and doctors have developed a solution to what are, for them, competing anxieties.

We started to recognise a pattern in how doctors talked about handling their consultations, and we came to call this ‘opening up and closing down’. Effectively, doctors describe a need simultaneously to ‘open the patient up’ and get information from them and ‘close them down’ and stop the flow.

Entitlement anxiety

Finally a point on entitlement anxiety for doctors. We hypothesise from this work that doctors – particularly GPs – may now be brought into this frame via performance management. Are they entitled to refer, or to prescribe within guidelines? ‘Might I get into trouble if I prescribe or refer, as I wish to do at this point, with guidelines, targets, budgets, evidence-based medicine?’ For example,

Figure 6: Doctor's fear and patient's fear



In reality these competing needs are experienced and operated simultaneously or in a kind of oscillation; doctors have to open the patient up otherwise they fear missing the crucial moment. (Even with the ‘fat envelope’ patient, they have to listen because this time there might really be a red flag.) At the same time they have to feel able to close the patient down and keep control otherwise they are unstoppable or insatiable and the doctor fears running out of resource, human as well as practical.

It is possible that managing this oscillation is part of the challenge and the satisfaction of practising medicine. Like managing the force of gravity in a sport like skiing, the doctor has to manage very powerful forces; alternating giving into a powerful force and resisting it. It seems possible that there is a kind of professional and personal satisfaction in doing something somewhat risky and challenging and pulling it off, again and again.

‘It varies greatly; some patients will just explode and tell you everything, others it’s quite a difficult process of taking the details, then also finding out [...] information. And because we’re limited to three or four minutes, having to make a decision in that time, whether referral or a course of treatment, obviously makes the situation difficult.’

(Workshop 7)

'You watch how they are, you look at their body language, if you're sort of asking questions, how they are, what's going on, why they've come in to see you and they're responding to that and their answers are getting longer and longer and they're opening up and telling you more and more, you keep going. Whereas sometimes if they're very closed and shut off and they're not telling you much at all, you reassess your style until you're getting the answers that you want to get from them because you have got a limited amount of time, you need to get as much information as you possibly can to decide what you're going to do with them.'

(Workshop 7)

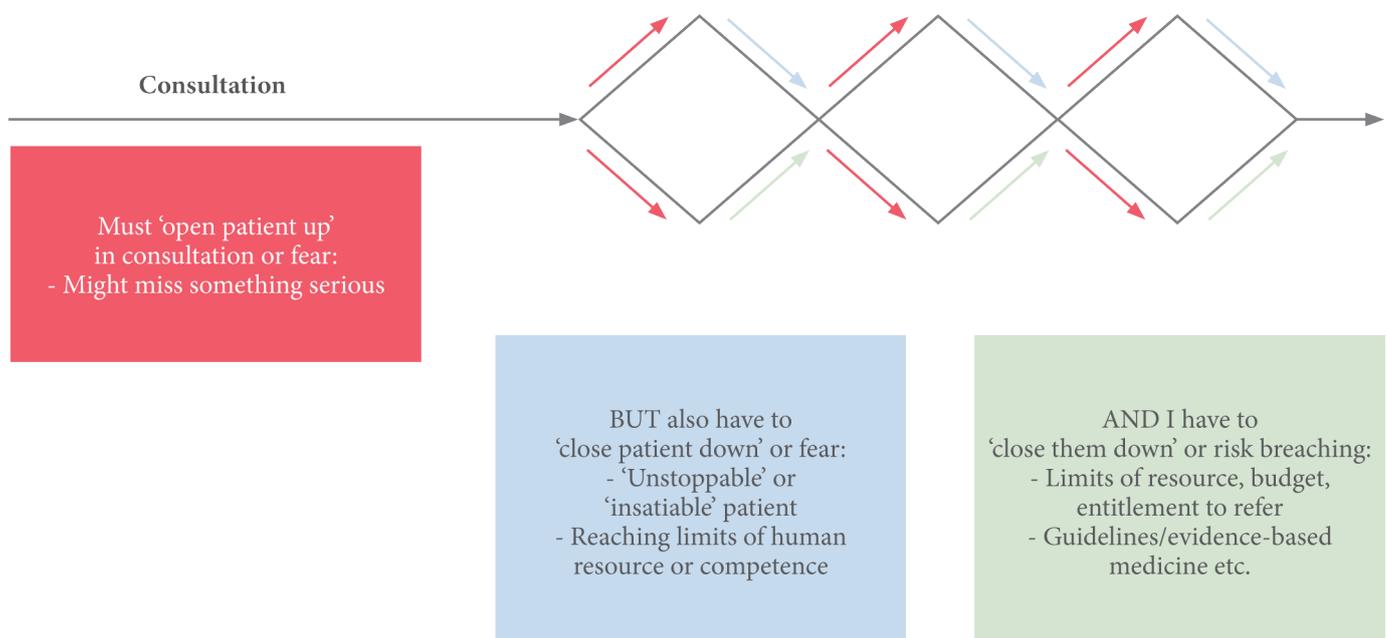
For patients, on the other hand, this oscillation might perhaps be confusing or even teasing. They are not quite sure if they are being invited to open up or if they are being shut down, and at what point which applies.

We suggest that it is this dynamic of opening up and closing down, contextualised by multiple fears, which is at the core of the doctor–patient dynamic, and which is itself replicated in different ways throughout the system (see Chapter 6 on system dynamics).

Again, in looking at quality across the system, a number of possible implications are immediately evident.

- **Equity:** patients' ability to get what they need and/or want from the consultation in the face of entitlement and interaction anxiety is likely to vary.
- **Safety versus efficiency:** the doctor's opening up and closing down dynamic is driven by having to trade off the need to be efficient against the need to be safe.

Figure 7: The doctor's solution: 'opening up and closing down', driven by competing fears



Chapter 4

Invisible structures

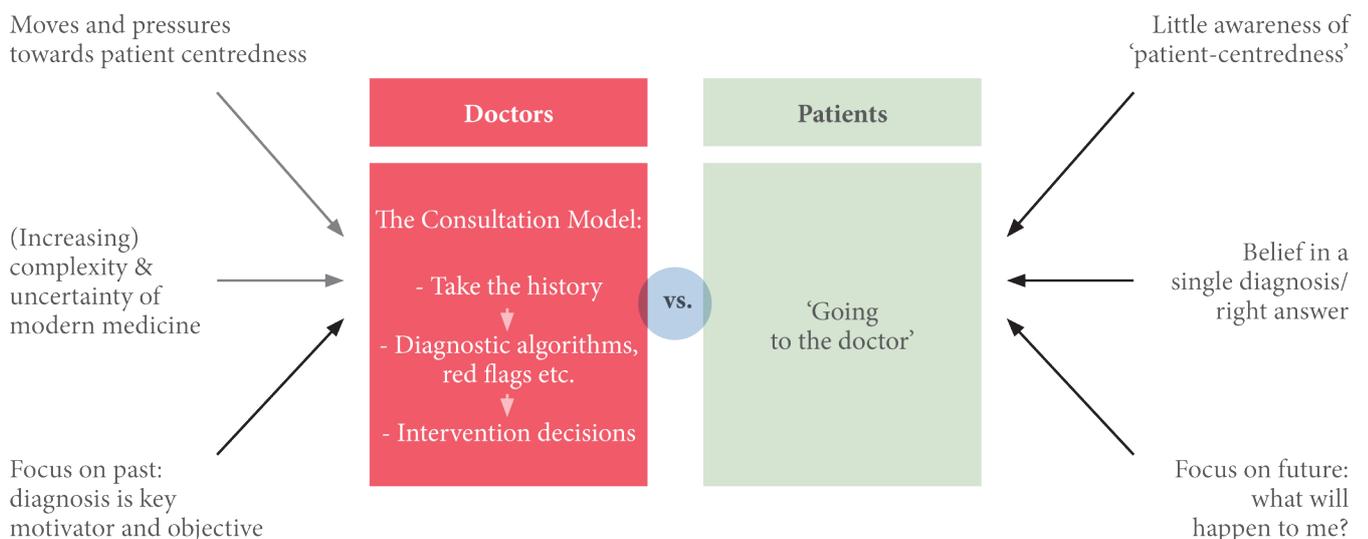
Different views of the consultation

We hypothesised from our data a number of ways in which there is a gulf of understanding between doctors and patients about the consulting process itself. These have implications for the clinician–patient dynamic and for effectiveness and healthcare quality. This parallels the asymmetry of power and information that has been widely explored in the literature about doctor–patient interaction.

The consultation ‘map’

The first and most general of our hypotheses is that doctors have a ‘map’ which patients cannot see. Doctors manage their consultations with a formalised, codified consultation structure: they are taught this in medical school and it continues to be reinforced throughout their clinical practice. Other interactive forms (such as ‘The Round’) also have distinct rules which are learned and perpetuated, sometimes linked with other structural rules such as theatre schedules.

Figure 8: Doctors manage interactions with a formal consultation structure – but this is invisible to the patient



‘It’s the structure of a consultation is like that isn’t it? You open the door, you have the notes and you go Mr So and So or Mrs So and So, “Come in”, you shut the door and you say the first thing ... It’s your territory, yeah. You’re taking the lead. [It’s not like] you go into their house and they lead you in and talk to you sort of thing, and then you try and get bits from what they’re telling you; it’s the other way round. I suppose they don’t feel as empowered by that, they feel like they’re being led in some way, being asked questions and with some time constraints etc., sometimes they feel that they don’t get their opportunity to say as much or ask as much, or guide things as much as they’d like. I do feel sometimes with time, we do struggle and we don’t actually fully have time to say “what do you feel about these things?”’

(Workshop 15)

‘Surgical ward rounds for example are an hour long, no matter how many patients there are because they have to get to theatre by a certain time. By nine they have to be in theatre, yeah. So that’s a very short sharp ward round and I suspect the relationship that surgeons have with their patients is very, very different to the relationship that medical doctors, shall we say, have with their patients.’

(Workshop 15)

Doctors have a map for their distinctive forms of interaction with patients; they know where they are going. But this map is not made explicit to patients and is effectively invisible. For them the consultation is an amorphous part of lived experience: simply ‘going to the doctor’ or ‘the doctor coming round to see me’ in hospital. The experience itself can feel random or entirely out of their control.

For the patient, the experience is of being in a glass maze. As in many of the conventions and social structures which organise our lives, we may only become aware of the walls of the maze when we bump up against them, when we do not really understand the rules that determine what is going on. For example, we are socialised at an early age to understand that the question ‘how are you?’ does not require or indeed allow a long answer about the real state of your health. We only notice those rules when they are broken: if you tell someone exactly how you are in answer to their conventional greeting, it won’t be long before they start to treat you as odd and socially dysfunctional.

In the consultation, patients may only sense there is a structure when they realise they have ‘missed their slot’; that there was a moment or opportunity to say something which is actually now gone. Imperceptibly, the doctor has moved on to another stage in the structure and that contribution is no longer sought or welcome. This does not feel good or productive either to patients or doctors:

‘The neurologist I saw was absolutely fantastic and he let me keep my scans of my brain and stuff which was quite interesting. But ... I don’t know, I think they’ve got such short amounts of time to spend with each patient, you’re kind of in and out of there and left a bit, “what do I do now, I’ve got a question, oh well I’ve missed my slot now”, kind of thing.’

(Workshop 13)

‘Probably when they bring out a prescription form and start filling it in before you’ve finished talking about it, which I have had. [You’re] in there for two or three minutes and then sort of out and then you think ... “oh dear, I should have said this ...” In fact now if I go to the doctor’s, I try and make a few notes beforehand because I nearly always forget what I’m going to say.’

(Workshop 7)

‘M1: It’s more frustrating if they don’t [have a list] and you’ve allotted the 10 minutes to dealing really well with the

problem and then it's like "oh and I've just had a load of rectal bleeding" and it's like, "stop". It's like "why didn't you say that earlier because then we wouldn't have spent the last eight minutes on about how ...?" And why haven't they said it earlier on? Why don't they say that?

M2: Well it's a kind of hidden agenda isn't it?

M1: They're embarrassed or something.

M3: It's checking out are you in a good mood and we're getting on alright ... "can I actually open this one up now?" If a person said to me "I have three things", I will often say to them "tell me quickly what they are and then we'll start".

M2: Let's negotiate.

M3: On those people I want to make sure that number three isn't a horrible thing.'

(Workshop 17)

It is as if patients do not know the dance and they cannot even hear the music; they can feel wrong-footed, clumsy and disempowered.

'I don't think I feel intimidated, I just think that what you want from them can be difficult to get and the whole process is just really ... it's convoluted. Yes, and it can be embarrassing and/or it can just be upsetting or confusing, just complicated. I don't think I'm intimidated.'

(Workshop 13)

"So Mrs Jones, how are you feeling at the moment?" it's normally the first thing he says to me and it's the same sort of question every time. And then I'll be thinking, "must remember to ask all the questions" because I've always got so many questions. In between our visits recently, a few things have changed, so I'll say "at the moment ... I'm either good, bad, indifferent, this is happening, that's happening". (Q: Do you write those

things down or do you have them in your head?) I have them in my head and most of the time I forget, because we start one place and we'll end up somewhere else and I nearly always [...] I just always think I'm going to remember. But the conversation ... because I'm not steering it, if I was steering the conversation I think I would, but because it literally goes in so many different directions, every time I go there, that that's why I don't seem to remember.'

(Workshop 11)

Energy and focus during the consultation

The second hypothesis is that there is a crucial mismatch in energy and focus through the period of the consultation. For doctors, in a prototypical consultation, diagnosis is the primary aim – the focus is getting to a correct diagnosis. The doctor's response to fear is action; the doctor drives the consultation towards a diagnosis and then relaxes, because their anxiety has dropped after the diagnosis is reached. There is obviously a stage of deciding on intervention and so on, but their attention and energy is largely on the past – taking the history and the differential diagnosis. For the patient it is the other way round; their focus is on the future, 'what's going to happen to me?'. So they may be quite passive through the process of history taking, because their energy and anxiety rises at the point of diagnosis, just at the point at which it drops for the doctor.

Thinking further about what might be going on in the consultation, it seems that there are challenges and changes being made to the consultation model which are again invisible to patients but may be causing discomfort to doctors. One of the things the model is now being asked to accommodate is patient centredness. For many doctors this means making adjustments to parts of the model, though not a radical rethinking of the model itself. But, as far as we could see, patients had not really heard of the policy shift towards patient centredness and they do not really know that is going on for the doctor. Secondly, doctors are clearly aware of the increasing complexity and uncertainty in modern medicine, with increasingly specialised knowledge and fewer clear or simple answers. Yet, from our

conversations, many patients still turn up at the doctor's expecting there to be a clear diagnosis, a simple answer and a concrete medical intervention.

'We had a lot of discussion around that patients don't always expect to help themselves. If you give patients lifestyle advice for example, like lose weight or whatever, they may not see that as proper treatment or help from the doctor. They expect you to do something, to give them a tablet or do an operation.'

(Workshop 16)

'If someone comes in with pain then they're looking for an answer to what's causing that pain, wherever that pain is in their body. And a lot of situations where you can't actually say your pain is caused by this, you can exclude a lot of things but at the end of the day you can't necessarily say your pain is definitely being caused by this. We're better at ruling out causes of trouble than we are at ... And the modern version of medicine is to be more open and honest with patients, in a sense. Does that then create further problems when you say actually we can't tell? We can rule out things that are likely to be seriously dangerous and will kill you, but actually we just don't know.'

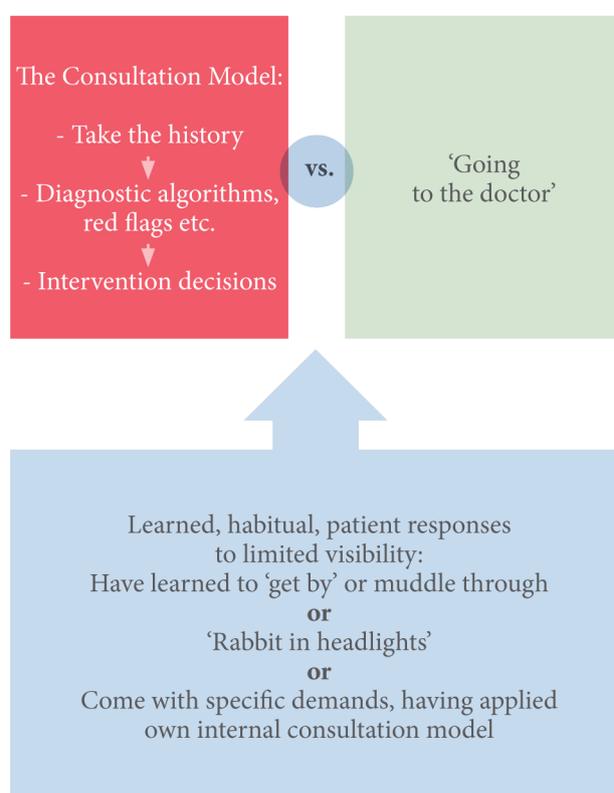
(Workshop 16)

So the consultation model is being asked to accommodate more and more change. Such a model can of course adapt, but if enough change is imposed or expected, eventually the model, the structure itself, collapses and a completely new way must emerge. Today's consultation model, which was, and for a lot of purposes still is, entirely appropriate is perhaps beginning to show some signs of strain.

Patient responses to invisible structures

Let us return for now to our first and most general point – that the doctor has the map and the patient does not. In fact the doctor not only has the map but drives the vehicle and the patient may not know that they have reached a crucial crossroads, or that they have reached the end, until they get there and it is too late. We saw, in the accounts of both clinicians and patients, a number of adaptive and maladaptive responses to this mismatch in the visibility and control of the shape of the interaction.

Figure 9: Patient responses to invisibility of the consulting structure



We could see reported in our data three kinds of patient response to this situation.

‘Getting by’

Firstly, it is clear that many patients have learned to ‘get by’ or muddle through. Over time they develop a vague idea of what is likely to happen when they sit in front of the doctor: the doctor will say ‘what can I do for you?’ or similar, and they give some account of why they have come. The doctor will ask questions, then at some point the doctor will probably tell the patient what they think the issue is (or is not) and what they recommend they do.

‘The majority of the patients they know what exactly they’re coming for, the majority of them. They have a short thing prepared [...] it’s like well what symptoms have I got and they know. [...] They’ve been trained haven’t they, because they’ve seen doctors, by the time you’re talking about somebody who’s middle aged, especially if they’ve got a chronic problem. They’ve been trained into what doctors are expecting from them. They know they will be asked how long they’ve had it for, and they will have sat there and thought about it. (Q: Is that helpful to you or not?) Yes, usually. [...] I mean it’s usually easier to consult with people who’ve sat and thought about it. They have got a bit of a list. It’s kind of more of a technical interaction but you feel less that you’re going to miss something.’

(Workshop 17)

This shows some adherence to the formal consulting model, but is far less formulated or concrete for the patient. The patient is very unlikely to have any awareness of issues which are central to the doctor like ‘red flags’, for example, or the procedures of differential diagnosis. To the patient, therefore, the questions the doctor asks may make little sense, or seem disconcertingly ‘off-topic’. In addition, ‘muddling through’ is based on the patient’s lived experience. Younger patients have to develop this and can be very nervous – they just don’t know what to do and they may fear the doctor’s disapproval if they fail to behave in a proper manner.

‘When I go to a GP, either they make me feel like a child [...], sometimes I wish that I was little again and I could have somebody else explain what the problem was, have my mother explain what it is so I don’t have to do it. Which is weird because I’m usually quite happy to explain how I feel about something. But when you’re at the doctor’s, when you start to explain something and you think they’re not getting it, or you’re not getting the response that you hoped, or they’re going down what you feel like is the wrong alley, you just think “if only my mum was here and she could just tell them what it was and it could just go away”. [...] I think sometimes they don’t have a very sympathetic attitude, so if you’re saying it really hurts and I’d like something to stop it hurting, [they say] “it’s one of those things”. So it makes you feel like you’re being a child for being bothered about it, just be an adult.’

(Workshop 13)

The ‘getting by’ response is also perhaps a factor in why some patients find patient centredness so disconcerting. If you are muddling through and have a loose pattern in your head about what has happened before, but the doctor suddenly says, ‘so what would you like to do about this then?’, your structure, such as it is, is thrown. That is not what doctors are supposed to do; it is not what you have learned that doctors do.

‘Sometimes where there’s a difficulty is an expectation that they might be involved in making some choices about their healthcare, because often patients [don’t understand it’s] often not black and white, “we can do this or we can do that”. And patients are often quite surprised that we might involve them in making choices. [...] You get quite a lot of “you’re the doctor” type of thing.’

(Workshop 15)

‘Rabbit in headlights’

A second common patient response – and we heard many examples of this – is what we called ‘rabbit in headlights’: a paralysis and inability to focus, to ask questions or to hear properly what is being said by the doctor in the consultation.

Perceptions of time can become distorted. The consultation passes by in a flash for the patient and they emerge dazed and confused about what went on – and why they still do not have an answer to the question or worry that took them there in the first place. But this applies even to routine consultations, such as with a GP; we are not just seeing this in obviously high-stress situations for the patient such as the receipt of a serious diagnosis.

‘Once you are in patient mode, you suddenly become a different person. You become like the schoolchild who’s seeing the head in the school. You may hear the first sentence that’s uttered, and it depends on which word is emphasised that you centre on, and then you forget everything else, because you’re not listening. It’s not that you’re not listening but you’re not actually taking it in. And I’ve been to the doctor’s or somewhere, and I’ve forgotten half of what’s said to me even before, because unless you sort of tell them, look, either write it down or bring your [partner] with you ...’

(Workshop 19)

‘The patients who come in for planned major surgery, we will see them in the clinics several times during their staging process and we’ll be able to go through things on multiple occasions and they can come with their relatives [...] often when you first see them their minds are racing they don’t really assimilate the information that you give them. That’s the same as somebody who [...] becomes acutely unwell, even if we have the time to speak with them I think they don’t actually assimilate the information, they can’t really discuss it at length with their relatives or think about it, it’s very difficult

for patients to think of questions on the hoof. There is a real difference when you can see patients more than once, divided by a length of time when they can discuss with their relatives and friends and they can assimilate the information and they come back for a second time [and] you can have a much more fruitful conversation with them.’

(Workshop 16)

It also applies across the social and educational spectrum. Indeed, several of our expert interviewees – all acknowledged experts in the field of healthcare – also reported this as their own experience in being a patient. Social status, education, or even deep expertise in the health service and how it works, do not insulate people from this response.

Bypassing the consultation

These first two responses to the invisibility of the consulting structure are adaptive, or possibly maladaptive. But the third pre-empts the whole business: the patient cuts straight to the chase and comes in with specific demands, whether for prescription, referral or sick note. This attempt to bypass the consultation model infuriates and enrages doctors: the code or the etiquette is being broken. Like someone speaking out of turn, there is no acknowledgement or respect for the consulting structure that is central to the doctor’s training and professional identity.

Invisible structures throughout the system

We would suggest that invisible structures like this pervade the system and that we are not just seeing this at the level of doctor–patient interaction. Everyone is operating within a glass maze; the relations, logics and processes that guide decisions across the system are simply not mutually visible. This means clinicians will experience the same kind of ‘what’s going on?’ in engaging with other parts of the service like managers, appointments systems or lab services.

'Just people interrupting you or wanting a piece of you ... the transport arriving late. Classically in an older person's clinic, nobody arrives until an hour after you've sat there which is often quite useful time because we all have computers now ... but if all the clinic arrives at once, that inevitably affects the consultation. And it's all about pressure isn't it, in the system?'

(Workshop 15)

'I work (as a physio) in surgical wards and very much when the surgery has been done and the initial checks have been done [...] bearing in mind these patients have quite often been unwell for some time prior, they're not actually functionally fit for discharge, but medically fit and as soon as the wound's okay, our lovely doctors say, "right, you can go home now". And it's like, well actually, no they can't go now, because you've done this fabulous surgery which has basically debilitated them for one reason, but the reason they've gone on for ages is they've actually become so deconditioned, they've not maybe been out of bed for a couple of weeks, so there's an OTPT assessment and quite often dietary advice that's needed, to then start a process of discharge planning ... And what happens is, there's actually conflict right from the beginning, so relationships then can become compromised, and it means that we're the negative people that are coming to see the patients, rather than we're actually part of the team, we're all trying to strive to the same thing.'

(Workshop 3)

'One of the issues with our planned and emergencies is of course they can end up in bed side by side. So patients in the same four-bedded bay can be having very different experiences during their admission, and witness the experiences of other patients being seen by the same doctor every day. [...] So if you're an

emergency admission you notice that every day you're seeing a different doctor and the person in the bed next to you is seeing the same doctor every day. Or sometimes I'm going into the same room every day to see my patient, but a patient in another bed starts asking me questions because they start seeing me coming into that room every day. That happens quite a lot.

(Q: And presumably you need to deal with that in some way?) It's not possible to deal with it.'

(Workshop 16)

'The other thing we talked about was the imperative of having same sex bays and although the initiative of having same sex bays [...] is because it's good for the patient experience; the consequence is that people are endlessly moved around in order to reconfigure a bay for males and females. So actually people are benefiting in one sense in that they're not in a mixed sex environment but the [benefit] is all taken away from you every time you get moved. [...] And actually it's happening on a pretty large scale with poor consequences. [...] Often patients may be moved within different bays in the unit, maybe two or three times during their stay, and of course there are a different group of nurses in each bay, so each time they have to get used to a new set of staff, and that I'm sure is very difficult.'

(Workshop 16)

'But isn't it also to do with a degree of understanding about how the system works? It's not obvious is it to everyone else in the world, what doctors are responsible for, what a healthcare assistant's responsible for, what a sister's responsible for ... it assumes a degree of knowledge of the system which is a bit like ... if you went on the Tube or in M&S you don't have a great sense of who's

responsible for what. You assume if you see someone in uniform, you go up to them and sometimes you think, “I think this person might be the senior manager but hey they’ve got a badge on, I don’t care that I’m asking them where the jam is”. I just think “they work here, it’s their job to tell me where the jam is”; I don’t care that they’re a visiting senior manager.’

(Workshop 7)

Again we offer a few immediate thoughts about implications for quality in terms of the quality domains used by the Health Foundation and others.

- **Safety:** there is a clear risk to the patient through missed symptoms or side effects if they respond with ‘rabbit in headlights’ to a consultation.
- **Efficiency:** patients may well re-present if not satisfied with a first consultation through a dysfunctional dynamic.
- **Equity:** patients’ ability to get what they want and/or need will depend on their strategies for getting by – or may be limited by adopting other responses, like paralysis, or making demands.

As one of our policy group participants reflected: what would happen if the patient was given the same level of insight into the dynamics of the consultation as the doctor? They wondered first if that is possible and second what would its implications be. Note that we are talking here about giving patients information and insight not about conditions but about the hidden routines of medical practice. Not the content of diagnosis and prescription and advice (which remain the doctor’s area of expertise) but the process of consultation (which might be said to belong to both of them).

Chapter 5

Fragmented conversations

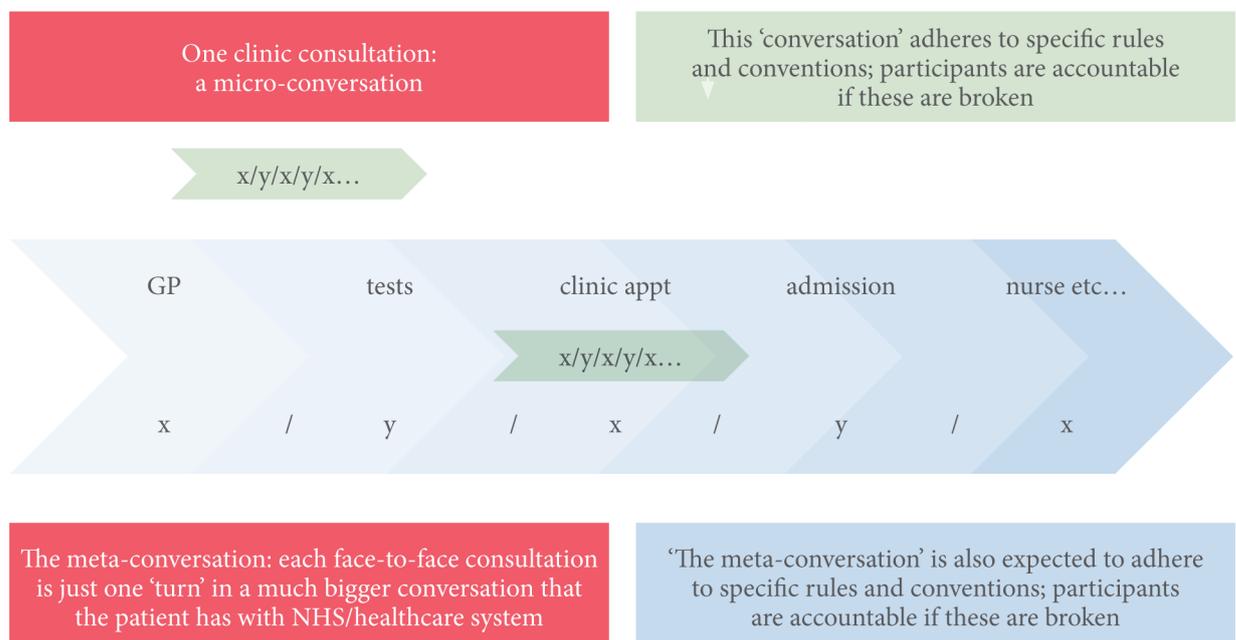
Clinician–patient interactions are, of course, conversations and we looked at them in the light of what we know from empirical work (especially in the academic field known as conversation analysis) about how conversation works in practice. (See appendix 2 for useful sources of information about the field of conversation analysis.)

Rules and conventions

Certain invisible rules apply to everyday conversations. As socialised, competent adults we operate with delicately managed interactive rules that help us organise ourselves socially; rules about how we manage turn taking, for example. If the rules and conventions of conversation are broken

and not adequately repaired through things like apology, explanation, acknowledgement and so on, then essentially our social interaction breaks down. Certain kinds of interaction – including doctor–patient consultations – are known to be ‘special cases’, systematically different from everyday or ‘ordinary’ conversations. There is well documented evidence that medical consultations have a particular fingerprint and operate to a particular set of conventions: their rules and patterns reflect the kinds of mismatches and structures that we talked about before. In this context, breaches of the rules, like the patient trying to drive the conversation or pre-empt the consultation stages, often result in sanctions being applied and breaches may be punished interactively.

Figure 10: The ‘consultation’ within a bigger ‘conversation’



The bigger picture

By scaling up we can think about the individual consultation as just one ‘turn’ in a much bigger conversation between the patient and the health service as a whole. For the patient, this conversation is one turn in a meta-conversation that includes other face-to-face conversations (for example with nurses or receptionists) but also things like tests, scans, admission processes and letters. Perhaps unsurprisingly, patients expect the meta-conversation to follow the same kinds of rules as an individual face-to-face conversation. In particular, they expect that each contribution they make will be heard and will be used to inform the reply – the next consultation or the next engagement they have with the health service. Because that is how our conversations work: I expect what I say effectively to be taken into account by the next thing you say and I will make strenuous efforts to make what you say make sense in those terms. This is a foundational mechanism in social interaction.

‘I think patients are quite understanding if you’re honest with them, if you say “this is the reason why we’re running late, sorry”, it helps to clear the air before you start by saying that, although you’re saying you start the relationship feeling guilty, you’re clearing the air in such a way. Because if you were not to apologise and not mention it and not acknowledge the fact they’ve been waiting, the whole time throughout the consultation, the patient I feel would be a bit annoyed, “I’ve been waiting all this time and they didn’t even acknowledge that”.’

(Workshop 7)

Effect on patient experience

So there are negative emotional consequences for patients if the rules are broken in the meta-conversation. If they are not ‘heard’ – their notes are missing, or what they said to their GP has not been communicated well to (or is being ignored by) the consultant, or promises are not kept – patients will feel ignored, demeaned and insulted at a deep level.

‘I’m just thinking about what you just said, when I go and see my GP and they say “how can I help you?”, [...] I would like them to say “Hi [name], I notice that you came six months ago”; just some sort of acknowledgement that they have actually looked at your notes ... There’s nothing wrong while you’re sitting down saying, “Let me just have a look at your notes ... oh I see you were here six months ago”, so you see that they’re actively looking at you, that’s it.’

(Workshop 9)

‘You know, the way it is now, not years ago. I’ve been on a ward all day long; a doctor’s supposed to come round and hasn’t turned up. Well, they have some commitment to that patient. They’ve done the procedure and they’ve done the operation, they know first hand what’s going on. I don’t, I’m not in theatre, and I just think that if they’ve dealt with that patient and operated on that patient, they should be there...’

(Q: So are you having conversations with that patient basically keeping them happy because the doctor’s not there?)
Yeah, “where’s the doctor, the doctor hasn’t turned up”; the family have been waiting all day; “oh he’s coming tomorrow now”. You know, it’s not good enough. I know they do a marvellous job but at the same time, it is kind of neglect.’

(Workshop 19)

‘Fifty per cent of the patients I’ve known since the first moment I arrived on the renal unit, 1996, and they’re still there with us. [...] You’re on first name terms with patients. When you sit down with a patient, you’re not going through the sort of classic taking history, because you actually know the history. It’s, “so how are things?” you know, you pick up where you left off. Yeah, it’s like a conversation that’s been carrying on.’

(Workshop 3)

Additionally, of course, what has just been ‘said’ at any one point will affect how patients enter the next part of the meta-conversation – so how they have been treated at outpatient reception will affect how they enter the clinical consultation. So patient records going missing is not just an administrative inconvenience, it seriously affects the quality of the patient’s experience and helps account for the fury and despair that we know surrounds such errors. It may also have serious consequences for health if it means the patient disengages, feeling insulted and unheard.

‘Pt: But that brings us back to expectations, because when we start on dialysis, we’re told very clearly by the clinician that dialysis should revolve around you; you shouldn’t revolve around it, so we put our life in place to do that, and then when that changes [...]

Dr: And you’re right; then we send you a letter saying that we may have to move you (to a different dialysis shift).’

(Workshop 3)

‘Transport for us is a huge issue down at patient dialysis, because it’s the start of the patient’s journey into this unit, and they do it three times a week. If it goes wrong, and it goes badly wrong [...], they’ve to be ready for six o’clock in the morning, they’re travelling in, they’re aware of the time, so by the time the guys get with us they’re really very anxious, very angry, very tired and it’s an extension of their day and stuff like that there. So it has a huge impact on how they’re even feeling about (dialysis), because their quality of life is just plummeting down [...] So you have to deal with that there, and of course because we work alongside (the ambulance service) and have no control, that’s where you have the problems. [...] I think it actually exhausts a lot of the staff because it’s continuously, six days a week.’

(Workshop 3)

Holding the meta-conversation together

As some of our policy group participants commented, the only glue that holds this meta-conversation together is the patient, yet none of the clinicians or others in the system whom the patient sees has the goal of sending the patient away equipped to be that glue.

‘The patients will be seen twice a day by the medical team, plus the nursing staff numerous times through the day, but the patients don’t always remember what they’re told. And then the relatives come in later in the evening often when the medical staff who are normally looking after patients aren’t there. The patient can’t quite remember exactly what they’ve been told and then the relatives may go and ask the on-call doctor, who doesn’t know the case at all, who may give them incomplete or incorrect information. They may ask a nurse who may not know the case; they may get a different snippet of information. So it’s not uncommon that that leads to concern and anxiety in the relatives.’

(Workshop 16)

‘I think there’s a lot of patient anxiety whenever they’re moved a lot; often patients are boarded on the units as we run out of beds within our unit. So they’re often boarded in the evening to try and create a space for overnight, so it’s an unusual time of day for patients to be moved and the staffing levels are lower and almost universally patients think they’ve been forgotten about. Their notes perhaps go missing when they’re boarded, the staff on the ward don’t know anything about their case, they’re not [inaudible] and that really leads to anxiety in the patients.’

(Workshop 16)

Doctors, for example, are seriously disadvantaged in how they can keep that meta-conversation going. (See Figure 11)

For the patient this is an ongoing conversation, but for the individual doctor it can be very difficult to keep track of that conversation. Even where there is continuity of care, the clinician is not equipped. Some GPs commented that one of the worst sins they commit is to call a patient back to discuss test results and then, when they sit down, to say, ‘What can I do for you today?’. The patient gets upset or angry; in conversational terms the rules have been broken. The patient is effectively saying ‘You asked me here, you opened this conversation, it’s your turn to speak, not mine.’

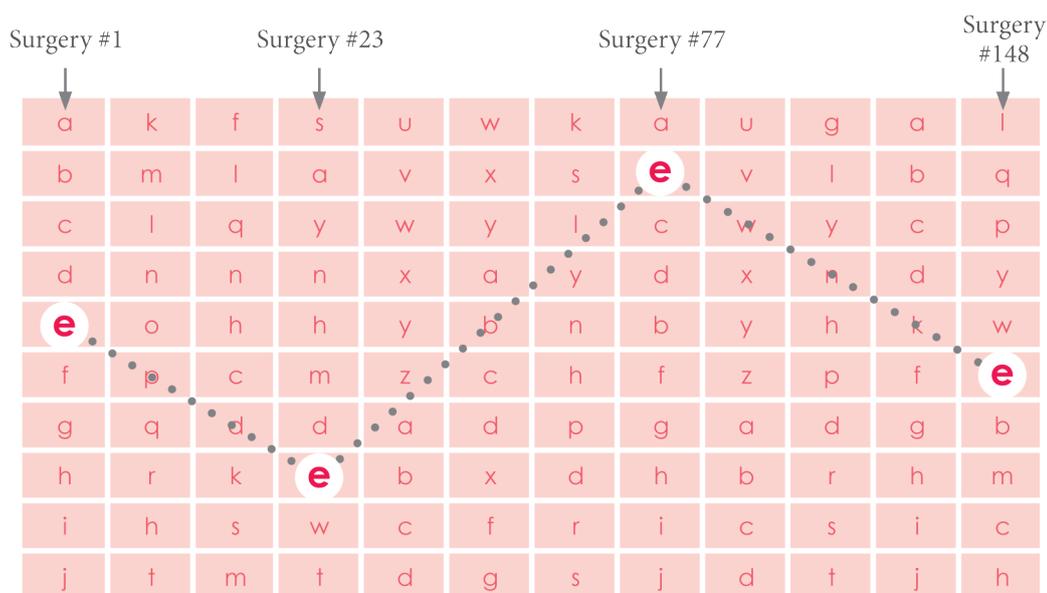
‘Those first five minutes, calling someone by the wrong name, not having the right notes in front of you, saying Mrs instead of Miss, all of that can start things off on a very bad foot and then it’s difficult sometimes to get back into a good consultation – and that’s maybe what the

patients remember. If it’s just that they’re irritated because they’ve been waiting a long time, generally that can be restored relatively quickly. If it’s that there’s a test in their notes that you didn’t know anything about and hasn’t been pulled out and you don’t know the results, then that I think is a little bit more difficult to restore.’

(Workshop 15)

‘Because if the patient’s attending for the first time then questions like “How can I help you today?” are valid but it won’t be appropriate if they’re revisiting you for the same issue and if you say that then the consultation starts off badly because the patient then feels that you really have forgotten them. [...] For example if it was somebody coming back after a depressive illness and you were just following them up then you would say “We last met four weeks ago, how have you been?”,’

Figure 11: Keeping the ‘conversation’ going: difficult for doctors



To patient ‘e’ this is an ongoing conversation... but the doctor has limited ‘vision’ of it as such. She/he may have seen hundreds of other patients between each consultation with ‘e’

something like that. You acknowledge that it's a continuing ... yeah. I have sometimes, occasionally fallen into the trap where I have genuinely forgotten the patient was coming back with the original problem and I said "What can I do for you today?" "Well, you asked me to come back".

(Workshop 17)

'What I find awkward is if they haven't booked the appointment with the doctor that did the test; "Well you should know". Well actually I don't because no, I didn't ask for it and it's not my result and I don't know you.'

(Workshop 17)

'It can be very easy for the unit to be chaotic [...] So patients may be sitting in Accident and Emergency waiting for a bed, they may be brought through to a combined assessment area, the nurses may be busy and they may not be seen for an hour or two and then they're maybe transferred up to the main ward an hour, after that to a different set of nurses. Very frequently, the overnight team for example may be completely different ... well, is completely different to the daytime team. And it's often the case where the junior staff overnight are not present on the following ward round, so the patient will be seen the next day by a completely different team of doctors who have not met that patient before and there is nobody with them who knows the patient's history. So it's very easy in that situation for the patients to think "nobody knows what's happening with me". So I think one part of a busy emergency unit is to try and keep that perception of chaos to a minimum, even though it can be sometimes quite chaotic. And that's quite a challenge I think.'

(Workshop 16)

Disengagement and non-participation

Again as our policy participants commented, much about the way things are constructed in healthcare makes care very transactional. The way in which medicine is taught as a series of disembodied symptoms somewhat detached from the patient, and the way in which outpatients systems are constructed, results in patients having single interactions with the system rather than continuous ones.

'It's just the fact that what you actually inherit is a pretty peeved person, because they've been through a process where they've been asked the same question six or seven times and they've come to the conclusion that no one is listening. And if it's an unusual answer that they've given ... for example there was a young chap who was a widower and everyone said the same thing to them, he'd had this about six times in one morning and then everyone wants to know what had happened. Which took it away completely from why he's come to hospital: it was about his social status rather than the chest pain he was experiencing. And he was very angry by the time we actually got him and it was quite hard dealing with that, because he just thought "nobody here is actually listening and I don't know what I came here for".'

(Workshop 16)

'I really recognise that whole thing where even in a letter, a referral from a GP, when you start asking patients questions about a problem that they've got in a clinic, they get quite exasperated: "Hang on, I've already had an x-ray and told my GP, I'm here to see you to sort the problem out, not to go through it all again". They definitely seem a bit ... that you already somehow know what the answer is. I think people see it as a disjointed organisation; you have to go through so many people to get to the right one. And that maybe seems to be disorganised.'

(Workshop 16)

'I control my pain relief, and I come into hospital and that's taken away. I've got Fentanyl patches but I lose control (of them), and it's quite stressful, because I know when to take my tablets and then they go in this cupboard and I can't get at them. [...] I think with any patient with a chronic condition, you are the expert in managing your long-term condition, and to suddenly have that control taken away from you when you come into hospital is bizarre and detrimental. And yet we don't seem to have a way round that at the moment, [...] then if the consultant came in [...] or one of the nurses came in, you're in a sort of different place in your mind aren't you? [...] You sometimes feel a bit resentful, because they're not listening.'

(Workshop 3)

The implications for quality of fragmented conversations across the system are clear. Patients are unlikely to engage and participate fully either in individual consultations or in their own care if they are constantly wrong-footed in the conversation and/or if they feel ignored or insulted by the system itself.

Chapter 6

System dynamics

An important part of our work was testing whether elements of the current dynamic may have been adopted by or else shaped by elements of the wider organisational/NHS dynamic. As we describe below, we believe this to be the case. Intervening in the patient–clinician dynamic will in itself change the NHS over time. This impact can obviously be speeded up by reinforcing interventions at other levels.

Brief overview of our systems approach

‘Every system is perfectly designed to achieve exactly the results it gets.’

In order to change a system, it is necessary to understand how it currently works. It is important to distinguish between designed systems and adaptive systems.

In general, designed systems (sewage, road, mechanical devices) follow the laws of mechanics and physics and adaptive systems are more biological and social. This is reflected in the difference between rules (more frequently applicable in designed systems) and ‘rules of thumb’ (social systems). Similarly, redundancy is almost always waste in designed systems, but can be the source of adaptive capacity in biological systems. In designed systems helpful rule changes can be introduced from the top of the organisation (or by individual intelligence). In adaptive systems, the appropriate rules of thumb can only be uncovered with multiple perspectives. As an example, when dealing with cultural diversity clinicians could

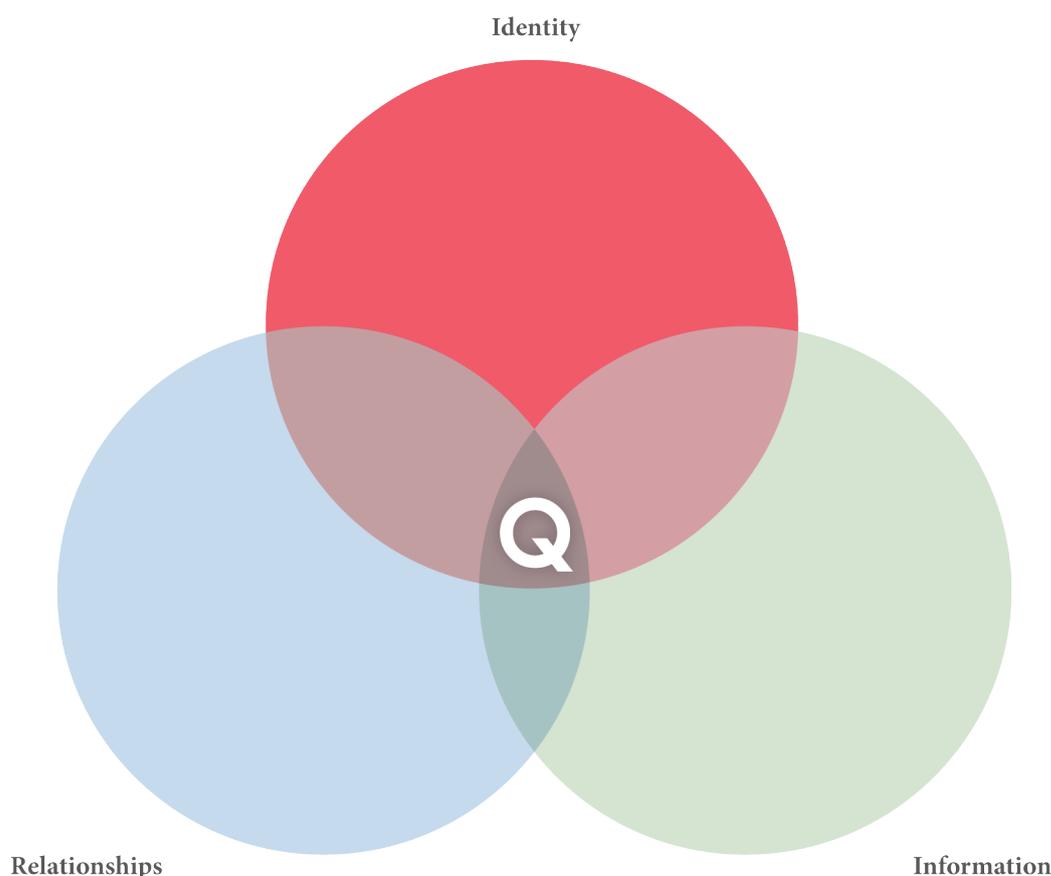
adopt a rule of thumb that asking is a sign of respect, not a display of ignorance. The dominant model of doctor–patient consultation privileges one viewpoint; so, for example, the Calgary–Cambridge consulting model talks of ‘incorporating the patient’s viewpoint’, which means bringing this into the doctor’s model, not giving it genuinely equal status or rearranging the entire relationship between ‘perspectives’.

This work suggests that not only is the quality of the direct interaction reduced by the current dynamic, but also that the adaptive capacity (ability to innovate) of the NHS is handicapped by the current dynamic (protected doctor and disempowered patient). We believe many of the system rules of thumb have been copied or adapted from the patient–doctor dynamic and have shaped the wider organisational/NHS system through their scalar or emergent properties. We have focused on the adaptive systems perspective in order to look at interventions that will transform the system.

Dynamic of the system

The model we use for intervening in complex adaptive social systems is one where quality would be an emergent outcome of the interaction between identity, relationships and information.

Figure 12: Interaction between identity, relationships and information



Myron Rogers

The strategy would be framed by clarifying the following.

- What is the question we are trying to answer here?
- What is the system for that question?
- Does the system know it's a system? Does it have access to itself?
- What wants to happen?

(Rogers and Wheatley, 1998)

Thus intervention would take the form of evolving the identity (meaning) of what the consultation is. This would then change the roles (and therefore rules of thumb) being used by doctors and patients. The new model we suggest would change what is seen as the skills required for being a doctor. They would need expertise in understanding uncertainty and to be organisationally literate. A doctor without relationship skills would simply not be a doctor. At the relationship level the set of guiding principles

is needed not only between patients and clinicians, but also between the consultation and the rest of the system that delivers care to that patient (which could comprise different organisations as well as carers). Information is a source of both order and energy. The system would strive to get open access to information (hard and soft, clinical and organisational, patient experience, cost and outcome) and the flow of information would be the central key around which everything would be organised (in-formation).

Dynamic within a system

While we think the patient–doctor dynamic shapes the core elements of how the system operates by iteration and interaction of its underlying identity and rules of thumb, its operation is also influenced by the general system dynamics of any organisation. A useful conceptualisation (based on work by Barry Oshry) is to see any system (or organisation) as having top, middle and bottom spaces.

Whether someone is a top, middle or bottom depends on the question the system is engaging with. Trust CEOs are tops within their organisation. But in a policy meeting with the secretary of state, the Department of Health (DoH) and strategic health authority CEOs, they are bottoms. Tops live in a world of complexity and responsibility. Middles live in a world of crunch (between the demands of tops and bottoms) and bottoms live in a world of neglect (they can see things that could be put right by tops). The tops' reflexive response is to suck up responsibility and feel burdened. Middles slide between and get torn. Bottoms hold 'them' responsible and feel done to. This dynamic plays out within the consultation and the organisation (and wider NHS system). In the consultation process, doctors are tops and feel burdened. Within their organisation, they are bottoms and feel oppressed. The lack of integration of the middles (where they bring information from across the system and work with it, identifying key issues and a common approach), exacerbates the 'fragmented conversation' discussed in Chapter 5 and prevents it being connected.

Non-joined-up patient conversations are an inevitable outcome of systems 'illiteracy' – the inability to see either the history of how we got here or the system as a whole. Instead of

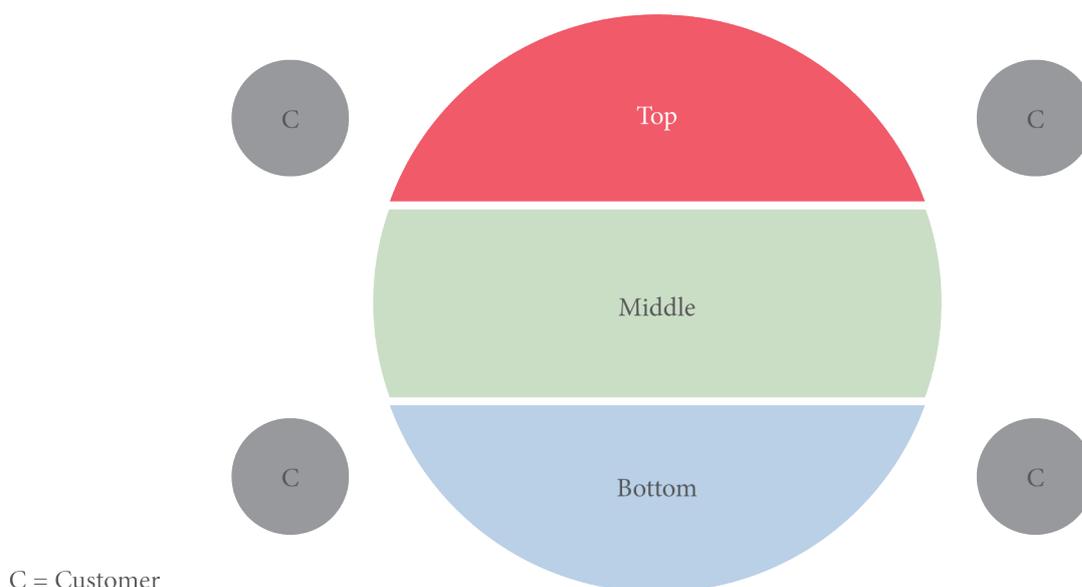
system integration, the reflexive response is to blame someone else or some other part and say partnership is impossible.

Another example is that of 'virtual teams'. We believe there should be real concern that the 'virtual clinical teams' we heard about in acute hospitals could have neither middle integration (across specialty as well as organisation) nor bottoms taking appropriate responsibility. This clearly has potential for systemic disaster. When groups (clinicians or managers) use 'not enough time' as an explanation for doing things badly or not doing them at all, it is usually evidence that the wider system's dynamic has gone wrong. It is a classic reflexive bottom response in the absence of middle integration.

We heard of many other examples of the dysfunctional interaction between poor systems dynamics and the particular dynamics of the NHS but we believe these distract from the main focus of this report.

Doctors have been the dominant power source (role, intelligence and class) in the NHS and consequently their models have been emulated by other groups seeking power. This not only has direct and obvious impact on quality, but the underlying ideology is a source of many difficulties the quality movement faces across the NHS.

Figure 13: Top, middle and bottom spaces



Based on Barry Oshry, Seeing Systems, Berrett-Koehler 1995

There is a real possibility that if the fundamental dynamic of the NHS (the patient–doctor dynamic)

embeds good practice, it will shape widespread good practice across many elements of the NHS.

Examples of wider systems impact of factors underlying the current patient–doctor dynamic

On a Health Foundation’s study tour on quality, one participant talked about the ‘pandemic fearfulness’ across the NHS. We believe that the fear we describe as driving the patient–doctor dynamic has permeated the wider NHS. Caught between the fear of engaging (including holding them to account) doctors and the fear of not meeting top down demands (whether targets or simply ‘feeding the beast’) managers do what is necessary to manage their fear rather than doing what is actually necessary to ensure quality for patients.

The dynamic of opening up and closing down has, when adopted within the system, reinforced a model of tokenistic consultation (only looking to confirm what they have decided; incorporating others’ views rather than building on or starting with them). Patients have largely been engaged by managers at very late stages in projects or in very narrow ways (through fear they will ask for too much or be unreasonable). Very few organisations have patients embedded in all core organisational processes (unlike organisations like Dana-Farber Cancer Institute).

The dynamic of opening up and closing down is a mechanism doctors have devised to cope with those few patients who they fear are insatiable but apply to every patient. Management has developed mechanisms to deal with the few incompetent doctors and applies them to all doctors. (It is worth noting that while doctors have developed a model for a few patients then applied it to all, they are furious when management adopts the same practice.)

Energy going into diagnosis has led to a near complete lack of interest in or research into compliance and concordance. There is an enormous amount of research on diagnosis and intervention (in both primary and secondary care), but close to none on the impact of consultation on the patient’s trajectory.

The lack of curiosity about or tracking of patient outcomes and consequences of the consultation episode (intended and unintended, concordance, PROMS etc.) over the last 50 years has contributed to an NHS culture of not being curious about the outcomes of policy, managerial or organisational decisions.

People working in isolation usually respond by doing more or doing harder rather than doing differently. One of the biggest disablers of quality or continuous improvement is ‘doom loop’ (Argyris, C. (1991) ‘Teaching Smart People How to Learn’, *Harvard Business Review* 69(3): 99-109), where people only focus on doing better what they know how to do better and stop questioning whether they are doing the right thing. The closed nature of the consultation and its lack of connection to the organisation at large increase the propensity for single loop learning.

The complete absence of any true feedback system within the patient–clinician consultation has been mirrored in the dearth of feedback and disconnection across the organisations and system as a whole. There is a desperate need to introduce real-time feedback systems.

The preservation of the consultation ‘behind closed doors’ led to the disconnection of the doctor from the organisation and the organisation from the patient (who was seen as the doctor’s property). Separation of the consultation kept management separated from clinical work. As delivery of healthcare is a shared enterprise, any separation will diminish quality.

continued on next page

The doctors' view that there is not enough time to do the consultation properly has not led to many attempts to innovate or coproduce the outcome differently. Very few practices ask the patient how much time they need and organise around it, despite evidence suggesting it works well. We had a strong reaction against it from many doctors in the sessions. Managers replicate trying to deal with issues in inappropriate time slots, or resort to imposing uni-perspective solutions because of 'lack of time'.

Disconnection of the consultation behind closed doors has led to disconnection of technical 'good doctor' and behaviour that had a negative impact on the patient. Behaviour that would never be allowed if it took place in public is tolerated. (The test of a good consultation is that it could be broadcast on TV and no one would find it unacceptable.) The model was one of competition (with at the extreme end, the domination of the patient). It is not seen that if a clinician cannot deal with people and organisational issues they are simply not competent. Within the wider system, this culture allows managers to get away with bullying behaviour at all levels of the system. There has been an almost total absence of any governance process or accountability around the consultation, and this can consequently be seen across the NHS governance system.

Working behind closed doors, combined with doctors' anxiety as to their effectiveness (as there has been historically no data), has institutionalised a fear of transparency. This reluctance to share clinical outcomes and thereby be accountable is a major hindrance to continuous improvement and public confidence in the NHS.

The focus on parts not wholes leads to interventions such as training in communication skills, which will reinforce rather than change the system.

Seeing patients as collective categories such as 'the clinic' or 'the waiting room' has not helped managers respond to diversity or individual patient journeys.

The separation of the consultation from the organisation reinforces in clinicians the mindset that quality is what they do individually and is not a systemic and/or organisational issue. This disassociation with the organisation makes clinical engagement, innovation (change that sticks) and quality improvement enormously hard.

The systemic disempowerment of the patient has made it hard for organisations to both think about and genuinely engage the resourcefulness of users. This is particularly critical as new sources of energy and resourcefulness are needed for the critical challenges the NHS faces.

Ideal/desired dynamic

The current patient–doctor dynamic largely protects the doctor from scrutiny and disempowers the patient. It is not difficult to imagine that this was functional at the inception of the NHS. It protected the doctor from any scrutiny in return for making difficult rationing decisions on behalf of the state and offering treatments whose outcomes were poorly understood. It also disempowered the patient, which enabled mass ‘production’. Any challenge or demand for a second opinion which would massively increase cost and increase waiting times was designed out.

Today’s health service operates in a significantly different technological and socio-cultural context. To date the response has not been to change the fundamental dynamic, but to add a veneer of niceness, for example better communication skills, to it. Given its fundamental role as the bedrock of clinical care, any changes to the patient–clinician dynamic will be felt across the system over time.

The dynamic needs to reflect that there are (at least) two parties engaging who have separate identities and possibly separate goals. The process of engagement must allow both parties to seek to achieve their desired goals in a way that supports their personal integrity. At the end of the consultation or interaction, both parties need to have a sense of ‘I did my part well/did myself justice’ (technically and socially) even if they continued to disagree or did not get what they hoped for. In this dynamic, a consultation ending with ‘I don’t feel you took sufficient account of xxx and I want a second opinion’ and ‘There is nothing I can do for you re. x’ could both be good outcomes.

Ideally, both parties understand that the consultation is a point in a process (the patient’s life, the clinician’s career). Both therefore need to be curious about the patterns and outcomes of their decisions and actions over time and willing (with the right systems to support them) to track them over time. These are patterns of usage, diagnosis and concordance, among others. This should allow the system to embed an approach of continuous improvement and the identification of constraints that would encourage innovation.

The consultation has to take place within a context of being better connected to the system. This would connect the clinician to the organisation and allow each consultation to be joined up to the patient’s conversation with the NHS.

The mindset would be of both participants being on the same side, both contributing to engage with the patient’s issue. The sense of ‘being in it together’ would reduce the fear quotient in the dynamic.

Chapter 7

What could be done?

Based on the five themes that arose during this study, a number of possible areas of intervention might be tested as means to change the dynamic described here. We set out these broad strategies below in relation to each of the five themes.

Intervention strategies

A key tenet of quality improvement is that ‘improvement can’t happen in darkness’. Similarly, in intervening in systems, it is first necessary to understand ‘what is’.

Therefore we recommend that quality improvement interventions should be part of a strategy that aims to:

- surface and make unsustainable some of the systemic forces and practices that maintain status quo
- co-create a desired model of the patient–doctor dynamic (not just in the moment of consultation, but of their relationship to the whole system)
- develop processes and support systems that increase likelihood of the patient and clinician being at their best in the moment of interaction
- support organisations to be ‘joined up’ around the consultation (both before and after)
- institutionalise learning about what supports and grows the above, and identify constraints that could be overcome with supported innovation.

Any strategy should aim to promote interventions that address:

- the identity (meaning) of the consultation
- the necessary relationships within it (and between it and the rest of the system)
- the information (in the widest sense, not just conventional data) around which the consultation should be structured.

What interventions could look like

The following list is intended to suggest possible quality improvement interventions and areas that such interventions might want to address. However, it is not meant to be either exhaustive or prescriptive. The suggestions are written with the assumption that any interventions would be based on learning, grounded in experience, developed and prototyped with the appropriate multiple perspectives (e.g. patients and managers as well as clinicians). Clearly, many interventions can impact on a number of categories. For example, supporting patients to prepare for the consultation helps make the underlying (invisible) structure more visible and reduces fear.

The consultation model

An analogy that we thought of when doing this work was of the patient and doctor engaged in a dance – but only the doctor knew the steps and could hear the music. We felt that it would be important to develop a new model that is robust in the face of the complexity highlighted. Any new model would need to be developed on three levels:

- when this approach would be appropriate
- how to do it (for participants)
- how to promote it (organisational and system roles).

Fear

We described the underlying clinician–patient dynamic as driven by fear. We found it useful to tease out different dimensions (interaction, existential and entitlement) of the fear and separate the doctor’s from the patient’s. Many interventions cut across these categories.

Patient fear

Interaction anxiety Preparation is a key process for reducing the patient’s anxiety that what matters to them will not get heard in the consultation. Every patient should be supported to prepare: thinking through what they want, which consultation model is most appropriate, what behaviours and information would be most helpful, how they signal this to the doctor, what they might need from the rest of the system, and so on. Clearly this in itself helps make the consultation process more visible.

One key underused resource is the waiting area and the time the patient spends there. Currently they mostly contribute to the patient’s disempowerment, but they have the potential to become a rich environment in which the patient can prepare (or finalise preparation) for the consultation or take any ‘next steps’ after the consultation. The physical and information environment could be radically restructured to support patients in both the process of preparing as well as providing supporting information.

This could be equally useful for the next steps after seeing the doctor. Another clearly underused resource is the ‘community of attendance’ – other patients waiting or just coming out of a consultation. While communities attending for a

similar condition are an obvious resource for each other, there is potential for generic support from anyone.

Many young adults talked about going to the doctor alone as being one of the rites of adulthood. A module could be developed to teach children about the consultation process and strategies for preparing for it and being effective in it.

Existential anxiety Society’s anxiety about illness is not the central focus here. However, preparation for and a better understanding of modern medicine (including randomness and probability) and the process involved in engaging with it might help reduce some aspects of this anxiety.

Entitlement anxiety From society’s perspective a certain amount of entitlement anxiety is a public good. Given there are limited resources, patients thinking twice as to whether they should be using public resources helps keep costs down. We think commissioners should intervene if they believe specific communities are disadvantaged through inappropriate entitlement anxiety. Other intervention should be around:

- helping patients prepare and think through their use of services
- encouraging feedback loops that explore patterns of usage
- improving doctors’ response to patients’ entitlement anxiety.

This last could be achieved by:

- doctors recognising that patients’ entitlement anxiety exists
- not punishing ‘mistakes’ (particularly by young adults)
- rewarding good behaviour (personally and systemically ... this could include charts of % patients doctors believed used them appropriately and % patients who thought with hindsight they used doctors appropriately). This could start local conversations about appropriate usage.

Doctor fear

Existential anxiety In one workshop a clinician said ‘only geneticists and oncologists understand uncertainty’. We are aware of the important role doctors can play in managing uncertainty

for the patient. However, our workshops and interviews suggested there is a need for a deeper understanding of risk, uncertainty and randomness among doctors. This not only relates to outcomes (of them making a mistake or missing a diagnosis as well as of a patient's condition) but also to the impact of uncertainty on behaviour. The work we advocate should be done by patients in understanding the process of diagnosis and intervention and preparing for the consultation should over time help reduce the doctor's anxiety. The more skilled the patient, the better the outcome for everyone will be.

Interaction anxiety One recurring anxiety for doctors was the insatiable patient – one who would talk endlessly about irrelevant issues. While understanding the process and preparing properly should reduce this, it will not make the anxiety go away. Work is needed to test whether this is true and what interventions might work in those cases. We heard many anecdotes about successful interventions. These ranged from the equivalent of 'relax, let them get on with it, they always stop leaving enough time to do the necessary work', to 'the right question three minutes in always turns it around'. Learning from this should obviously be disseminated and influence medical training. A more explicit consultation model which acknowledges that both parties have goals will also allow doctors a platform to say no to patient requests they regard as inappropriate.

The second concern was 'will they do what I say they ought to?'. Given the absence of feedback loops, or any other way into the conversation, a large percentage of doctors seem to have lapsed into a passive response to this, despite their passion for a good outcome. Having concordance and feedback loops as part of the new model will allow more honest conversations.

Entitlement anxiety Doctors are becoming increasingly accountable for (and constrained in) the interventions they prescribe. While this has to be addressed by the organisational (Trust or PCT) relationship, a different relationship with the patient and evidence around outcomes will significantly strengthen their ability to ensure quality is at the heart of organisational decisions.

Invisible structures

The consultation

We strongly recommend that there is considerable benefit in making the consultation process more explicit, as well as the processes around the consultation that make up the conversation. Patients need to understand the model and prepare accordingly. They need to be able to choose which dance they want, know the steps needed and be able to hear the music. Organisations should frequently video and review a percentage of all consultations. 'Consultation audit' should become a routine part of increasing transparency with regard to both process (both steps and music) and outcome.

Energy

We asked exceptionally highly regarded clinicians who do significant amounts of research why they never research what patients do after their consultation (in terms of compliance and concordance). We were intrigued by their response: 'it's too difficult ... the outcome might vary between different groups'. We would encourage interventions that got doctors more interested in outcome and concordance. These could range from supporting appropriate technology (see below) to designing organisational and systems incentives.

Better systems to gather history (not to eliminate the process, but to reduce the amount of time needed) might help. An example is Massachusetts Institute of Technology's (MIT) *I'm Listening* – a system for automatically conducting patient pre-visit interviews. It does not replace a human doctor, but can be used before a consultation to prepare the patient, deliver educational materials or triage care, and preorder appropriate tests, making better use of both doctor and patient time.

Fragmented conversations

Support systems to connect the whole

Support systems could be developed for doctors to provide some way of both contextualising and analysing the clinic to give clinicians a richer sense of the mix of people they were seeing and help them feel more in control of their workflow. This might include, for example, patterns of age, gender, frequency and type of visit, and how long ago the appointment was booked.

Connections should be made visible. For example, records should be structured in such a way as to make it easy for the part of the system that is engaging with the patient to ‘pick up the conversation’. It should be clearly visible to everyone which parts of the system are involved in a particular patient’s care (ideally graphically and dynamically given the diffusion of technology).

Surfacing the ‘whole conversation’

It appeared that a majority of the clinical teams (acute and primary) we spoke to talked about becoming increasingly ‘virtual’ in response to systemic pressures (ranging from the Working Time Directive to part-time salaried employment). Patients are increasingly being seen without any continuity of carer. Many junior doctors reported they did not even meet the clinician to whom they were handing over. Systems that made the whole conversation more visible would be invaluable in reducing the likelihood of poor quality outcomes. Patients need to be able to make sense of their whole experience (currently finding it both bewildering and anxiety-raising) and doctors need to be able to see the consequences (intended and unintended) of their actions on behaviour, understanding and outcomes.

Links into organisation

Increasingly quality care is being understood as an outcome of the organisation as a whole. It becomes essential to integrate what goes on behind closed doors into organisational life and *vice versa*. Organisations need better real-time links between the networks that provide care for the patient. Clinicians should have feedback as to how approachable reception was, how long individual patients have been waiting, what the waiting time in associated diagnostics is, among other

organisational measures. Real-time information about the workload of clinicians and patient experience should be visible to all.

User groups should review all organisational processes (from making an appointment onwards) and be active participants in continuous improvement processes that follow the reviews. The organisation’s response and progress in implementing user suggestions should also be tracked transparently. Patients’ resourcefulness should be seen as a key organisational resource.

Currently the patient is the glue that holds the conversation together. The better the patient does it, the less seriously the organisation takes responsibility for its role and the less it invests in systems to connect up the patient experience. As well as it not being appropriate for all patients (or any patient in certain circumstances) it also loses the learning gained from understanding the collective experience. Interventions need to be explored that develop the capacity of the system to hold the conversation together.

System dynamics

Real-time feedback loops

Currently feedback systems are conspicuous by their absence. Feedback is one of the most powerful interventions in a system. The closer to real time feedback is, and the more specific it is, the more powerful its impact.

There was no public information available in any organisation we held workshops in on clinical outcome, organisational relationships or patient experience. The only consistent feedback in waiting rooms was non-attendance (DNA) rate. This is both perverse (it is not providing feedback to those who did not turn up and DNAs benefit attending patients who wait for a shorter time) and punitive towards those who did turn up (keeps them in place and stigmatises them as members of a deviant group).

The lack of feedback also shows how the dynamic operates to protect the doctor and organisation (no data on the number of diagnoses the doctors missed, how long patients are kept waiting, how rude the receptionists were to patients and so on).

Developing real-time feedback systems around a ‘healthy’ patient–doctor–organisation dynamic would be a powerful systemic intervention. Service users should have to give an account for their behaviour in the same way as NHS employees.

Radical technology

There are significant possibilities in the radical use of technology; not traditional telemedicine or to simply automate existing processes, but to change the dynamic between patients and clinicians as well as relationships within the system. While technology may have a role to play in the feedback systems described above, it has additional possibilities in evolving a new basis for patients to relate to the system. Here we are simply pointing to areas that we believe should be scoped further, but have real transformative potential.

The MIT New Media Labs have piloted some very interesting work based on three principles:

- patients are the most underused resource in health care
- the revolution must take place in our everyday lives, not in the doctor’s office or the lab
- information transparency, not just information access, is the solution.

Patient–doctor relationships

Promising experiments have tried to radically address the information asymmetry between the patient and the doctor by the use of a bundle of approaches. These include shared decision making, moving from synchronous to asynchronous communication (with attendant gains not only in quality but scope for productivity gains) and the use of an avatar as an intermediary (which collapses the time spent focusing on past and allows patients to express themselves more openly, with fewer language constraints). Technology allows us new ways of understanding and supporting patients’ medication usage or concordance with any agreed intervention.

Patient–patient relationships

There has been some powerful work in the UK and abroad where patients connect to each other (either as groups who share a diagnosis or users of a particular organisation’s services). This could be to support original research or simply be a support network.

Patient–system relationships

Collective discovery at MIT aims to leverage the intuition and insight of patient communities to capture and mine information about everyday experiences. Moving the community discourse from anecdotes to data will lead to better decision-making, stronger self-advocacy, identification of novel therapies, and inspiration of better hypotheses in traditional research.

In the UK, the Care Quality Commission (CQC) is using sophisticated bots to scan local media for stories that might reflect underlying quality concerns.

It is not difficult to imagine systems that would radically transform users’ and carers’ ability to have a real voice in the system.

Appendix 1

Methods and sample

Interviews and workshops

Expert interviews

May – June 2009	Mix of UK locations	15 interviews between 30 minutes and 2 hours each with acknowledged experts in field of clinician–patient relationships and interaction
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Workshops

1/7/09	London	Patients only: seven patients
2/7/09	London	Nurses only: seven nurses
7/7/09	London	Mixed: three patients, three doctors, four other HCPs, one manager
7/7/09	Leeds	Patients only: seven patients under 35 years
13/7/09	London	Mixed younger: six patients under 30, four doctors under 35
26/7/09	London	Mental Health Trust team: two patients, two doctors, three nurses, one Occupational Therapist (OT)
30/7/09	London	Mixed: eight patients, five doctors, two other healthcare professionals (HCPs)
3/8/09	London	NHS managers: six managers
3/8/09	Ilford	Patients: eight patients
3/8/09	Ilford	GPs: six GPs
8/9/09	Leeds	Acute care clinical team cardiology: six doctors
9/9/09	Huddersfield	GPs: six GPs
15/9/09	Edinburgh	Mixed clinical teams: renal team: two patients, three doctors, one physiotherapist, two nurses. Acute medical team: two doctors, three nurses
15/9/09	Edinburgh	Patients only: seven patients
15/9/09	Edinburgh	Mixed clinical teams: Orthopaedics: three doctors, one physiotherapist, two nurses. Obstetrics/gynaecology: one doctor, two nurses. Cardiology: two doctors. Gastro team: one doctor, one nurse

Expert workshops

3/9/09	London	Change experts: six individuals with expertise in individual change
11/9/09	London	Change experts: six individuals with expertise in systemic change
11/9/09	London	Change experts: six individuals with expertise in integrating individual/systems change
29/9/09	London	Policy experts: drawn from NHS and other key stakeholder groups

Workshops lasted between two and two and a half hours each. All interviews and workshops were fully or partly recorded, and the majority of these recordings transcribed. All fieldwork was carried out by Martin Fischer and Gill Ereaut. Patients were recruited by Saros, a professional market research recruitment agency, to a specification designed by the researchers and the Health Foundation. Patients were paid a cash incentive to attend; clinical staff travelling to workshops were offered an honorarium or locum fee where appropriate.

Our approach for the workshops

What we mean by ‘the patient–clinician dynamic’ is the powerful but invisible web of forces which creates the context for, and thus shapes, each interaction between patients and clinicians and its meaning for all parties. As noted earlier, we aimed to collect and explore qualitative data through a set of frameworks based on two different but complementary theoretical backgrounds: complex adaptive social systems and discourse analysis. We used our theories eclectically and pragmatically – for example, using discourse analysis as a set of lenses of sensitising constructs through which to look at this data (rather than performing specific micro-analysis on what was said). Our major objective – the core of the brief we took – was to create fresh perspectives on familiar issues and scenarios that could shape future strategy.

From our initial interviews and overview of key literature we developed a number of themes and dimensions that appeared to be fruitful ways into the patient–clinician dynamic. These were all somewhat slippery ideas – abstract nouns which have multiple meanings within them – and we needed to break apart these meanings and help our participants work at a more detailed and subtle level. We did this primarily by setting up open qualitative conversations, aided in many cases by other approaches, including ‘thoughts bubbles’ and visual metaphor boards.

Thoughts bubbles

These are a very simple and flexible tool to invite participants to make visible for us things which they ‘know’ but which can take some time to emerge in a group discussion context. The blank template for the workshops where thoughts bubbles were used was this:

Participants were invited to complete all four bubbles – to imagine what is being said by each party and what is being thought but not said. Usually we asked participants to define the kind of interaction they chose to tell us about, asking only that there should be a patient and clinician involved. These then formed the basis of discussion with the individual and the group. (We did not make interpretations of these without input from the person who produced them.)



Visual metaphor boards

Possible strands within the patient–clinician dynamic which our interviewees and the literature had identified – like power, respect and responsibility – are often abstract and conceptual. Visual metaphor boards, using a wide range of carefully selected images, show several different interpretations – visual metaphors – of the same term. They were created in sets of two, one for each of two opposing ideas. This material works to help people break open abstract concepts – both to be more precise (‘what kind of power are we talking about?’) and more concrete (‘in this situation, in this way, this is what being powerful/powerless felt like to me’). We used the following pairs of boards when appropriate (boards were not used in all workshops).

- powerful/with authority – powerless/vulnerable
- active, responsible – passive, not responsible, done-unto
- knowledge – ignorance
- respect – disrespect
- short term, in the moment, now, one-off – long term, built over time, ongoing
- choice – no choice
- me alone – us/we together.

The full range of boards was used in two ways.

- As a planned session within the overall workshop design. In some workshops we deliberately explored the dimensions we hypothesised might be important by working through the set of boards with the group.
- Constant reference. The boards were used at some stage in several other workshops as appropriate. So, for example, if someone referred to an issue of ‘choice’, we might use that board to explore exactly how this ‘choice’ is imagined.

Appendix 2

Literature scan

The literature scan included the following items. Note this was not a full literature search and review, but a top-level scan to understand the dominant themes and approaches taken across a range of disciplines on the issue of patient–clinician interaction.

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