

DEVELOPING EFFECTIVE COMMUNICATION BETWEEN DOCTORS AND CLIENTS:

SEXUAL AND REPRODUCTIVE HEALTH CONSULTATIONS



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A PARTNERSHIP PROJECT:
UNIVERSITY OF TECHNOLOGY, SYDNEY (UTS)
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At all times the staff and clients were remarkably generous, being prepared to share their experiences and their insights about the health consultations and to openly discuss the communication that occurs between the doctors and the clients.

The rich and authentic video and audio recorded data collected as part of the research has enabled us to undertake a unique analysis of the language of the consultations between doctors and clients. We trust our observations and research findings will be useful to Family Planning organisations and to General Practitioners who undertake sexual and reproductive health consultations.


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Note: Pseudonyms have been used throughout this report and in all other published material.

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is a professional, collegial and friendly environment.
Staff strive to create a context where reciprocal
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are integrated with medical expertise and practice



EXECUTIVE SUMMARY

Nationally and internationally there is an increasing recognition of the critical importance and impact of communication within health care settings. The link between ineffective communication, communication breakdowns, client dissatisfaction, negative client outcomes and critical incidents is now well established, particularly within the acute care, emergency and surgical contexts (eg NSW Health 2005a; 2005b; Rhodes et al. 2004). Poor communication is the catalyst for most client complaints (NHMRC 2004; NSW Health Care Complaints Commission 2005; Taylor et al. 2002), sometimes leading to costly litigation. Conversely, it is now well documented that effective communication is a major contributor to client satisfaction with health care in general (O'Keefe 2001; Salomon et al. 1999; Sitzia and Wood 1997).

The research site for this project, Family Planning NSW (FPNSW), Ashfield is a professional, collegial and friendly environment. Staff strive to create a context where reciprocal interpersonal relationships between clients and staff are integrated with medical expertise and practice.

The professionalism and teamwork of the FPNSW staff were evident, and they demonstrated and articulated commitment to their work, the organisation and their clients. Staff showed an interest and keenness to be involved in the project. Evidence of this is the number of doctors who agreed to have their consultations video-recorded, and their willingness to reflect on and discuss their communication with researchers following the consultations.

While the project focussed on the doctors and their communicative encounters with clients, staff involvement extended from the CEO of FPNSW to the nurses and clerical staff. Sixteen FPNSW staff were interviewed, including doctors, a nurse, a clerical staff member and management. In addition, focus groups were held and non-participant observations of work practices and specific observations of consultations were carried out in order to familiarise the research team with the Family Planning context. Twenty doctor-client consultations involving six individual doctors were video and audio recorded. The consultations, interviews and focus groups were transcribed and analysed, field notes were taken and relevant documents were examined.

The research was conducted over approximately one year. Analysis of the data began during the data collection phase and continued for eight months after visits to the research site were completed. Ethics clearance was obtained from both partner organisations, and the project followed rigorous ethical procedures. Informed consent was obtained from participating clients and staff, transcripts were de-identified and all data were stored securely.

Consultations were characterised by extremely high levels of communicative competence on the part of the doctors. There was a significant match between what the clients and doctors understood as the main messages and meanings of the consultations. Both clients and doctors expressed satisfaction with procedures and communication in terms of information and explanations given and received, examinations, length of consultation time, empathy, rapport and advice. The consultations at FPNSW are usually 30 minutes in length in order to accommodate training requirements. For practical reasons the taped consultations in the study were also 30 minutes in duration and did not include a training practitioner. The positive impact on communication of this extended time frame and the limitations of translating the findings into time-poor settings including general practice, are acknowledged.

A feature of the consultations was the way in which the doctors integrated medical expertise with a concern to establish an interpersonal relationship that positioned the client as a confident and knowledgeable partner. The doctors established rapport and empathy with clients, while ensuring that medical content, processes and advice were explained in detail.

Each of the doctors, through a range of communicative strategies, ensured that clients were active participants in their own healthcare and they strove to empower clients during all stages of the consultations. This was achieved by:

1. Developing shared knowledge and shared decision-making:

- » Allowing space for a client to tell her story
- » Encouraging client participation and reflection through the use of particular questions, statements and acknowledgements
- » Finding out what the client already knows
- » Moving from technical (medical) to common sense (everyday) concepts.

2. Providing and checking information has been understood:

- » Explaining processes regarding what will happen next as well as about a client's condition and about the treatment and on-going management
- » Repeating key information verbally, checking and tracking questions and comments
- » Providing written information to take away and using 3D models
- » Providing clear instructions for medication and other follow-up treatment, appointments, etc.

3. Presenting medical knowledge and expertise:

- » Making the reasoning processes for treatment, advice, etc. available to the client
- » Communicating professional judgement sensitively
- » Asking for and valuing the client's knowledge and experiences.

4. Identifying, valuing and negotiating issues that are important to the client:

- » Negotiating between doctor and client about treatment
- » Responding to a client's anxiety about her medical condition
- » Remaining non-discriminatory, non-judgemental, open and respectful.

The doctors used particular language choices to develop empathy and rapport including:

1. Greeting the client with an informal introduction; using given names throughout the consultation; using *we* at key points in the consultation
2. Giving supportive, empathetic and reassuring feedback, verbally and non-verbally
3. Expressing personal attitudes and values (doctor and client)
4. Mirroring the client's comments regarding symptoms, attitudes or concerns
5. Interspersing some interpersonal chat with medical talk
6. Using colloquial language and informal expressions
7. Using modality and modulation
8. Sharing laughter and jokes where appropriate
9. Using collaborative completions.

Doctors often used a combination of strategies to check that clients understood what was being explained or discussed. Non-verbal strategies further enhanced client empowerment, empathy and rapport.

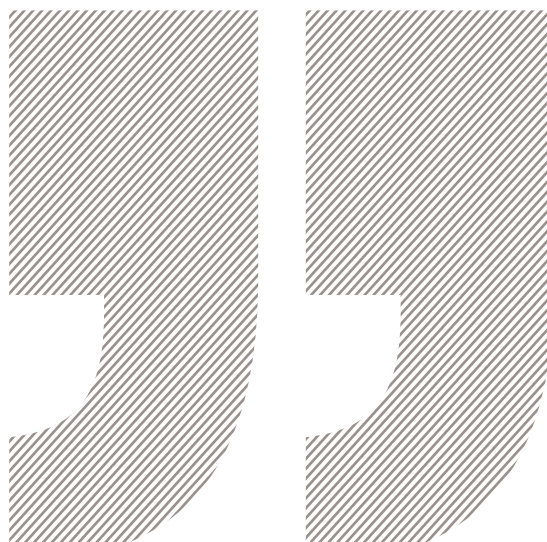
In some instances the practitioners gave very detailed and sometimes repetitive information which they were aware could overwhelm the client. Occasional communication difficulties also arose with clients from culturally and linguistically diverse backgrounds when the framing of questions and statements was overly complex.

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Section 1 outlines the aims of the project and the research methods. Sections 2 and 3 of the report detail the purpose and type of consultations and interviews with staff. Section 4 of the report describes the 20 doctor-client consultations including specific examples of the language and communication strategies the doctors used. Section 5 discusses the post-consultation interviews with doctors and clients. Section 6 provides concluding comments and suggestions for professional development. The final section, Section 7, outlines suggested recommendations.

A **key outcome** from the study is a detailed description and analysis of the interactions in FPNSW consultations, describing both the language and discourse features that constitute successful interactions, as well as the features that contribute to occasional disparity between the messages conveyed and received by doctors and clients. This, in turn, forms the basis of a framework for the description and analysis of doctor-client interactions applicable across a range of reproductive and sexual health contexts. The findings will contribute to professional development and service improvement approaches within FPNSW.

The **key recommendation** arising from the project findings is the design and delivery of two professional development modules for medical practitioners. The first module would explore in detail the ways in which doctors can build an effective interpersonal relationship with clients at the same time as addressing clients' medical concerns. The second module would build on the approaches and knowledge developed in the first module to produce video role-plays focussing on effective and less effective communicative situations. The role plays would be used for discussion and reflective activities.



1. INTRODUCTION

THE RESEARCH PROJECT FOCUSED ON HOW COMMUNICATION UNFOLDS IN CONSULTATIONS BETWEEN CLIENTS AND DOCTORS. THE OVERALL AIM OF THE PROJECT WAS TO UNDERSTAND HOW SPOKEN MESSAGES ARE CONVEYED AND RECEIVED BY DOCTORS AND CLIENTS IN SEXUAL HEALTH CONSULTATIONS AT FPNSW, IN ASHFIELD, SYDNEY. IN PARTICULAR, THE RESEARCH CENTRED ON DESCRIBING AND ANALYSING THE LANGUAGE AND COMMUNICATION STRATEGIES USED BY DOCTORS AND CLIENTS WITHIN CONSULTATIONS TO DISCOVER THE EXTENT TO WHICH ALL PARTICIPANTS LEFT THE CONSULTATION WITH SIMILAR UNDERSTANDINGS OR MESSAGES.

1.1 AIMS OF THE PROJECT

The overall aim of the project was to understand how spoken messages are conveyed and received by doctors and clients in sexual health consultations. More specifically the aims were:

1. To describe and analyse the language and communication strategies used by doctors and clients within consultations in FPNSW
2. To examine FPNSW consultations in terms of differing demographics, cultural and linguistic styles, beliefs and attitudes of both clients and doctors
3. Through follow-up interviews, to analyse the congruence or disparity between the messages conveyed and received by both doctors and clients.

1.2 RESEARCH METHODS

1.2.1 DATA COLLECTION

The data collection and analysis were carried out over a period of 12 months from August 2007 to July 2008. The study used qualitative ethnographic methods combined with discourse analysis and a study of non-verbal communication. The methods are outlined below.

Observations

- » Initial familiarisation visits to the research site were undertaken which included an information session for staff outlining the project.
- » Non-participant observations of the clinic at work, over a range of shifts, were undertaken.
- » Field notes of familiarisation visits and observations were written.

Interviews and focus groups

- » Interviews, up to one hour in duration, were conducted with eight doctors, the Chief Executive Officer, the Director of Research, the Senior Medical Coordinator, the Medical Director, the Director of Nursing, the Clinic Manager, a Clinic Nurse and the Head Receptionist.
- » Staff focus groups, up to one hour in duration, were held with five doctors and management staff, including the Medical Director, the Director of Nursing, the Clinic Manager, the Medical Education Coordinator and a Clinic Nurse.
- » Post-consultation interviews, up to fifteen minutes in duration, were conducted with the doctors and clients who had been video-taped.

Doctor-client consultations

- » Twenty doctor-client consultations were video-taped and transcribed, involving six doctors and four of their clients.
- » Observational notes were written by researchers during the video-taping.
- » Interviews and focus groups were digitally recorded and transcribed.
- » A short take-away questionnaire was given to clients for follow-up comments.

Video reflection

- » The doctors participating in the videoed consultations were offered the opportunity to view and reflect on their consultations.
- » One-to-one meetings between doctors and one of the researchers were held to discuss and further reflect on consultations.

Documentation

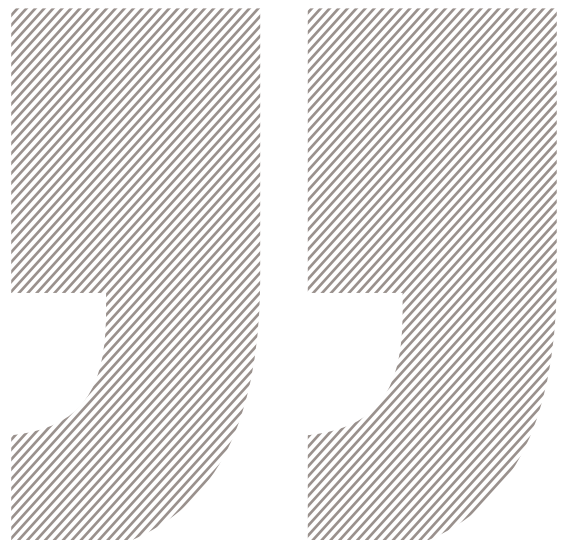
- » Relevant clinic documentation was examined, including procedural guidelines and protocols, workplace policies, handouts and pamphlets.

1.2.2 ANALYSIS

The data were analysed in the following ways:

- » Detailed discourse analysis was undertaken to identify the language and communication strategies used by doctors in the consultations.
- » Interviews and focus groups were analysed for the themes that emerged.
- » Observational notes were analysed to provide contextualised descriptions of the sociocultural conditions in which the consultations occurred.
- » Relevant documents, including procedures and processes of consultations, leaflets and other information given to clients, were examined to provide wider contextual knowledge.

The most in-depth analysis was carried out on the consultation data. The interactions were professionally transcribed and the researchers then had both the videos and the written transcriptions of the consultations to examine. The theoretical approach to the discourse and language analysis was based on systemic functional linguistics, conversational analysis and pragmatics. The main focus of the linguistic analysis was on how the language of the consultations was structured and used in authentic sexual and reproductive health interactions. The focus was on how language makes meanings for the doctors and the clients in the social context of the consultation.



2. MEDICAL CONSULTATIONS

SECTION 2 PROVIDES AN OVERVIEW OF THE PURPOSE AND TYPE OF FPNSW MEDICAL CONSULTATIONS. WHILE THE PRINCIPAL PURPOSE IS TO PROVIDE HIGH-QUALITY, EVIDENCE-BASED SEXUAL AND REPRODUCTIVE HEALTHCARE. THE CONSULTATION DATA SHOWS THAT DOCTORS ARE ALSO AWARE OF HOW IMPORTANT IT IS TO DEVELOP EMPATHY AND RAPPORT WITH CLIENTS. CONSULTATION DATA REVEALS FOUR MAIN CATEGORIES OF CONSULTATION WHICH WILL BE DETAILED IN THIS SECTION.

Analysis of the consultations reveals them to be not only sites of high quality healthcare but also sites that encourage and equip clients to become involved and to gain a sense of control in the decisions concerning their personal healthcare.

2.1 PURPOSE

The principal purpose of FPNSW consultations is to provide high-quality, evidence-based sexual and reproductive healthcare. The consultation data shows that doctors understand this purpose as involving medical and medically-related information, advice, discussion, explanation, procedures and treatment. However, it also shows foregrounding of interpersonal experiences and relationships through a focus on empathy and rapport, as seen in post-consultation remarks from one of the doctors:

I think she told me what she wanted to tell me ... I hope she took away a sense of being heard (Post-consultation interview D2).

This comment illustrates not only that the client is understood holistically, but also that the consultation is understood as a site of interpersonal relations, as well as medically-related actions and information.

Analysis of the consultations reveals them to be not only sites of high quality healthcare, but also sites that encourage and equip clients to become involved and to gain a sense of control in the decisions concerning their personal healthcare.

One doctor explicitly described this process to her client during a consultation:

This sort of thing is very much about you working out what is happening to you and what works for you and then us helping you to kind of fine tune it. But if it gives you a better sense of control over your life, then you can often make some changes in other areas that will allow you to have a more ... consistently smooth existence (Consultation C15).

This was also recognised by the clients as seen in these remarks from two post-consultation interviews:

Cause she said, like, she didn't push me into doing anything, she thoroughly explained what, which I did, as I said I did research so I sort of knew that there is things to do. And, as I said, because, and as she said, because I'm managing it that it's okay until it gets worse and I've got the option of coming, so that's good. It wasn't as if she was saying to me, oh, you have to do this or she was saying anything bad against it, which was really good, knowing that I can do either one or the other... And informed, yeah, properly. And I'll probably deal with my symptoms even better now knowing that that's just normal (Post-consultation interview C14).

Basically ... giving me the options, she's given me some materials to read about, read up on based on the questions I've asked about the contraceptives that I'm interested in. Um ... and she's ordered tests that I was hoping would be ordered in order to get some answers, if there's any, to the main reason I'm here (Post-consultation interview C05).

In the post-consultation interviews the clients themselves articulated both medically oriented and interpersonal reasons for their visits to FPNSW. They saw their needs as being met generally by the organisation and met particularly by the doctors. The following client comments reflect the success of the consultations in meeting client needs:

No, I think she's pretty easy to talk to, really (Post-consultation Interview C01).

Because I think she fully explains to you, as she's like, sympathetic towards what you're saying and she really does understand that (Post-consultation interview C14).

... in some ways I feel that my, the reason I'm here hasn't been brushed under the carpet (Post-consultation interview C05).

I think she explains it really well and I like the fact that she's honest and says it's not perfect ... her honesty about it, not like ... she doesn't sugar coat it, she's more direct and that's the kind of [person] just say it, it's not going to work, this could work (Post-consultation interview C17).

And they didn't try and pretend they knew everything. She listened and went, okay. And then she did ... the others were ... sort of like, they listened but they, it felt like they were looking down at you because you couldn't have really suffered that long (Post-consultation interview C17).

2.2 TYPES OF CONSULTATIONS

The recordings and transcriptions of consultations reveal four broad categories of consultation for the purposes of linguistic analysis. These categories reflect the study content and do not in any way attempt to describe the breadth of consultation types in the sexual and reproductive health setting. It is acknowledged that consultations will always include a mix of category types and a broad mixed type consultation has been included in the analysis. It is also noted that counselling type consultations are not included in the study which most likely reflects the fact that clients seeking counselling for sensitive issues may have declined to participate in the study.

The broad categories are:

- » Management consultations where the doctor and the client explore options for managing issues such as fertility control or menopause. For example, a client may be asking advice about contraceptive options or management of side effects (Appendix 2 contains an example of a management consultation)
- » Diagnosis and treatment consultations where clients are seeking diagnosis and treatment for symptoms such as a vaginal discharge or urinary frequency

- » Pre-procedural assessment consultations where the doctor talks through structured information about procedures and possible side-effects and problems after a client has made a decision, for example, to have an intrauterine device or contraceptive implant inserted
- » Procedural consultations where the doctor carries out a procedure such as inserting a contraceptive device. The consultation may include a review of the client's medical history and a preliminary test such as a pregnancy test.

Consultations can be divided into steps or stages, each with a specific purpose, for example, history-taking or diagnosis. Many of the stages are an integral part of all consultation types; however, there are some sections of each of the consultation types that are distinctive. FPNSW doctors are often able to predetermine the consultation type, for example, through access to written information provided by their clients regarding their problem or concerns. This allows the doctor to prepare for the consultation. Doctors are aware that there are often other reasons for the visit that may need to be drawn out.

Explicit knowledge of the structure of consultations based on in situ investigation, may be useful in the following ways:

- » Allowing consultation protocols and guidelines to be updated to take account of what is considered usual or good practice
- » Giving doctors authentic examples to use in training and professional development activities
- » Illustrating how a consultation that is often presented as a linear process, is quite complex due to, for example, the recursiveness of some steps
- » Coupling a reflexive approach with doctors' own practices to examine the coherence of their consultations; question the place of digressions; explore whether there are too many repetitions or recursions, and so on.

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2.3 LENGTH OF CONSULTATIONS

One of the main factors supporting the client-centred approach of FPNSW consultations is the 30-minute timeframe allocated to these consultations. This relatively long consultation time reflects the fact that FPNSW is a training organisation and many of the consultations would include the presence of another health professional for training purposes. It is acknowledged that this generous time schedule is not reflective of most busy general practice settings, and translation of the study outcomes into other settings needs to consider this difference. The 30-minute timeframe allows for consultations with many stages, some of which recur as the doctor and client explore multiple facets of client concerns and care. A distinctive feature that may arise from the longer timeframe, and the consequent capacity to recycle stages, is the number of client and doctor digressions. Digressions are one of the strategies doctors employ to develop rapport and the timeframe presents opportunities for this and other strategies to occur.

The following extract could be seen simply as an example of a digression or as an occasion where rapport between doctor and client is being constructed:

Client: *But then it says here, instead of using commercial lubricants which contain preservatives or antiseptics, try using [] or yoghurt.*

Doctor: *You could try yoghurt.*

Client: *Okay. [SMALL LAUGH]*

Doctor: *But, yeah, I think==*

Client: *The thing is, I wouldn't be doing it if it hurt anyway, so like, what is the reason to use it in the first place?*

Doctor: *This is, this is, the reason to use what?*

Client: *Any kind of lubricant.*

Doctor: *Well, you know, I was actually just reading about it, cause we spoke about it last week, I rang you last week when the results came back, and I was just reading the latest on it and one of the points was, and I don't, can't explain to you why but they said that, you know, maybe using some lubrication with intercourse may actually help. But I don't know the mechanisms with that==*

Client: *==Right, okay.*

Doctor: *So you may decide not to worry about that part. With the yoghurt, with sex, in the old days, like when I first did Family Planning which was about 20 years ago, we used to say you could actually dip a tampon into acidophilous yoghurt, just plain acidophilous yoghurt, put it inside your vagina and leave it in for sort of 10 minutes and then remove it and it works on making the vagina, it changes the flora in the vagina and thrush don't – the flora means the bugs, the normal bugs – or the equilibrium of the bugs and thrush don't like that. So it's actually changing the acidity of the vagina by using acidophilous yoghurt in that way. And I*

Extra time enables the doctor to lead the client to an understanding of her condition, and to an informed decision, and it further enables the doctor to validate what the client is feeling.

think that's where they come right into it when they say, you know, this sort of yoghurt.

Client: *We've done, when I was in the south of France I wasn't near a pharmacy and I had it and I used yoghurt and that==*

Doctor: *==Vaginally?*

Client: *Yeah. Only because I hadn't, you know, wasn't able to get to, and that did work, it really helped a lot.*

Doctor: *Yeah. So it sort of, you know, people ask, well, what if I drink all those yoghurt drinks and the Yukult sort of drinks. There's actually no evidence to show that it actually affects you vaginally, you know in that way. I mean, it's certainly healthy, they're healthy sort of things to do but I don't know if it will have much effect on the vaginal, sort of using the yoghurt locally.*

Client: *Okay (Consultation C02).*

Within FPNSW consultations the client is seen as an informed decision-maker and many clients in the post-consultation feedback sessions commented that it is the extra time given to them that motivates them to come to FPNSW, as seen in this client comment:

Um, I feel it's a bit more relaxed, with Family Planning. And there's no way I would've been able to spend so much time with my GP because of course ... I mean, I have a good relationship with my GP but, then, he's a very, very busy man and I just feel ... I'm conscious that, okay, there are a lot of clients waiting as well so I just try and get straight to the point to try and get out of there as fast as I can. And I think I do myself a disservice there so I thought, okay, I'll come here because I know that I can take a bit more time and go through, you know, concerns I have and get some questions answered

(Post-consultation interview C05).

Extra time enables the doctor to lead the client to an understanding of her condition, and to an informed decision, and it further enables the doctor to validate what the client is feeling.

One client's post-consultation comment sums this up:

For me? Well, I was very pleased with the results because it's like what I actually thought and, like, I found that no-one really understood me fully like she did. So, and that it was, I wasn't going mad or anything like that. So, it's good to know that that's actually normal, that I'm experiencing. Because I actually thought it was all in my head at one stage. Cause I used to get right, left and centre different information. So, yeah (Post-consultation interview C14).



With more time, more questions are asked and answered, more information is given and more extensive time can be spent exploring the client's experiences, as seen in this exchange.

Doctor: *So if there are times, you say there's many times where it hasn't been as bad as other times and you just, what, it just sort of settles down—and goes away?*

Client: *==Yeah, yeah.*

Doctor: *And how long does it take to settle down?*

Client: *Four days.*

Doctor: *Okay. And do you use anything else to sort of, you know, are you applying anything else? So you're just leaving it alone.*

Client: *Mm.*

Doctor: *And just washing with water, is that right?*

Client: *Yeah.*

Doctor: *So nothing else?*

Client: *No.*

Doctor: *Okay.*

Client: *But I think when I have (been) sore, as I say, wearing like lycra clothes, it probably does aggravate it a little bit.*

Doctor: *Yeah, yeah. So when you, how many times have you actually gone to the chemist and had—treatment?*

Client: *==About six or seven times.*

Doctor: *And tell me what you've used.*

Client: *Canesten.*

Doctor: *And what sort of dosage?*

Client: *Oh, the sort of three day one. And the last one I used the new pill you take.*

Doctor: *So the (Diflucan)—*

Client: *==Yeah.*

Doctor: *with the Canesten or separately?*

Client: *Yeah, with the cream so.*

Doctor: *Canesten. So it's usually the three days, over the six of those times maybe you've used the three day—*

Client: *==Yeah, yeah.*

Doctor: *the vaginal?*

Client: *Yeah, yeah.*

Doctor: *Yep... And the last time was the tablet and— the cream?*

Client: *==Yep.*

Doctor: *And when you use it, do you notice any difference?*

Client: *Well, obviously, yeah, it does goes away. When it's been that bad I generally tend to—*

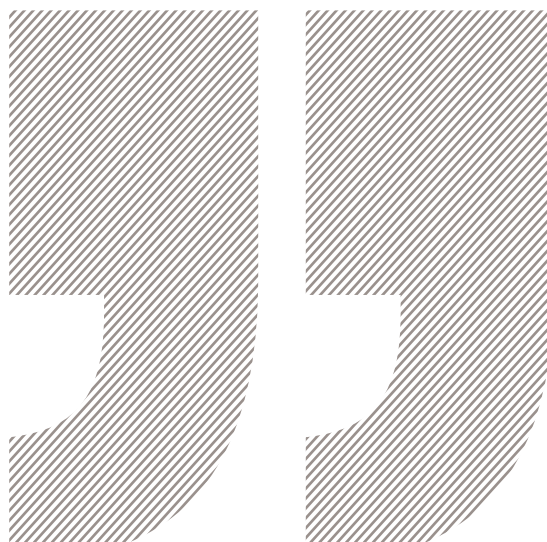
Doctor: *==Does it go away fairly promptly? Like the next day or something?*

Client: *No. Normally t wo days (Consultation C02).*

The client comments and the consultation extracts above demonstrate how strongly the interpersonal is foregrounded, particularly in the building of empathy and rapport between doctor and client.

Despite the relatively long timeframe allocated, consultations occasionally and inevitably run overtime with clients left in the waiting room prior to their allocated appointment. As noted by several of the doctors, this can impede communication as clients may become irritated or angry.

In the data set of 20 recorded consultations, seven ran overtime. The longest consultation ran for 47 minutes and 18 seconds and was characterised by lengthy digressions and many recursions. It is interesting to note that 13 of the recorded consultations were completed well within the 30-minute allocation, with most concluded within 22 minutes. Despite the shorter duration, these consultations were characterised by effective communication strategies and high client and doctor satisfaction. It may be useful to explore different ways the interactions can combine medical and interpersonal experiences satisfactorily without lengthy digressions or recursions.



3. INTERVIEWS AND FOCUS GROUPS

SECTION 3 IDENTIFIES THE THEMES THAT EMERGED FROM INTERVIEWS AND FOCUS GROUPS CONDUCTED WITH FPNSW STAFF. IN PARTICULAR THE ORGANISATIONAL CULTURE, WHICH WAS ASSESSED VERY FAVOURABLY BY STAFF, WILL BE DISCUSSED. THE VALUES AND BELIEFS OF THE MEDICAL STAFF WILL BE DETAILED INDICATING THEIR CONCERN FOR THE WHOLE CLIENT.

Doctors' concern with the whole client is evident in their views of the roles and relationships of clients and doctors, their awareness of the importance of client empowerment and their attitudes of respect and tolerance.

3.1 FPNSW – THE ORGANISATION

In this section the interviews with staff and the focus group findings are discussed. Many of the interviewed staff members have worked at FPNSW for 10 to 20 years or longer. In the interviews and focus groups, the overall organisation was assessed very favourably by those interviewed. The positive working environment, team support, extended consultation times and the general effectiveness of communication within FPNSW emerged as important features. The values and beliefs of the doctors regarding their work were emphasised in their responses.

Doctors' concern with the whole client is evident in their views of the roles and relationships of clients and doctors, their awareness of the importance of client empowerment and their attitudes of respect and tolerance. Analysis of the interviews and focus groups reveals the following four main themes:

1. Organisational culture
2. Values and beliefs of medical staff
3. Communication strategies in consultations
4. Communication difficulties in consultations.

Most of the interview questions related directly to communication. Notably however, the first two themes emerged spontaneously, even though there were no specific questions focussing on the organisation or the values and beliefs of staff (see Appendix 3 for interview questions).

3.2 ORGANISATIONAL CULTURE

Effective communication within the organisation

FPNSW is perceived by staff to communicate effectively as an organisation, as can be seen in these comments:

Communication-wise they've done their best to keep all channels open as much as possible for us (Interview Dr4).

[It] impresses me the way communication happens here at FP (Interview Dr7).

Effective communication within FPNSW contributes to a feeling of being in a positive and supportive team environment, *as communication is so important to teamwork*. Some of the comments about communication began with statements such as *it's not perfect but* Staff commented on the effectiveness of the email system in keeping them informed, and on administrative and medical staff meetings as an opportunities for grievances to be aired. Critically, staff felt comfortable in speaking up if there was a problem. Staff talked about informal *grapevine* communication such as chats in the tearoom, staffroom and corridors, or when cleaning up a room together. In addition, in terms of professional communication regarding clients, doctors noted that all their peers were generally good at writing up notes and were *conscious of the fact that*

The culture of the organisation and the doctors' beliefs and values provide the context and underpinning for the communication strategies used in the consultations.

everything really clearly needs to be documented and you've got to keep great notes.

The organisation itself features strongly in interview responses. Both clerical and medical staff recognise the importance of the organisational context and how people work together professionally and interpersonally.

Positive working environment

All staff commented on the special working environment of FPNSW, seeing it as a great environment to work in. Staff expressed both gratitude and pleasure to be working in the organisation, as stated by one doctor:

We actually work like a family ... and being in a family of women, we're all very understanding of each other (Interview Dr3).

Most commented on the happy and friendly atmosphere eg *We get on well and it has a good vibe*. Comments were made about FPNSW being a supportive place to work eg *We all feel, I feel supported and valued*. Support was seen as professional, with staff encouraged to undertake ongoing professional development, and also personal, with doctors able to work part-time and flexibly as their family lives were taken into account. Comments were made about the lack of hierarchy within the organisation, eg *Everybody's very open and we feel we can approach everyone*. A clerical staff member stated *I feel at ease knocking on the CEO's door and having a chat ... I think that's something special*.

Team support

A theme that emerges very strongly in the interviews is one of support. All members of staff from the Head Receptionist through to the CEO feel supported by other members of the FP team. The CEO felt supported by the directors and noted that the dedication of senior staff is such that *they're here and available if needs be*. The Head Receptionist felt supported by her management – *You know if you can't handle it, someone else can*. The Clinic Manager stated that she is *strongly supported* by senior management. One of the nurses commented – *We're working with very senior and experienced people that are available at the drop of a hat*. The doctors felt supported by everyone including clerical staff, nurses, other doctors and management.

All the doctors speak about *corridor consultations*, of being able to seek immediate advice and assistance from other members of the team, if needed.

Many doctors talked about the availability and approachability of the Medical Director for consultation and debriefing, describing her as *very approachable and very encouraging*. Doctors spoke about the support they received from the nurses who prepared pathology, followed up clients and *filled the drawers with goodies*.

The role of reception is crucial in the FPNSW team as the staff members who work at and around the front desk are the first contact

a client has with the organisation. Clerical staff commented on the importance of treating clients with respect and dignity. They are aware that *the way you welcome someone in sets a feeling of the whole process*. In a practical sense, doctors know that reception will remind them if they have clients waiting, or will make clients tea and coffee if they are waiting for a long time.

Extended consultation times

Doctors recognise that they are *really fortunate in having half-hour appointments*. They are aware that this is only possible because FPNSW has a further responsibility as a professional development and training organisation. Many of the doctors have worked previously, or work concurrently, as general practitioners where they have much shorter consultation times. The doctors noted that they still need to maintain boundaries around time but one commented that she never felt rushed.

3.3 VALUES AND BELIEFS OF MEDICAL STAFF

Comments made by the doctors exemplify a number of shared underlying values and beliefs.

Roles and relationships of doctors and clients

As doctors discussed the ways they communicated with clients, there were often strong indications that they believe medical components of consultations needed to be seen as arising from, or part of, an interpersonal relationship, as can be seen in the following comments:

The woman that's sitting here is so important for me (Interview Dr8).

Treat people as people [rather than what's wrong with them] (Interview Dr5).

Ethos of client empowerment

A strong theme is the perceived importance of client empowerment and autonomy. Doctors understand that clients should be active agents in decisions about their sexual and reproductive health, as seen in these comments:

A lot of the stuff we do here is about empowering women (Interview Dr9).

Because it's their body, it's their decision at the end of the day (Interview Dr4).

Respectful, non-judgemental, open-minded approaches

Doctors are very aware of the need to approach each consultation with no preconceived views, as highlighted in these comments:

You leave it [judgement] at the door (Interview Dr5).

We're all different and we just have to accept the diversity of people (Interview Dr4).

Make people feel unjudged ... that's very important in getting people to open up ... to have a genuine interest and an open mind is really important (Focus group 1).

The culture of the organisation and the doctors' beliefs and values provide the context and underpinning for the communication strategies used in the consultations.

3.4 COMMUNICATION STRATEGIES IN CONSULTATIONS

There was a general feeling that *we ... pride ourselves on being good communicators*. In the interviews the doctors raised, and expanded on, a large number of strategies they employed. The culture of the organisation and the doctors' values and perspectives on the purposes of their work translated into an array of rapport and empathy strategies and client empowerment strategies used in the consultations.

Rapport and empathy building

To build rapport and empathy doctors saw initial contact as important. They talked about how they welcome clients, set clients at ease and encourage clients *to tell their story*, using the following strategies:

- » Greeting clients with a smile and a handshake
- » Welcoming clients
- » Introducing themselves, usually by first name
- » Starting with an open question which allows the clients to dictate the consultation
- » Making eye contact
- » Actively listening with no interruptions and giving clients extra time to answer
- » Prompting clients to encourage further information
- » Observing body language and facial expressions to see if clients are, for example, anxious or tired
- » Talking during examinations on interpersonal topics such as recipes or children
- » Being friendly, open and encouraging.

Client empowerment

Doctors said they encourage clients to give them as much information as possible by using the strategies outlined above. In turn, the doctors try to impart as much knowledge as they can to enable clients to make informed decisions about their diagnosis, treatment and any procedures. Doctors also explain at all stages of the consultation what will be happening next by:

- » Advising clients when they are going to ask personal questions
- » Explaining procedures or when things might be painful
- » Giving written information such as fact sheets and care plans
- » Using diagrams and models

- » Repeating information and getting clients to repeat information
- » Talking slowly
- » Giving clients a range of ideas about their problem and management
- » Letting clients know they do not need to make a decision immediately
- » Validating aspects of their lives eg amount of discharge and frequency of sex
- » Checking that people understand information, procedures etc
- » Encouraging people to ring back if they have questions
- » Telling clients they do not have to answer if they find it too embarrassing.

3.5 COMMUNICATION DIFFICULTIES IN CONSULTATIONS

The FPNSW doctors were asked to reflect on any obstacles that affected communication with clients. They expressed a variety of concerns ranging from distractions and organisational factors to issues related to client knowledge and culture:

- » Knowledge, language and cultural barriers with clients from language backgrounds other than English, or clients with limited educational backgrounds can cause communication difficulties. In some cases there is a need to use interpreters or family members to translate and interpret
- » Relatives in the room, such as children or husbands, can cause communication problems because *you're not dealing with one person, you're dealing with two*. For example, if a mother accompanies her daughter the doctor may feel the need *to advocate for the daughter without putting mother off*
- » Organisational factors such as keeping people waiting or interruptions from phone calls can lead to defensiveness and the doctor *has to gain their trust again*. The doctors were aware of trying to develop rapport but being conscious of the consultation timeframe
- » Information-giving means striking a balance between giving enough information so that clients can make their own decisions and giving too much information and *overwhelming them with information*. The doctors were conscious of their medico-legal obligations in consultations and feeling an *education imperative* to inform the client, while using technical language.



4. ANALYSIS OF COMMUNICATION

IN SECTION 4 THE ANALYSIS OF THE CONSULTATION DATA IS PRESENTED AND DISCUSSED. THE ANALYSIS CONTAINS EXAMPLES OF INTERACTIONS BETWEEN CLIENTS AND DOCTORS THAT ILLUSTRATE MANY OF THE POINTS RAISED IN THE INTERVIEWS, PARTICULARLY THE COMMUNICATION STRATEGIES USED BY THE DOCTORS. THE ANALYSIS CONCENTRATES ON HOW TO CHARACTERISE AND ACHIEVE AN EFFECTIVE DOCTOR-CLIENT RELATIONSHIP, AND IT DESCRIBES THE DISCOURSE AND LANGUAGE FEATURES OF SUCCESSFUL NEGOTIATIONS BETWEEN CLIENTS AND DOCTORS IN FPNSW CONSULTATIONS.

A key reason for attending to the interpersonal aspects of communication in the consultations is to point out that communicative wellbeing is part of the consultation experience. If a client feels that rapport and empathy have been established, this contributes to their satisfaction with the consultation.

4.1 COMMUNICATION STRATEGIES IN CONSULTATIONS

Doctors need to learn complex rhetorical strategies that enable them to work with clients in building the shared knowledge that is vital for an accurate diagnosis and an effective treatment plan. The doctor must establish a medical diagnosis, develop a management and/or treatment plan and give advice, while at the same time building an interpersonal relationship with the client to enhance client control and empowerment regarding their sexual and reproductive health. It is the balance between these two aspects of the consultation that determines the effectiveness of the consultation.

The analysis of the consultations focuses on the balance between the medical and the interpersonal aspects of the consultations. It describes how medical knowledge and expertise are articulated and performed by doctors through their probing of the medical concerns of the clients. This is then mapped onto the clients' representations of their subjective experiences of what their problems are.

A key reason for attending to the interpersonal aspects of communication in the consultations is to point out that communicative wellbeing is part of the consultation experience. If a client feels that rapport and empathy have been established, this contributes to their satisfaction with the consultation.

The discussion that follows explores how the medical content, developed through advice, information, procedures and medication, and the interpersonal relationship between the doctor and the client, are represented in the interactions that were observed and video-taped.

To examine the consultation talk, the communication strategies used by doctors are divided into two broad categories. The first relates directly to the medical aspects of the consultations, and the second relates more specifically to the interpersonal aspects that doctors incorporated into their biomedical expertise and practice during the consultations. The two categories are communicating medical knowledge, and communicating the doctor-client relationship: developing rapport and empathy. The key features of these two areas are:

Communicating medical knowledge

1. Developing shared knowledge and shared decision-making:
 - » Allowing space for a client to tell her story
 - » Encouraging client participation and reflection through the use of particular questions, statements and acknowledgements
 - » Finding out what the client already knows
 - » Moving from technical (medical) to common sense (everyday) concepts.
2. Providing and checking information has been understood:
 - » Explaining processes regarding what will happen next as well as about a client's condition and about treatment and on-going management

- » Repeating key information verbally, checking and tracking questions and comments
 - » Providing written information to take away and using 3D models
 - » Providing clear instructions for medication and other follow-up treatment, appointments, etc.
3. Presenting medical knowledge and expertise:
 - » Making the reasoning processes for treatment, advice, etc. available to the client
 - » Communicating professional judgement sensitively
 - » Asking for and valuing the client's knowledge and experiences.
 4. Identifying, valuing and negotiating issues that are important to the client:
 - » Negotiating between doctor and client about treatment
 - » Responding to a client's anxiety about her medical condition
 - » Remaining non-discriminatory, non-judgemental, open and respectful.

Communicating doctor-client relationship: developing rapport and empathy

1. Greeting the client with an informal introduction; using given names throughout the consultation; using *we* at key points in the consultation
2. Giving supportive, empathetic and reassuring feedback, verbally and non-verbally
3. Expressing personal attitudes and values (doctor and client)
4. Mirroring client's comments regarding symptoms, attitudes or concerns
5. Interspersing interpersonal chat with medical talk
6. Using colloquial language and informal expressions
7. Using modality and modulation
8. Sharing laughter and jokes
9. Using collaborative completions.

What follows are examples from the consultations of each of the categories above. In Appendix 1 we describe a consultation that demonstrated a combination of these strategies.

4.2 COMMUNICATING MEDICAL KNOWLEDGE

4.2.1 DEVELOPING SHARED KNOWLEDGE AND SHARED DECISION-MAKING

This broad category constitutes an overall framing for the consultations.

FPNSW doctors empower clients by enabling and encouraging them to be part of the decision-making process about their own sexual and reproductive health.

Communicatively allowing the client to share in the decision-making is one of the key features of the consultations. It is noted that most of the other points and strategies could be seen as contributing to developing shared knowledge and decision-making in that a concern with client empowerment is an important goal in the work of FPNSW staff generally. Notwithstanding this recognition, it is useful to draw out some particular ways shared knowledge/decisions are developed.

In the following extract the doctor introduces the idea that the client is suffering from depression. This is a key moment in this consultation in terms of getting the client to think about something that she has not actually raised with the doctor as a concern:

Doctor: *==Now. I'm just wondering. I'm going to put an idea, I'm just going to talk about an idea ... , I suggested that we try the anti-depressants because of its properties for managing premenstrual symptoms and of course you just take it for a short period of time when that's happening. Now, I'm actually wondering whether we've actually uncovered that you've got a bit of real depression==*

Client: *==Mm.*

Doctor: *that is there all the time.*

Client: *I think I [sighs], well, I suppose post-traumatic stress disorder is something that I had identified by a counsellor.*

Doctor: *Yeah (Consultation C15).*

The doctor leads the client towards considering that she might be suffering from depression. The client's response demonstrates that she takes up the idea and the consultation goes on to discuss continuing anti-depressant medication not only for its original treatment purpose – managing premenstrual symptoms – but also to manage depression. However, interestingly, depression is not mentioned again by name in the rest of the consultation.

What is notable in this extract are the strategies the doctor uses to inform and lead the client into new thinking about her health. The doctor builds up indirect and mitigating language, for example, *just wondering ... , just going to ... , actually wondering ... , a bit of ... ,* into a question that leaves openings for the client to agree or disagree, to add, to make further suggestions, etc. The doctor could have chosen to make statements such as 'Your symptoms show that you are depressed' or 'I think you are suffering from depression', or she could have asked a direct question such as 'Do you think you are depressed?' In both these cases, the doctor would be positioning herself as a more definite assessor of the client's problem, and the opportunity to deviate from the 'diagnosis' is limited.

There are also examples in the consultation of the doctor handing over control to the client very explicitly. This can be seen in comments such as:

Doctor: *And I'd like to know how you would feel about that (Consultation C15).*

FPNSW doctors empower clients by enabling and encouraging them to be part of the decision-making process about their own sexual and reproductive health.

Doctor: *I think you've got good insight, yeah* (Consultation C15).

Doctor: *All right. Well, look, I think we'll agree that you do it the way that you've outlined to me. And maybe do it over another, say, three months. And then let's review it* (Consultation C15).

From the data, four discourse strategies have been identified that doctors use regularly to build shared knowledge and decision-making:

Allowing space for a client to tell her story

A common strategy used by all the doctors and used repeatedly by the same doctor in the one consultation, is eliciting and incorporating the client's 'stories' into the medical encounter.

Doctors allow clients to talk at length about issues and concerns; they encourage and give space for client questions, as well as a chance to reflect on their experiences.

For example, an opening is created by the doctor through the following kinds of questions early in the consultation:

Doctor: *Now, how are you actually going?* (Consultation C05).

Doctor: *And what kind of a day are you having, Alyssa?* (Consultation C05).

Doctor: *How can I help you today?* (Consultation C18).

These open questions invite a narrative from the client. In the two examples below, the clients are firstly given an opening to talk and then encouraged to continue their stories through the supportive comments by the doctors that do not impede the communicative flow:

Doctor: *What side effects did you have?*

Client: *Well, initially, headaches.*

Doctor: *Yeah?*

Client: *Also sleepiness. And morning fogginess, basically. I'm one of those people, I open my peepers and I'm all, I'm there.*

Doctor: *Right.*

Client: *Ah, [LAUGHS]*

Doctor: *So you're a==*

Client: *==I might be grumpy but I'm there.*

Doctor: *Yeah.*

Client: *Whereas, yeah, it took me a while to wake up, which wasn't a bad thing because my biggest problem is actually insomnia, which really impacts quite a lot on my health and which just worsens as the PMT sets in, which is, like I said, very prolonged. Um... the problems I had was actually coming off it and when I actually got my period ...*

Doctor: *And stopping ...*

Client: *Again, I stopped taking it as soon as I got my period but when I have my period I felt like I've been hit by a bus anyway*

Doctor: *Right*

Client: *So there's not a lot of difference between how I feel when I have my period and when I took the first half of the tablet, it was almost identical*

Doctor: *Right*

Client: *And ... then when, when I stopped taking it after a few days I actually had a bit of a backlash of mood swings. And I actually had a friend point out to me how erratic I was being and ... I don't know, maybe it's better to actually halve the dose again and then come off it really slowly or whether I shouldn't take it as a full time thing.*

Client: *Okay* (Consultation C15).

Doctor: *So we can start. Gemma, thanks very much for doing all of this. **How can I help you today?***

Client: *You called me because you've got the results back saying that you received the thrush results, that there was a moderate amount of ==thrush so you wanted to see me*

Doctor: *==mm hm, mm hm, mm hm.*

Client: *and then also you said you wanted to do a recheck because you thought there could be (a possibility of) polyps.*

Doctor: *That's right, yep, yep. So, when I saw you==*

Client: *==and I had to go to get the breast ultrasound ==*

Doctor: *==Yep*

Client: *which I have done.*

Doctor: *And that was normal.*

Client: *It was normal and they have said that I could have a (fine needle) if I want to be 100% and I'm waiting to book that at the moment but I'm quite confident and comfortable that everything's okay.*

Doctor: *Okay so they gave you the option to have the (fine needle).*

Client: *I didn't go to Sydney breast clinic in the end, I went to, I just got a referral from my doctor. I was just too, the logistics of getting down here==*

Doctor: *==too far away.*

Client: *It was just too hard to get it done and rather than wait, wait, wait, wait, wait, I thought I'll go and have it done and if I'm not happy with the results then I'll make an appointment to go to them there. I just didn't want it to be like two months by the time and then I'm worrying about it.*

Doctor: *Sure, sure* (Consultation C02).

Elicitation can occur throughout the consultation. In the following extract the doctor creates the opportunity for the client to elaborate on her experiences with a specialist:

Doctor: *==And he examined your breasts?*

Client: *He examined that one there, which he had no issues with at all and that one there, which because I didn't have my notes from last time or my scan from my ultrasound because I don't know what happened after the move, where they went, he wasn't able to say definitely this is the one that (the fine*

Doctors allow clients to talk at length about issues and concerns; they encourage and give space for client questions, as well as a chance to reflect on their experiences.

needle) for because I think he was saying it was in a different position of the [] and obviously because when I had it done before I was just post breast feeding so that's probably why. So he said, if you want to be 100% sure, have the (fine needle). But I just, I didn't think I need to go there because I feel quite comfortable. Bear in mind, there's no family history, these are not new lumps, they haven't got any bigger.

Doctor: Yep. Yep.

Client: And I've had tests on them before. I felt quite comfortable
(Consultation C02).

In the course of this client's story, it becomes clear that she has her own ideas about her condition and possible treatment. She does not think she needs to have a fine needle biopsy, and she feels she knows what is happening with her body. Thus, the space opened by the doctor, followed by listening to the story, allows the client to present herself as observant, knowledgeable, having opinions about treatment and in charge of her own body.

Importantly, the clients are able to tell their story without interruption, unless the doctor wants something clarified to aid her understanding. The story-telling is enhanced by the doctor's supportive comments, including *mm, hmm, yes, okay, right, all right, etc.*, comments that encourage rather than impede the communicative flow.

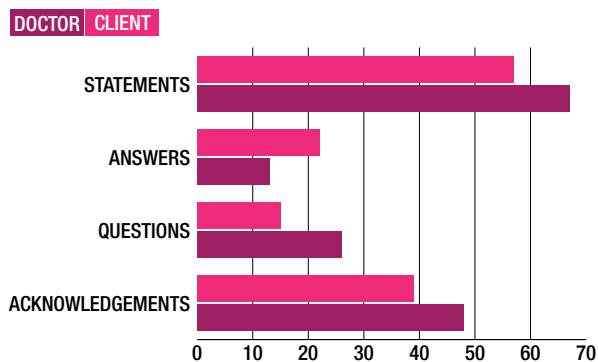
Encouraging client participation and reflection through the use of particular questions, statements and acknowledgements

The client sharing in the decision-making is achieved through, and indicated by, the use and frequency of particular kinds of questions, the number and type of statements and acknowledgements made by the doctor and client, and the length of the doctor and client turns. This analysis of the kinds of utterances made by the doctors and clients is called a Move analysis. A detailed Move analysis of each of the doctor-client transcripts indicated that the doctors asked relatively few questions, showing that they did not dominate the talk. This also shows that the clients were encouraged to offer opinions, to state their views and preferences about management or treatment, and to participate in the decision-making process.

For example, in one 15-minute consultation (see Appendix 2), the doctor asked only 15 questions, which is in marked contrast to the other FPNSW medical consultations. In the same consultation there were 41 acknowledgements of the client's contribution and 19 statements by the doctor. Interestingly, the client in this interaction made 36 statements, gave 13 answers and asked one question. Also noteworthy is the length of the client turns in this same consultation (see CS and CA in Appendix 2). This is also an indication of the degree to which the doctor opens out space for the client to talk.

Similarly, in a 33-minute consultation, although there were 48 questions from the doctor, the client asked 15 questions and made 81 statements. The doctor gave 84 acknowledgements, constantly supporting and encouraging the client to tell her narrative about her health concerns, and validating her own views about the treatment.

FIGURE 1: QUESTIONS, STATEMENTS AND ACKNOWLEDGEMENTS OF DOCTORS AND CLIENTS IN ONE CONSULTATION IN FPNSW
(Consultation C16).



In figure 1 the frequency of questions, statements and acknowledgements in another consultation is mapped.

The figure shows that the doctor asked relatively few questions (26 in all), and made 67 statements over a 15-minute period. In this interaction, the doctor asked more questions and made more statements than the client, however, the client did play a large contributory role. The doctor did not dominate the talk and encouraged the client to offer opinions, state her views and preferences about the management of her sexual health, and to participate in the decision-making process. There was an ongoing build up of rapport between client and doctor, and an informality was maintained throughout.

The types of questions asked by doctors obviously vary according to the kind of information that they want to establish (see Appendix 6 for further information on questions). Doctors used a number of different types of questions in the consultations recorded:

- » Open questions such as *So, how, how've you found it?* and *What side effects did you have?* and *Now, what can I do for you today, Alexandra?* were used initially to establish the client's broad medical concern. They were also used throughout the consultation to encourage clients to provide background information relevant to the diagnosis
- » Closed questions such as *Did he actually give you the Implanon, have you actually got it with you today?* and *Is that okay?* were used to probe for more specific information
- » Assumptive questions – which are questions in statement form that make particular assumptions and only allow for a yes/no answer – were used to check information, or to check the doctor's understanding. For example, *No diabetes in yourself?* and *So you had it removed in September?*

Clients are encouraged to reflect on their problems and to make their own decisions.

Open questions give clients discretion in relation to their responses, and allow them the space to tell their stories. Both closed and assumptive questions tend to limit a client's response to *yes* or *no*.

A significant feature of consultations is the way in which clients feel free to ask questions, which is also an indicator of the reciprocity in the consultations. The following examples occurred in the same consultation:

Client: *I train in martial arts, will I be okay to do exercise tonight?* (Consultation C06).

Client: *[It] goes between the muscles layers?* (Consultation C06).

Client: *So would it delay it, having this on or it just will come on once the breastfeeding stops?==* (Consultation C06).

Many of the doctors invited questions from the clients at various points during the consultations, as seen in these examples:

Doctor: *Okay? So, have you got any other questions about it?* (Consultation C02).

Doctor: *I'll let you have a read of that and I'll just write the script for Nystatin and ask me if you've got any questions* (Consultation C02).

Doctor: *.. so, I'm going to get you to sign a consent form if that's okay. Do you have any questions?* (Consultation C01).

Clients are encouraged to reflect on their problems and to make their own decisions. Clients are provided with information but during the consultations client responsibility is also supported by:

1. Posing alternative questions:

Doctor: *Are you happy to continue taking it like this on for the time that you're premenstrual for a few months to see how you go? Or would you prefer to take it consistently? Because [both], you know, I think there's evidence that you could do it either way* (Consultation C15).

2. Asking clients directly to reflect on their own experiences:

Client: *Because I put on about nearly 30 kilos==*

Doctor: *==Yep.*

Client: *So I thought that might've been, you know, a contributing factor to that.*

Doctor: **And do you think it was, when you look back on that?**

Client: *Looking back, I think it was in combination with other life style factors as well because I was studying and working fulltime. But at the same time, I was, at that time walking about two hours a day and I didn't really see much of a change in my weight so I just wanted to eliminate that as a, you know, I guess one of the [risks] or one of the contributing [things]* (Consultation C01).

Finding out what the client already knows

Doctors ask open questions draw out prior knowledge of symptoms, illnesses, treatments, and so on. So, for example, in assessment consultations, doctors asked clients what they knew about particular contraceptive methods and devices: *How did you hear about the Implanon?* and *Have you come across Implanon before?* (Consultation C11).

This strategy immediately suggests the client has something to contribute, rather than simply being a receiver of information, while at the same time it gives the doctor a starting point for discussion or information-giving. It is based on the sound pedagogical principle that understanding is enhanced if new knowledge is introduced by relating it to what the learner/receiver already knows. It also gives the doctor an opportunity to ensure the client does not have underlying misconceptions or misinformation.

Moving from technical (medical) to common sense (everyday) concepts

A common complaint from clients about their medical encounters is the amount of technical language or jargon that is used and which they often do not understand. In the consultations it was observed that doctors were careful to explain terms they felt might be unfamiliar to clients. They did this by embedding the explanation into the conversation so that it did not seem patronising or reduce the sense of client empowerment. Some examples are:

Doctor: *So we define the change into menopause which is, as you say, **peri-menopause**, when your periods start to change* (Consultation C14).

Doctor: *So you get what we call **anovulation**, it means no egg* (Consultation C14).

Doctor: *... **inflammation** is when you get swelling and pain* (Consultation C21).

Doctor: *This is **nitrous oxide**, this is exactly what we breathe in the air but it's compressed == into a cold spray* (Consultation C12).

Client: *Well, everyone that I know just, they go creepy-crawlies? ...*

Doctor: *... and the name of it is **formication** ... because it's like ants crawling under the skin and ants are made of == formic acid* (Consultation C14).

4.2.2 PROVIDING AND CHECKING INFORMATION HAS BEEN UNDERSTOOD

Consultations always contain a large amount of information from the doctor. Doctors are acutely aware that clients are likely to be overwhelmed with different kinds of information, and at different levels of importance.

Doctors recognise that client understanding is crucial and they incorporate several strategies into their interactions with clients to ensure they follow what is being said and what is happening.

Doctors recognise that client understanding is crucial and they incorporate several strategies into their interactions with clients to ensure they follow what is being said and what is happening.

Information in these encounters may be medical or procedural, and it shifts from technical explanations, to instructions for treatment, to keeping the client informed as to what is happening during their examination. Several ways that information giving and checking occurs are discussed below.

Explaining processes regarding what will happen next as well as about a client's condition and about the treatment and on-going management

Throughout the consultations, doctors talked about processes in terms of what to expect about symptoms, treatment, and follow-up. For example, in the following extract, the doctor explains the consultation process: what is going to happen next (an examination), and what should follow (an appointment next week for further treatment). She also reassures the client about the expected positive change in her condition:

Doctor: *Okay. Now, what I'd like to do first is just inspect the area and make sure we're dealing with what you've mentioned ... So, what, we'll do is we'll do as much as we can today and I'd like you to actually come back so we can do a little bit more next week. Okay? Again, remember, this virus will slowly disappear with time ...* (Consultation C12).

The use of *we* draws in the client as an active agent in the procedure, juxtaposed with the use of *I* when the doctor's professional expertise is foregrounded. In the next extract from a different consultation *we* is used to refer to the FPNSW doctors as an organisational entity. Here, it is policy that is being explained with the weight of medico-legal ramifications underlying the comments:

Doctor: *So the whole counselling session beforehand, which is also part and parcel of Family Planning Policy, for anybody having any sort of form of invasive procedure ... we like to inform our patients and ensure they are aware of all the pros and cons, side effects, what will happen on the day. So you're not just coming in and having it done, you're given a chance to think about your choice* (Consultation C11).

The doctor enables the client to negotiate by providing explanations about these processes: what is happening throughout the consultation, treatment and ongoing management. An example follows:

Doctor: *This tells you every possible ... I think it's mostly local so sometimes you can actually get ... a little bit of soreness, you know, if you're getting a reaction to it. But generally it's fairly well tolerated.*

Client: *Okay.*

Doctor: *... basically they say, as with any product that is applied to the mucosal surface, so the skin or the vagina there, oh, hang on ... [READING] Nilstat is virtually non-toxic, non-sensitising and is well tolerated by all age groups==*

Client: *==Okay.*

Doctor: *even on prolonged topical administrations, so prolonged doses. If irritation during vaginal, intra-vaginal use should occur, discontinue.*

Client: *Okay.*

Doctor: *Okay? It's going to be hard if you feel irritated there already==*

Client: *==To know whether, yeah. Okay.*

Doctor: *But, yeah, still worth pursuing.*

Client: *Worth a try. Definitely.*

Doctor: *Okay?*

Client: *No problem, thank you. So I don't have to come back really unless, you know, with that, if I can get that sorted I don't need to come back till I have my smear in two years?* (Consultation C02).

During examinations, doctors are careful to inform the client of what to expect and what they are doing from moment to moment:

Doctor: *Okay, so it's two fingers of cold jelly, okay? ... You right?* (Consultation C05).

Doctor: *What I need to do now is just introduce the finger, but I do need to put a bit of pressure from the top* (Consultation C13).

The client is even being prepared for the amount of information to be presented, and the number of questions that will be asked:

Doctor: *I'm going to bombard you with questions and information* (Consultation C01).

Finally, doctors usually spend some of the consultation time writing – recording information, writing prescriptions, and associated texts – and they signal this to the client. This serves to undermine the often uncomfortable feeling that silences induce, while at the same time the client is made aware of what notes are being recorded, as in the following example:

Doctor: *... so, it says identify present contraception, so can I **write** abstinence, is that okay?*

Client: *Abstinence [LAUGHS], it's right* (Consultation C01).

Doctor: *Okay? So, what I'm going to **write in the notes** is that we need to, like we've done all the talking bits of this but we need to examine you. And when we examine you we'll check your blood pressure and do your weight and then after that we can insert the IUD.*

Client: *Okay* (Consultation C01).



Repeating key information verbally, checking and tracking questions and comments

Key information is repeated in consultations and sometimes from one consultation to the next as a checking and confirming strategy:

Doctor: ... so **we went through** a little bit about your history **last week** but could I **just go over** that a little bit? (Consultation C01).

Doctors repeat what clients say to ensure they clearly understand:

Doctor: Do you have one every month or have you had ==

Client: ==Every month

Doctor: **Every month** == you have a bleed? (Consultation C08).

Following doctor-generated information, doctors sometimes ask questions to ascertain understanding and/or agreement:

Doctor: Does that sound okay? (Consultation C12).

Doctor: Do you have any questions you want to ask me? I mean please ask me as we go through this (Consultation C01).

Doctor: Got any other questions about that, Alyssa? (Consultation C05).

Notably, all the doctors repeatedly asked the clients if they understood information and if they had any questions – often several times in one consultation. In nearly every case there was little or no response from the client in the form of questions at these points. It may be useful to think about using different strategies to check understanding as research into this type of questioning shows that the FPNSW experience of lack of response is common. This might be due, in part, to clients feeling that they do not want the doctor to repeat things they have already gone through. Nevertheless, information is remembered best when something has to be done with it – some activity is required.

Providing written information to take away and using 3D models

Doctors do not rely on the verbal alone for giving information and explanation. They complement complex verbal information with demonstrations using models of parts of the body. Thus, the client is able to see and touch as well as hear the information:

Doctor: So, Implanon. Okay. It's a rod about this size, this is a sample, okay, **have a feel of it**, okay? (Consultation C11).

Doctor: So just going through this IUD business, **I'll just show you** what it looks like (Consultation C01).

At the end of a consultation the client is often given written information in the form of an A4 sheet with diagrams and written information, booklets or pamphlets. Clients are encouraged to read the material at home and to phone if they have any further questions or they do not understand something:

Doctor: **I can give you a little booklet** about hormone replacement therapy. I know you've done a lot of research already (Consultation C14).

Doctor: And **I've got some information** here that I can give you to take away and read about all that because I can imagine there's a lot to take in (Consultation C12).

Providing clear instructions for medication and other follow-up treatment, appointments, etc.

Providing instructions and guidelines for action is often embedded in explanations of what to expect or what will happen next. However, examples are presented below where the client needs to act:

Doctor: But what I will do is I'll, at the end of the session today I'll consent you, give you a script so you'll know to pick one up

Client: Yep.

Doctor: Okay. And then the very next thing will be to book you in for the next available insertion. It has to fit at a particular time in your cycle as well, okay? (Consultation C01).

Doctor: Now, how to look after that area. It is really important that you don't irritate it with whatever you're using for washing ... what I normally recommend to women is don't put anything down there that you wouldn't put on your face ... Okay. The reason being it's the same sensitive skin we're dealing with ... The best thing that you could use is something really, really mild. So Sorbolene ... (Consultation C12).

4.2.3 PRESENTING MEDICAL KNOWLEDGE AND EXPERTISE

Making the reasoning processes for treatment, advice, etc. available to the client

Doctors ensure that they explain to clients the reasons for their suggestions or recommendations for particular courses of action.

Doctors try to verbalise their reasoning processes as clearly as possible to give clients full information, options and so on.

In the following example, the doctor is explaining medication – an anti-fungal cream – and in doing so she shares her own thinking explicitly with the client, manifested in *I was actually thinking of just giving it to you because I wonder ...* and again later *I wonder ...*

Doctor: But I, because this showed moderate growth, the options of treatment are, I mean, you've had a lot of Canesten. There is a different sort of cream called Nystatin that we can use for 14 days.

Client: Afterwards?

Doctor: 14, no, no, 14 days so you could try it now so we try and actually get on top of it, treating you with this Nystatin which is a vaginal cream.

Doctors try to verbalise their reasoning processes as clearly as possible to give clients full information, options and so on.

Client: What's it for?

Doctor: It's an anti-fungal sort of cream, it works in the same way as Canesten but it's a different medication.

Client: Do you use it as a preventative or for ... ?

Doctor: Well, I was actually thinking of just giving it to you because I wonder whether you've got the thrush in your system.

Client: Mm.

Doctor: I mean, you might want to wait and see what happens and I can give you a script for it, that's one option. You know, if you have a flare up, then go for that. I wondered whether the thrush was resistant to the Canesten cause you've had it six to seven times and it seems to be recurring ... because when I swabbed you and even though you didn't have symptoms, you have a moderate growth of thrush there. I mean, it's either==

Client: ==Yeah, I don't mind, I'll try anything.

Doctor: one or the other so you might decide, no, I'll just do my sugar, avoid the lycra, get the lycra off as soon as I can.

Client: Well, I'll do that as well anyway but I don't mind trying the treatment ==as well (Consultation C02).

Communicating professional judgement sensitively

Even though client empowerment and autonomy are paramount, there are occasions when doctors display professional judgement that cuts across a client's suggestion, or try to lead the client into a particular course of action:

Client: ... because I was even looking into natural hormones ...

Doctor: **so, we are not ... we don't prescribe the natural ones here** because there are some safety issues with them ... so we would preferentially use the commercial preparations (Consultation C14).

Doctor: ... keep in mind that because you are using, well, you're infrequently using the condoms, **you are putting yourself at risk.** Okay? So I'm just trying to give you some information regarding your risks and how to best protect yourself, really, more than anything else.

Client: Yeah.

Doctor: Okay, so, condoms offer a form of protection for both yourself receiving a new infection and also for your partner getting an infection ... so it is important to keep that at the back of your mind (Consultation C12).

Occasionally, there is a situation where the doctor admits she does not have particular knowledge, and needs to point the client towards a different kind of expertise:

Doctor: Okay. Well, look, to be honest, eight years on one medication can be a long time because new up and coming medications come up all time. It, **I'm sorry, I'm not actually an expert in this area** ... I think it would

probably benefit you if you have a chat to your GP about maybe getting a referral and seeing what medications would best suit you now, eight years down the track ...

(Consultation C13).

Asking for and valuing the client's knowledge and experiences

Another way that doctors show they want to tap into clients' actions, thoughts and beliefs is by asking them about their actions and thoughts. A client's responses are often followed up by a validating, supportive or empathetic comment by the doctor:

Doctor: When you feel a little mood change, **how do you normally==go about?**

Client: ... I just do things so that I don't become stressed or overwhelmed ...

Doctor: Yep. **Good on you. It sounds like you really are very well informed about yourself and your condition and you know how to cope** (Consultation C11).

Doctor: **What's made you decide then to go down this road?**

Client: I think my periods are, um, just, they're a little bit, little bit heavier, nothing dramatically changed.

Doctor: Yeah.

Client: Um, the first, the first significant day of bleeding is a, is a bit heavier and more painful.

Doctor: Okay.

Client: And I just thought, look, I'm ... probably is [] that like the, the natural family planning is affecting our sex life ... And if I can improve my periods as well that would be ==

Doctor: ==Which it should, hopefully should do (Consultation C16).

Doctor: Yep, okay. **And what didn't you like about the Implanon?**

Client: Well, I just thought it contributed to my weight gain.

Doctor: Yep.

Client: After having the first child. So I just wanted to remove every other factor==

Doctor: ==Yep, yep.

Client: Because I put on about nearly 30 kilos==

Doctor: ==Yep.

Client: So I thought that might've been, you know, a contributing factor to that.

Doctor: **And do you think it was, when you look back on that?**

Client: Looking back, I think it was in combination with other life style factors as well because I was studying and working fulltime. But at the same time, I was, at that time I walking about two hours a day and I didn't really see much of a change in my weight so I just wanted to eliminate that as a, you know, I guess one of the [risks] or one of the contributing [things] (Consultation C01).



The doctor may even position the client as the expert:

Doctor: All right. Now, **you're absolutely sure** it's warts we're dealing with?

Client: Yes (Consultation C12).

One aspect of validation is the need to tap into client belief systems and mental representations of illness (Cicourel 1993). In the following excerpt the client puts forward a proposition that yoghurt might be a more natural lubricant to use while suffering from thrush and, rather than dismissing this proposition outright, the doctor takes the time to discuss it:

Client: But then it says here, instead of using commercial lubricants which contain preservatives or antiseptics, try using [] or yoghurt. You could try yoghurt.

Doctor: Okay. [SMALL LAUGH] But, yeah, I think==

Client: The thing is, I wouldn't be doing it if it hurt anyway, so like, what is the reason to use it in the first place?

Doctor: This is, this is, the reason to use what?

Client: Any kind of lubricant.

Doctor: Well, you know, I was actually just reading about it, cause we spoke about it last week, I rang you last week when the results came back, and I was just reading the latest on it and one of the points was, and I don't, can't explain to you why but they said that, you know, maybe using some lubrication with intercourse may actually help. But I don't know the mechanisms with that==

Client: ==Right, okay.

Doctor: So you may decide not to worry about that part. With the yoghurt, with sex, in the old days, like when I first did Family Planning which was about 20 years ago, we used to say you could actually dip a tampon into acidophilous yoghurt, just plain acidophilous yoghurt, put it inside your vagina and leave it in for sort of 10 minutes and then remove it and it works on making the vagina, it changes the flora in the vagina and thrush don't – the flora means the bugs, the normal bugs – or the equilibrium of the bugs and thrush don't like that. So it's actually changing the acidity of the vagina by using acidophilous yoghurt in that way. And I think that's where they come right into it when they say, you know, this sort of yoghurt (Consultation C02).

4.2.4 IDENTIFYING, VALUING AND NEGOTIATING ISSUES THAT ARE IMPORTANT TO THE CLIENT

Doctors at FPNSW know that it is crucial to their work to ensure they understand as much as possible about their clients.

Doctors probe for information and are alert to signs that help identify things that are important to the client. Beyond the processes

of identification, the doctors take these issues seriously and engage in discussion about them. This may involve, for example, negotiation of treatment, or validating concerns.

Negotiating between doctor and client about treatment

In a client-centred approach to treatment, one strategy is to elicit and validate the client's own view about what is the appropriate treatment for their own healthcare. In the following excerpt the doctor validates the client's way of dealing with her problem, and respects her comments about suggested treatment:

Client: I think I [SIGHS], well, I suppose post-traumatic stress disorder is something that I had identified by a counsellor.

Doctor: Yeah.

Client: I wouldn't begin to know what to do about it apart from trying to manage it by keeping my stress levels down.

Doctor: **Yeah, which is good. That's a really important thing to do.**

Client: And that's what I try and do. But it's really difficult in this sort of day and age, you know, it's like ... ==you know, there's always something.

Doctor: ==I'm starting to wonder whether you might be, you might find it a benefit to actually take this for a period of time. And I'd like to know how you would feel about that.

Client: Well ... I wouldn't necessarily be in agreement with taking a full dose.

Doctor: No, I don't think so==

Client: ==Cause I think it's too strong.

Doctor: because you actually had a few side effects, I **agree with that** (Consultation C15).

Another example shows the doctor negotiating medication that the client ends up rejecting in favour of the option of moving a contraceptive device into the other arm:

Doctor: ... if I give you the tablets for a week, you come back and see me next Friday ... if not I take it out and put it into the other side

Client: Mm, so you think with tablets it will (fix) it or ... ?

Doctor: Well it will relieve the pain and it will help the inflammation. And it might fix it. Um, I can't guarantee that ...

Client: Mm.

Doctor: **But I would be happy to remove it and put it in the other arm then.**

Client: Yeah, it's better than take tablets ... yeah, I don't like take tablets.

Doctor: Right (Consultation C21).

Sometimes a client may be quite forthright in her views about preferred treatment:

Doctor: Okay, So, do you want any help with that or are you okay with that, you think you can manage it?

Doctors at FPNSW know that it is crucial to their work to ensure they understand as much as possible about their clients.

Doctors are skilled at recognising concerns and at validating them.

Client: *Well, I don't really want anything that's synthetic*

Doctor: *Okay.*

Client: *See, that was my point.*

Doctor: *That's all right* (Consultation C14).

Negotiation may also be characterised by an open invitation to the client to suggest further treatment or action:

Doctor: *But tell me where you're up to now, Charlene, and what you'd like to do* (Consultation C17).

Responding to a client's anxiety about her medical condition

Clients often come for a consultation because they are worried about symptoms they are experiencing. They may be explicit about their worry, or it may be that the doctor picks up on an anxiety during the consultation that has a different explicit purpose. All four recorded consultations with one doctor included client anxieties – one was implicit and drawn out by the doctor, and three were explicitly referred to by the clients. Doctors are skilled at recognising concerns and at validating them.

Doctors may ask leading questions to encourage an explication of a concern, for example:

Doctor: *... have you got, what kind of things were you worried about or have you got any family history of problems []?*
(Consultation C05).

They also try to alleviate worries by referring to the unlikelihood of a problem, while at the same time suggesting the condition is checked out further:

Doctor: *Uterine, uterine cancers aren't very common or they're just not very common in young [healthy] women. But you still need to get everything checked* (Consultation C05).

There were a number of examples of doctors validating clients' symptoms by referring to the experience as a common or normal one:

Doctor: *... sometimes you can actually just get, oh, you can get a little, you can get a little bit of bleeding between your periods and it doesn't necessarily mean you've got anything serious going on* (Consultation C05).

Doctor: *So, really what's happening to you is absolutely normal ... and it's not very pleasant [referring to client's perimenopausal symptoms]* (Consultation C14).

Doctor: *mean, it doesn't mean that you're abnormal by having it* (Consultation C01).

Remaining non-discriminatory, non-judgemental, open and respectful

Closely aligned with valuing issues that are important to the client is the ethos of remaining non-judgemental about a client's activities and values. This can be seen in the way the doctors talk about and respond to information, symptoms and tests for sexually transmitted diseases, contraception and similar issues. In the example below, a test is suggested by the doctor for chlamydia – a suggestion that carries an implication of possible risk taking – however there is no comment other than a concern with the client's health:

Doctor: *Okay. And the other thing is, as you leave today, if you wish, and again I don't want to force this upon you but it is just something to think about ... totally up to you, doing the chlamydia test which is a simple urine sample ==*

Client: *==Mm hm.*

Doctor: *because chlamydia is a type of infection that tends to sit quietly* (Consultation C12).

The extract also constructs client autonomy by emphasising that having the test is the client's decision: *if you wish ... , don't want to force this ... , to think about ... , totally up to you ...*. Interestingly, the doctor's use of the mitigating *little* to describe the test, and the way she ends the interaction with a statement about the condition's insidious nature, gives an indication of her professional opinion, regarding the uptake of the suggestion.

The report now turns to the second category of communication strategies by exploring the development of rapport and empathy in more detail. The following section presents examples from the consultations to highlight specific interpersonal language features that doctors use across the different types of consultations. It should be noted that these strategies are not necessarily distinct from those discussed above. Rather, they represent a different cut of the data – the strategies are more explicitly linguistic. It is often a combination of these strategies that works together to communicate the doctor-client relationship.

4.3 COMMUNICATING THE DOCTOR-CLIENT RELATIONSHIP: RAPPORT AND EMPATHY

Empathy is the 'process for understanding an individual's subjective experiences by vicariously sharing that experience while maintaining an observant stance. It is the knowing of the experience of another which comes from experience, fantasy and emotion' (Zinn 1993, p. 306).

Brock and Salinsky (1993, p. 245) define empathy as 'the skills used to decipher and respond to the thoughts and feelings passing from the client to the physician.' Empathy should be distinguished from sympathy.

Factors influencing rapport and empathy include time constraints, situational constraints, language barriers, intercultural differences, socio-economics, field specificity (eg FPNSW versus general practice), and other variables such as the gender and experience of the doctor.



Doctors make particular language choices. These include using informal and colloquial language, addressing the client by first name, giving supportive feedback, valuing the client's concerns, initiating and responding to interpersonal chat and using humour and laughter.

Other factors include the purpose of the visit and the client's wish or understanding of what the relationship should be. An important factor is the doctor's willingness to engage with the client on a social level. It is accepted by both client and doctor that the doctor's role is that of the expert with medical knowledge and experience in dealing with a range of medical issues and processes. Thus, to enable clients to make decisions about their own healthcare, it is necessary to reduce any distance between doctor and client.

Doctors make particular language choices. These include using informal and colloquial language, addressing the client by first name, giving supportive feedback, valuing the client's concerns, initiating and responding to interpersonal chat and using humour and laughter.

Greeting the client with an informal introduction; using given names throughout the consultation; using *we* at key points in the consultation

Heightened personalisation in consultations is achieved in a number of ways and has the effect of assuring the client that the doctor is giving undivided attention to her, as well as making the consultation friendlier. According to Poynton (1990, p. 214): 'Full forms of given names are not simply class markers ... they are a means of maintaining distance in social relations, along with other lexis conventionally referred to as formal'.

All the doctors introduce themselves with their first name and they all use the client's first name as well. For example:

Doctor: *Okay, so Noreen, I'm Bonnie, hi.*

Client: *Hi, Bonnie.*

Doctor: *Now, you're here for a pap test, is that right?*

Client: *Yep.*

Doctor: *Yep. Anything else we're doing today? (Consultation C07).*

Doctors make a point of using the client's first name from the outset:

Doctor: *Hi, Jade, is it? (Consultation C13).*

Doctor: *Now, what can I do for you today, Alexandra? (Consultation C11).*

The use of a client's first name continues throughout the consultation, for example in the history-taking stage:

Doctor: *So you know if your, with your bleeding, Alyssa, have you got, what kind of things were you worried about or have you got any family history of problems []? (Consultation C05).*

And then in the examination stage:

Doctor: *And I know you can feel me doing it, Alyssa (Consultation C05).*

The use of a personal name (vocatives) varies according to the stage of the consultation, with the examination stage presenting the greatest number of instances of the doctors using the client's first

name. Examinations are often unpleasant and stressful experiences for the client and the doctors respond intuitively by using interpersonal strategies. The distribution of client first name examples is illustrated in the figure below for one doctor-client consultation.

Doctors always go out to the waiting room to meet and bring the client into the consultation room personally. They also accompany the client back to the reception area at the end of the consultation. The client is not presented to the doctor by a nurse or a clerical worker – actions that would reinforce hierarchical positions. During these times there is the opportunity for informal chat and greetings.

Doctors use different kinds of informal greetings – the two extracts below include the word *nice* to indicate a positive appraisal of the encounter. The second example also tells the client that the doctor remembers her – she is not just another unknown person.

Doctor: *Okay. So it's nice to meet you (Consultation C14).*

Doctor: *So, nice to see you again. I think I saw you on the 1st February (Consultation C15).*

The use of *we* is commented on several times in discussion of the data. Doctors use it particularly to construct solidarity and create an environment where the client is a co-investigator of her own condition and a co-producer of her own treatment:

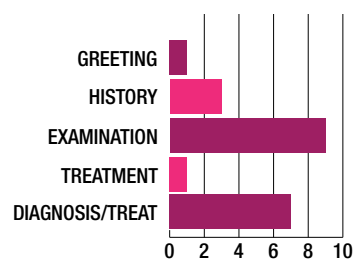
Doctor: *... the problem with menopause is it comes at a time in our life when **we're** usually trying to deal with a million other things as well (Consultation C14).*

Doctor: *You want to see what's going on don't you? ... **We** both want to see what's going on (Consultation C21).*

Doctor: *All right. Well, look, I think **we'll** agree that you do it the way that you've outlined to me (Consultation C15).*

The third extract is interesting in the shifts the doctor makes from *I* to *we* to *you* to denote both roles and relationships.

FIGURE 2.
DOCTOR NAMING USE BY STAGE
OF THE CONSULTATION (Consultation C05)



Giving supportive, empathetic and reassuring feedback, verbally and non-verbally

The seating arrangements of the consultations help construct a supportive context: the doctor and client sit quite close to one another (notwithstanding the small space of the consultation room and the presence of the camera and researcher), and they sit facing one another with only a very small section of a desk separating them. In addition, the doctors continually make eye contact with clients and often nod – especially when clients are recounting something that is embarrassing or worrying them. Occasionally the doctor touches the client on the arm or shoulder at these times.

The consultations are dialogues that consist of turns taken by each of the participants. As clients talk, doctors provide instant feedback that what the client is saying is important, valued, okay, and so on. Throughout the consultations, doctors use short, positive feedback markers such as *mm, okay, yes/yeah, all right*. These let the client know the doctor is listening and that they can continue speaking. Examples of different kinds of feedback include:

- » Acknowledgments: where the doctor claims agreement or understanding of the previous turn eg *mm, yeah*
- » Assessments: when the doctor shows appreciation in some way of what has just been said eg *excellent, wonderful, exactly*
- » Newsmarkers: where the doctor marks what the client says as news eg *really, is it!*
- » Non-verbal vocalisations eg *laughter*.

There are numerous points in the consultations when the doctor specifically responds to a client's comment or concern in supportive and empathetic ways. This sometimes takes the form of reassuring the client by suggesting that many others share similar worries:

Doctor: *So you know you're not going crazy [LAUGHS]. A lot of women actually come in say, oh my gosh, what's going on with me?* (Consultation C13).

During an examination, the doctor lets the client know she is familiar with a feeling and then immediately offers an appreciative comment as well:

Doctor: *I can appreciate that that's really uncomfortable ... all right?* (Consultation C12).

In the final example of a longer interchange, the doctor makes language choices that offer supportive feedback in every turn:

Client: *I got quite ill.*

Doctor: *It's not a very nice test.*

Client: *It wasn't so much the test, um, they had trouble getting the blood.*

Doctor: *Yeah. That's partly why it's not such a nice test.*

Client: *Seven.*

Doctor: *Oh no.*

Client: *Seven times.*

Doctor: *That's too many, isn't it?*

Client: *And by then they said they'd go ... try and get blood from somewhere else because my veins were that bad ...*

Doctor: *Yeah* (Consultation C17).

Expressing positive attitudes constitutes a specific form of feedback to clients. Even though this strategy could be seen as part of giving supportive, empathetic and reassuring feedback, it is a significant feature of the doctors' responses to clients in that they use positive comments that are evaluative and regularly express attitudes:

Doctor: *Because you are absolutely right* (Consultation C11).

Doctor: *Oh, I don't blame you, I don't blame you!* (Consultation C11).

Doctor: *Excellent. All right* (Consultation C11).

Doctor: *Okay. Well that sounds great* (Consultation C11).

Client: *No, no, no. I mean of the night. Um, not wearing like a panty liner during the day.*

Doctor: *Yeah.*

Client: *And using QV wash.*

Doctor: *Okay.*

Client: *And I haven't had thrush since I came back.*

Doctor: *That's really good, isn't it?*

Client: *Mm hm.*

Doctor: *That's excellent* (Consultation C17).

Expressing personal attitudes and values (doctor and client)

A characteristic feature of the FPNSW consultations is the frequent use of attitudinal language by the doctors to express their attitudes and values. This in turn encourages the client to feel able to express their own attitudes and emotional reactions. A short extract from a consultation appears below that illustrates the build up and sharing of attitudinal language. Individual Moves and Turns from this extract are cited as examples of specific strategies elsewhere in Section 4, however, it is useful to see the development of rapport in the interaction as it unfolds.

The full transcript of this consultation appears in Appendix 2 where there were 30 expressions of attitude from the doctor and the client in the first 28 turns. In the 15 minute consultation there were 194 expressions of attitude.

Doctor: *So, nice to see you again. I think I saw you on the 1st of February.*

Client: *Yeah, yeah. You trialed==[]*

Doctor: *==Trialing the [] to see if we could help your premenstrual symptoms.*

Client: *Yes.*



Doctor: So, how, how've you found it?
Client: Well, I took it as suggested and the first half tablet it was like I got **hit by a bus**. But that's **okay** because I felt like **throwing myself under one anyway**==
Doctor: ==Right.
Client: so I guess, yeah. [LAUGHS] **Very apt.** [LAUGHS] **Very apt.**
Doctor: **We'd better get onto Sydney Transport eh?**
Client: Well, side effects **actually** wear off.
Doctor: What side effects did you have?
Client: Well, initially, headaches.
Doctor: Yeah?
Client: Also sleepiness. And morning **fogginess, basically.** I'm one of those people, I open my peepers and I'm all, I'm there.
Doctor: Right.
Client: Ah, [LAUGHS]
Doctor: So you're a==
Client: ==I **might be grumpy** but I'm there.
Doctor: Yeah.
Client: Whereas, yeah, it took me a while to wake up, which wasn't a **bad** thing because my **biggest** problem is **actually** insomnia, which **really** impacts **quite a lot** on my health and which **just worsens** as the PMT sets in, which is, like I said, **very** prolonged. Um...the problems I had was **actually** coming off it and when I **actually** got my period==
Doctor: ==And stopping.
Client: Again, I stopped taking it as soon as I got my period but when I have my period I felt like I've been **hit by a bus** anyway.
Doctor: Right.
Client: So there's **not a lot of** difference between how I feel when I have my period and when I took the first half of the tablet, it was almost identical.
Doctor: Right.
Client: And ... then I, when, when I stopped taking it after a few days I **actually** had a **bit of a backlash** of mood swings.
Doctor: Right.
Client: And I **actually** had a friend point out to me how erratic I was being and ... I don't know, **maybe** it's better either to **actually** halve the dose again and then come off it really slowly or whether I **shouldn't** take it as a fulltime thing (Consultation 15).

Mirroring client's comments regarding symptoms, attitudes or concerns

Mirroring is a strategy that occurs when doctors repeat something the client has said. In a conversation it shows a willingness to participate in the other person's experience. In the consultations doctors frequently mirrored their clients' expressions explicitly as in the first three extracts, or sometimes rephrased what the client said as in the fourth extract:

Client: Which is a **bit of a joke** ==
Doctor: ==I know, it's a **total joke** (Consultation C16).
Client: But then my friend said it's normal because it's a **dangerous day.** [BOTH LAUGH]
Doctor: Yeah, yeah. Could be the **dangerous day**, that's right (Consultation C08).
Client: I don't think I've seen iron on it, I will **have a look.**
Doctor: **Have a look** (Consultation C14).
Client: ... But, like, it goes **over the top.**
Doctor: Yeah, == it's almost like
Client: == and goes bang again.
Doctor: You have a **mini manic period**
Client: Yeah, it's **like a manic sort of up and down.** I mean I wouldn't be prepared to sort of label myself but it really does seem to coincide with the cyclical == things.
Doctor: == Yes, it sounds like it does (Consultation C15).

Interspersing interpersonal chat with medical talk

Empathy and rapport may be established by the doctor chatting with the client about aspects of either of their lives, unrelated to the illness. It is also during these moments of informal conversations that shared knowledge is built up.

Shared knowledge, as well as putting people at ease, is impossible without conversation (Hein & Wodak 1998). 'It is here that we learn of shared experiences and feelings' (Spiro 1992, p. 843).

In most of the consultations there are examples of this interpersonal chat, that is, interchanges between the doctor and the client about things not directly related to or important for the issue at hand. For example:

Doctor: ... and I detect an accent.
Client: Yeah, from England.
Doctor: From England. And you're here just travelling or == you've made the move? (Consultation C12).

Engaging in interpersonal chat puts the client at ease and minimises hierarchical roles. This is particularly so when the doctor relates to her own experiences. For example:

Doctor: I think that's very true. No, I've been interested to **see how my mother's** been dealt with in hospital too and == (Consultation C15).

Doctor: If you're anything like the normal sort of **brides to be that, myself was included** ... things can go a bit wild (Consultation C11).

Using colloquial language and informal expressions

A characteristic of the consultations is the informality exemplified in several of the categories and strategies discussed so far. Overall,

Empathy and rapport may be established by the doctor chatting with the client about aspects of either of their lives, unrelated to the illness. It is also during these moments of informal conversations that shared knowledge is built up.

the doctors use colloquial and sometimes even slang expressions to develop rapport and to enhance understanding. For example:

Client: So oral sex?

Doctor: Oral or **even fingers and things** like that (Consultation C11).

Doctor: Should be fine. [Just if you want] to keep the pressure bandage on to prevent any **swelling and stuff** (Consultation C06).

Doctor: You'd sort of be saying **whoopee** (Consultation C18).

Doctor: So we then recommend non-, sort of **making up their own lubes** ... with whatever it is (Consultation C18).

Doctor: Pants and **undies** off ... no, **hang on**, we'll do **the top** first (Consultation C18).

Doctor: I know you've come for your breast check because last time when you came I had a look at the notes and the nurses said that your breasts felt a **little bit lumpy** (Consultation C19).

Doctor: And when you're ready **give me a yell** and we'll give you some treatment (Consultation C12).

Using modality and modulation

Modality and modulation are language features that make statements less definite, or introduce an element of possibility. Examples include *may, might, perhaps, can, would, should, I think*, where in each case a space is created for another view, belief, opinion, etc., and for disagreement by the other person in the conversation. Doctors use this strategy to express a range of possible reasons for client symptoms:

Doctor: **I think** the commonest reason for getting a **little bit** of spotting, **just** as a one off, is **probably** no reason at all. **Sometimes I think** they **think** it's hormonal and related to ovulation, it's **probably** the commoner thing. Which it **kind of could** be, given the timing of what you've looked at (Consultation C05).

Or to suggest a possible course of action:

Doctor: So that's something you need to **maybe sort of** discuss with him **a bit** further or at least ... (Consultation C11).

Sharing laughter and jokes

Casual conversations between friends are characterised by shared laughter and jokes that express solidarity, friendship and an inclusiveness that is valued by most human beings. In the consultations, even when the client was very worried about an issue, the examination was unpleasant, or the encounter included ongoing health concerns, there were often shared jokes and laughter.

These instances work to reduce anxiety to some extent, as well as establishing a friendly atmosphere. For example:

Client: Well my mother had a very early menopause ...

Doctor: How early's early?

Client: Well, she never had her periods return after I was born ... so uh she was born in 23 and I was born in 58 so that made her 35.

Doctor: Mm?

Client: Yeah. So ...

Doctor: **Was it a shock having you born was it? I'm kidding I'm kidding!**

Client: [LAUGHS] Yes that's right.

Doctor: **I'm kidding** (Consultation C18).

Client: I used to go to the Chatswood one, Killamey, so it's about 40 minutes, 45 minutes. So, I only got three months supply, so. But I was having==

Doctor: **==Punitive, isn't it? [LAUGHS]** (Consultation C20).

Client: Well, I took it as suggested and the first half tablet it was like I got hit by a bus. But that's okay because I felt like throwing myself under one anyway==

Doctor: **==Right.**

Client: so I guess, yeah. [LAUGHS] Very apt. [LAUGHTER] Very apt.

Doctor: **We'd better get onto Sydney Transport eh?** (Consultation C15).

Using collaborative completions

A further strategy that demonstrates that the doctor and client are interacting closely and developing a shared understanding of what is being said is the use of collaborative completion where the doctor completes the client's utterance. (Note that the client can also complete what the doctor is saying).

Client: My last visit my blood pressure **was too high for==**

Doctor: **==The pill?** (Consultation C20).

Non-English Speaking Background Clients

Notwithstanding the communicative effectiveness of the FPNSW consultations and the satisfaction with the organisation as a whole commented on by clients and observed by the researchers, there are always opportunities for behavioural and/or organisational learning leading to change and improvements.

In one consultation with a client from a language background other than English, the post-consultation interview data showed that both the doctor and the client felt that communication had been about 80 per cent successful. Interestingly, there was agreement about the effectiveness of the communication, and importantly the doctor was acutely aware of the issue.

The transcript for this consultation reveals that there were two particular features of the interaction that posed difficulties for the



In the consultations, even when the client was very worried about an issue, the examination was unpleasant, or the encounter included ongoing health concerns, there were often shared jokes and laughter.

client. The first is the use of ellipsis by the doctor. Ellipsis is a form of abbreviated language where part of the utterance or sentence is omitted. For example, asking a one-word question *Operation?* with a rising inflection at the end of the word to denote that it is a question, rather than asking in full *Did you have an operation?* Ellipsis is a common feature of conversation – a kind of short cut that makes the talk flow. However, it also depends on a lot of assumed knowledge of language – both vocabulary and grammatical structures. There are always gaps in language knowledge for speakers who are not as culturally and linguistically proficient as first language English speakers. Examples of elliptical questions from this consultation appear below:

Client: ... maybe most I don't understand and so you have to slowly==
Doctor: ==Just let me know.
Client: Yeah, okay, okay.
Doctor: So, you've come to talk about the Mirena?
Client: Mm hm. Yeah. Because I just get married about half a year.
Doctor: Yep.
Client: And ah, and ... my husband and me decided in two years we want to have a baby so now I don't want to have baby any more. Yeah.
Doctor: Right. Have you got any kids?
Client: Yeah. I've got one.
Doctor: Oh, you have got one child? What year were they born?
Client: Mm?
Doctor: What year were they born?
Client: Oh, in China.
Doctor: **How old?**
Client: She's born in 1998.
Doctor: 1998.
Client: Ten years.
Doctor: Right, okay.
Client: Yeah.
Doctor: And was that a normal pregnancy? **Any problems?**
Client: No.
Doctor: Did you have the baby vaginally?
Client: No ... Mm, it means?
Doctor: **Normally, out the vagina==**
Client: ==No, no, no, no.
Doctor: **Operation?** You had a caesarean?
Client: Yeah, yeah.
Doctor: Okay. Do you remember why?
Client: Oh, because his head==
Doctor: ==Yep.
Client: Up.
Doctor: Too high?
Client: So, it's, yeah, so ... (kind of) normal.
Doctor: How long were you in labour before they did the caesarean, do you know? How long were you getting the pain for?
Client: Um ... I didn't feel any pain when I'm [] my daughter and just, I decided which day I go to hospital. (Consultation C08).

There were a number of further examples including:

Doctor: *Planned caesarean?*
Doctor: *Just that one?*
Doctor: *Use that exact one?*
Doctor: *Different one?*
Doctor: *Every month?*
Doctor: *So never had one before?*
Doctor: *Pulling out?*
Doctor: *Take any medication?*
Doctor: *Rough?* (Consultation C08).

Often, as in this case, the problem is not picked up because it does not become explicit. The person/client may understand some of the elliptical questions, and/or they may not signal misunderstanding either by a query or a response that is clearly inappropriate.

The second feature that causes problems is the use of complex questions and statements. These are utterances that contain two or more distinct questions or statements with different content or difficult rephrasing. For example, *How long were you in labour before they did the caesarean, do you know? How long were you getting the pain for?* Attempting to process the information is demanding, and the reframing of labour as pain in the second question may hinder rather than aid comprehension. Further examples appear below:

Doctor: *Operation? You had a caesarean?*
Doctor: *What about any problems with your bowels when you get that, like going to the toilet doing a poo, any == changes there?*
Doctor: *And when you do bleed for that one day is it heavy, do you have to change the tampons or the pads quite often or every few hours?*
Doctor: *And have you ever had a pregnancy in the tube? Like, in there. Any problem pregnancies like that?*
Doctor: *There's a copper IUD, which might be like what you had in China, and there's that one, which is a hormone.*
Doctor: *And because it's hormones there's some people, not very many, skin problems, decreased interest in sex, weight problems, that sort of thing.*
Doctor: *There's small chance that when they put it in they would damage your uterus, okay, and so if that happened you would have to go to hospital. Very rare, less than one in one thousand women.*
Doctor: *I'm not the one doing it, like I say, I'll give you the name of the doctor who will but it will be more hard than a woman who's had a baby through the vagina. (Consultation C08)*

Doctors are aware that they sometimes overwhelm clients with information and explanations. This occurs particularly in the pre-procedural assessment consultations when doctors must give clients clear information and explanations about the pros and cons of a

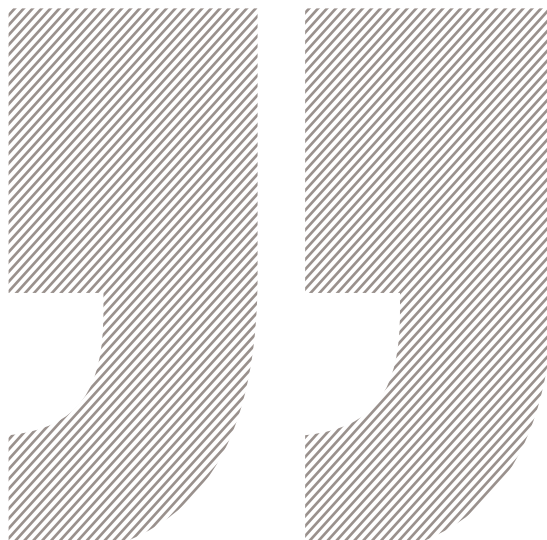
particular treatment; for example, different forms of contraception, (what they are, how they work, what can be expected in terms of processes, and so on). This context is a site for introducing complexity, and there is the temptation to use ellipsis to cut down the amount of doctor talk, and not appear to be lecturing the client.

Further communication strategies

Developing awareness of one's own ways of communicating is a first step to thinking about possible changes. Strategies that are specifically helpful, other than taking care with complex utterances and ellipsis include:

- » Signposting or signalling, where doctors announce what they are going to say next
- » Structuring information as coherently as possible and in a logical order
- » Thinking critically about digressions by balancing the need for understanding key information with developing rapport
- » Checking understanding by moving beyond simply asking *Is that clear?* or *Do you understand?* One way to check is to ask the client to repeat key points or information
- » Supplementing talk with other modes of information giving, such as written material to take away and/or demonstrating with models
- » Exploring critically how much is too much information
- » Exploring whether the generic staging could be more efficient
- » Ensuring an elicitation of what the client already knows and using this as a starting point.

In summary, a key outcome from the study is a detailed description and analysis of the interactions in FPNSW consultations, describing both the language and discourse features that constitute successful interactions, as well as the features that contribute to occasional disparity between the messages conveyed and received by doctors and clients.





5. POST- CONSULTATION INTERVIEWS WITH CLIENTS AND DOCTORS

SECTION 5 PRESENTS A DISCUSSION OF THE POST-CONSULTATION INTERVIEWS WITH DOCTORS AND CLIENTS. ANALYSIS OF THE INTERVIEWS WITH CLIENTS AND DOCTORS CONFIRMS THAT GENERALLY BOTH GROUPS FELT THAT THE CONSULTATIONS WERE SUCCESSFUL. AS ONE CLIENT EXPLAINS “I FELT THAT I GOT WHAT I REQUIRED”.

The aim of the post-consultation interviews was to determine whether the doctors and clients came away from consultations with similar ideas of the content covered, issues and problems raised and discussed, possible treatment and/or follow-up procedures and so on. Further, the interviews tried to capture if the communication was perceived to have been generally successful or not, and on what basis the doctors and clients came to their views. Notably, the doctors were quick to reflect on what could have worked better, and many were keen to discuss the consultations immediately with the researcher.

The 10 to 15 minute post-consultation interviews occurred immediately following the consultations. Two researchers were involved with one interviewing the doctor and the other interviewing the client. The interviews comprised a series of specific questions (see Appendices 4 and 5) and, when possible, they were recorded and later transcribed. The researchers also wrote notes during and after the interviews. The transcripts and notes were later analysed by thematically matching the responses of the clients and doctors. They were further analysed by identifying recurring themes across the client comments and the doctor comments.

The main finding is that there was a high level of congruence between messages given and received by both doctors and clients.

5.1 FACTORS INFLUENCING OVERALL EFFECTIVE COMMUNICATION

The interview questions included questions about the overall effectiveness of the communication. Clients tended to answer this question by articulating reasons for choosing to come to FPNSW: what they perceive to be the professional and interpersonal communicative competence of the doctors. The following are examples of how the clients talked about this communicative competence.

- » FPNSW doctors are specialists in reproductive and sexual health:

You feel confident that what you're coming here for are what they're experts in (Post-consultation interview C18).

- » Not only are the doctors specialists, they are female specialists. The consultations are perceived to be an environment in which women can talk to women about women's issues:

Me is how I am and I'm sexist. Where it's, like, I needed a female. My male doctor is very good and he said to me, he openly admits, I can't do this, I don't know enough about this field, you need to go somewhere else. But he said but it would be nice if I could have the results (Post-consultation interview C17).

I don't like going to my GP for my pap smear. I would prefer to come to Family Planning (Post-consultation interview C07).

There is a high level of congruence between messages given and received by both doctors and clients.

- » Clients feel listened to:

I felt like she heard me (Post-consultation interview C11).

They listen (Post-consultation interview C17).

- » Clients are given time to tell their story and to ask questions:

She really takes time to explain things and make sure I've understood ... asks lots of questions. And that's why I come here really (Post-consultation interview C10).

I had the opportunity to ask questions and they don't rush you (Post-consultation interview C11).

- » Doctors give clear explanations about process and procedures:

She did my pap smear and found some concerns that I had been expecting but she explained those clearly and has given me a referral (Post-consultation interview C18).

- » Client concerns are validated:

[they] don't just brush you away (Post-consultation interview C10).

- » Clients feel that they can trust the doctors:

I feel like I can trust her (Post-consultation interview C10).

I didn't feel like she was giving me advertising answers ... I felt like she was actually doing it from real experience and with real women (Post-consultation interview C11).

I like the fact she doesn't think she's God and says, it may not work ... and if it doesn't, we'll try something else (Post-consultation interview C17).

- » Doctors make clients feel comfortable talking about difficult issues:

She was very relaxed and very open, I felt, and very soft (Post-consultation interview C11).

She put me at ease [by body language, tone of voice, smiley, friendly, professional] (Post-consultation interview C12).

I felt I could come here without shame or embarrassment (Post-consultation interview C15).

- » Clients feel empowered and able to have control over the decision-making process:

She didn't push me into anything (Post-consultation interview C14).

We say what we want to each other (Post-consultation interview C03).

Clients also commented on the favourable organisational features that provide a supportive context, with clients preferring to visit FPNSW rather than their GP for sexual and reproductive health issues. This is because:

- » GP consultations are seen to be less anonymous:

But I do have a new GP and I'm sure if I went to her she would be fabulous. But I don't, I don't go to her just, I don't know. I feel like I'm anonymous here, do you know what I mean? Whereas she knows me from everything else (Post-consultation interview C15).

- » GPs have long waiting times and shorter consultation times so they are rushed for time:

They get you in, they get you out (Post-consultation interview C09).

Because usually when you go to GPs it's, like, tell your problem then, like, yeah, yeah, yeah and then go out (Post-consultation interview C03).

I mean, I have a good relationship with my GP but, then, he's a very, very busy man and I just feel ... I'm conscious that, okay, there are a lot of patients waiting as well so I just try and get straight to the point to try and get out of there as fast as I can. And I think I do myself a disservice there so I thought, okay, I'll come here because I know that I can take a bit more time and go through, you know, concerns I have and get some questions answered (Post-consultation interview C05).

- » GPs are not specialists in the field and many are perceived to be poor communicators:

Well, my GP, the one now that I see, she sort of said, look, I know, but I don't think she's as intense as [doctor name removed] is because she does a lot of other stuff as well, so, you know. And she was actually, when I said to her, cause I felt a bit funny saying to her that I was coming here because it's my own initiative that I did it, and she said to me, oh, that's a good idea ... She was very pleased that I was actually coming here (Post-consultation interview C14).

One vignette illustrates many of the points outlined above.

A client came to FPNSW after suffering recurrent thrush for twelve years. She had been told previously, by a male gynaecologist, that she *was a wet, moist person with tendencies to thrush and [she] would have to deal with it*. Another doctor had told her that if she kept having children that it would regulate her body. The FPNSW doctor gave her some ideas about how to deal with the thrush and this consultation was a follow-up visit a month later:

... because I've suffered for twelve years ... everyone I went to ... they just say, you know what, that's what happens with women ... cause



Client's comments from the post-consultation interviews provide strong evidence that the FPNSW doctors actually do what they say they do.

when she [the FP doctor] realised how bad I was, it was sort of like, 'okay you've been uncomfortable, you're chronic and how do you function'? ... that's what she said to me, 'how do you deal with this'? ... and it wasn't 'you've done it all wrong and it was your fault' ... she just sort of said, 'right, let's try' and gave me about five different things to try ... I went out that day and did everything she said to do. And from two days on from after that I have not had thrush (Post-consultation interview C17).

The client was happy, not only because her symptoms had abated, but also that her problem had been taken seriously and her concerns were listened to and validated.

In the staff interviews, doctors discussed their values and beliefs regarding clients and outlined the communication strategies they use in the consultations.

One question towards the end of the post-consultation interviews with the doctors asked them whether they thought anything had been left unsaid in the consultation and the most common responses were *yes* or *probably*. Thus the doctors are acutely aware that issues, concerns, symptoms, worries and anxieties that clients bring with them to the consultations are not always brought to the surface. This recognition contributes to the efforts made by the doctors to listen and observe as carefully as possible throughout the consultation.

It is evident that the clients interviewed choose to attend FPNSW for specific reasons related to both the professional and interpersonal communicative competence of the doctors.

Clients' comments from the post-consultation interviews, together with the actual consultation data, provide strong evidence that the FPNSW doctors actually do what they say they do.

5.2 SHARED UNDERSTANDING OF CLIENT'S PROBLEM OR CONCERN

All clients interviewed feel that the doctor understood their main reason for attending the clinic. How doctors articulated clients' main concerns matched their clients' explication of these concerns. Three examples below illustrate this matching:

Doctor: *So the consultation was involved basically in explaining what an IUD's all about and how it works and its side-effect and risks and benefits and pros and cons. (Post-consultation interviews Dr4).*

Client: *The purpose of my visit was to be counselled on the pros and cons of going for using the IUD as a contraception ... the doctor pretty much explained all the details ... what the effects are and how it works (Post-consultation interviews C01).*

Doctor: *She's here about her premenstrual symptoms ... and she had come back for a review because I put her on some medication to take. (Post-consultation interviews Dr2).*

Client: *It was a follow-up consultation. I had been given a*

prescription to deal with this particular issue (Post-consultation interviews C15).

Doctor: *She basically came for the results of tests that we did. And I wanted to check something that I saw last time when we examined her so we did that. (Post-consultation interviews Dr4).*

Client: *We looked at the results of all the tests I'd had ... she examined me to check that what she thought was probably a blood clot ... not a polyp (Post-consultation interviews C10).*

5.3 RECOGNISING AND VALIDATING CLIENT'S CONCERNS

The client often did not initially express their real symptoms or concerns. These could be implicated throughout the course of the interaction and/or picked up from non-verbal cues. For example, doctors accurately detected the unspoken anxieties of clients, such as a fear of cancer.

In the examples below the consultation data shows that the clients presented physical symptoms as the issues for discussion and concern in the consultations.

Doctors move beyond a purely medical consultation to pick up concerns to do with emotions and a sense of self. They focus on the whole person in their dealing with physical symptoms.

These shifts are foregrounded by both doctors and clients in the post-consultation interviews.

One client commented that she wanted to discuss symptoms that she felt were peri-menopausal. The client's symptoms had been dismissed previously by her GP as anxiety:

Doctor: *I think she needed validation for what she was going through ... I was wanting to get across to her that what's happening to her is actually normal. (Post-consultation interviews Dr2).*

Client: *I found that no-one really understood me fully like she did. So, and that it was, I wasn't going mad or anything like that. So, it's good to know that that's actually normal ... I actually was going through what I was saying I was going through (Post-consultation interviews C14).*

A second client presented with concerns about intra-menstrual bleeding:

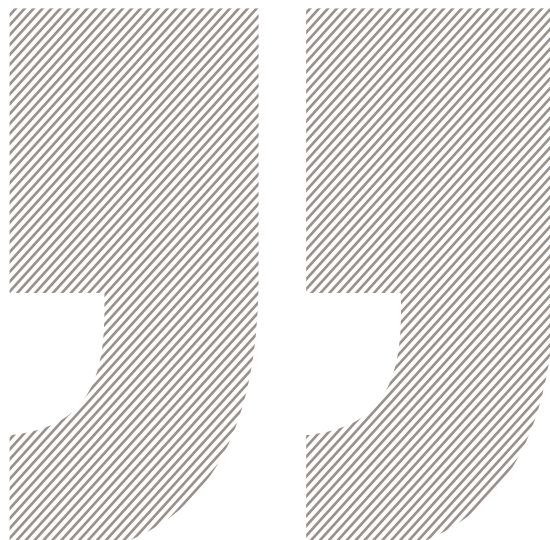
Doctor: *I suppose I interpreted her presentation as being that she didn't just want to leave it and see what happened ... I think what I probably did was validate her concerns (Post-consultation interview Dr6).*

5.4 COMMUNICATION MISMATCHES

There were minor communication mismatches in a few consultations. After one consultation with a client, whose first language was not English, the doctor stated that she felt that the client had only understood 80 per cent of the consultation and the client agreed she had only understood 80 per cent. Interestingly, while the consultation may not have been entirely successful in terms of effective communication, the doctor was aware of the gap, so much so that both the doctor and client separately offered the same percentage as a measure of what had been understood.

In a second consultation the doctor commented that she felt it was important for the client to understand that she was engaging in potentially risky sexual behaviour. However, the client did not mention this in the post-consultation interview. The doctor had not in this instance communicated her message regarding risky behaviour effectively, although it is also possible that the client felt this was too embarrassing to bring up in the post-consultation interview.

Doctors move beyond a purely medical consultation to pick up concerns to do with emotions and a sense of self. They focus on the whole person in their dealing with physical symptoms.



6. CONCLUDING COMMENTS

THE FPNSW CONSULTATIONS INVOLVED IN THIS RESEARCH ARE, WITHOUT EXCEPTION, INSTANCES OF EXEMPLARY COMMUNICATIVE PRACTICE. EACH CONSULTATION ACHIEVED EFFECTIVE MEDICAL DIAGNOSIS AND TREATMENT, AT THE SAME TIME BUILDING UP EFFECTIVE INTERPERSONAL RELATIONSHIPS.

It is the balance between the medical and the interpersonal that determines the effectiveness of a consultation. Establishing an interpersonal relationship with a client has implications beyond making the person 'feel good' about his or her experience. We propose that positive interpersonal relationships between doctors and clients result in more collaborative interactions which create a reciprocal flow of information. In turn, this produces better clinical outcomes such as mutually agreed treatment plans and better client compliance.

Communicating care is just as important as delivering care.

Interpersonal skills are usually described as spoken communication skills involved in the establishment and maintenance of effective relationships between people. In the medical context this is often represented as the 'therapeutic relationship', 'therapeutic alliance' or 'client rapport.' As suggested by Leach (2007, p. 70) it is 'a trusting connection and rapport established between therapist and client through collaboration, communication, therapist empathy and mutual understanding and respect'.

Further exploration of the relationship between the medical and the interpersonal in health care settings will, we feel, develop understandings of what constitutes effective communication. This, in turn, has implications for client safety and satisfaction.

In many medical consultations in other contexts there is a gap between what the clinicians think they have meant and what meanings are actually constructed by the client.

What is significant in the doctor-client consultations in FPNSW and in the follow up interviews with doctors and clients is the high level of concordance between what was actually said in the consultations and what the participants remembered as being the main points. Therefore, FPNSW can feel confident that clients, overall, are likely to take away understandings that doctors intended.

This project incorporated different approaches to individual and organisational learning. Firstly, the research included ongoing meetings, discussions and some informal presentations of data with and to FPNSW managers and doctors. This enabled sharing of ideas, raising of issues, particular focuses and so on. These activities also built a joint investigative relationship where what is important to FPNSW could be foregrounded at all times. It also enabled a co-productive relationship with all participants offering insights and ideas. This approach to the study precludes more traditional practices of researchers imparting their findings to the researched. Notably, the approach fits well with the underpinning philosophy of empowerment that is the ethos of the organisation.

Finally, an important part of co-production in research is creating opportunities for the participants – in this case the doctors who were recorded and video-taped – to reflect on their practices. In this project the doctors were given copies of their consultation transcripts and their consultation videos, and they were invited to spend one-to-one time with one of the research team to discuss communication issues, strategies and successes that emerged.

These reflexive sessions focussed on what the doctors wanted to discuss, together with how the analysis has been carried out by the researchers. This ensured that the discussions began with what the doctors think and know (as in the consultations themselves), and what they want to know, understand and do. The richness of this reflexive approach enables ideas for change, further professional development and other future directions to emerge collaboratively.

Professional Development

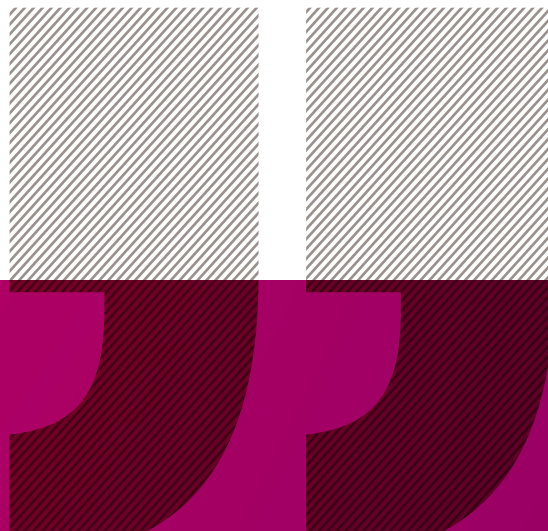
Findings from this project can be used by FPNSW for the ongoing professional development of doctors. The effective communicative and interpersonal strategies used by FPNSW doctors can be built explicitly into training courses that FPNSW currently offers to GPs for sexual and reproductive health (see Section 7 Recommendations).

What is significant in the doctor-client consultations in FPNSW and in the follow up interviews with doctors and clients is the high level of concordance between what was actually said in the consultations and what the participants remembered as being the main points.

7. RECOMMENDATIONS

DESIGN AND DELIVERY OF TWO PROFESSIONAL DEVELOPMENT MODULES FOR MEDICAL PRACTITIONERS THAT FOCUS ON STRATEGIES TO ENHANCE EFFECTIVE COMMUNICATION IN CONSULTATIONS.

- 1. A module that explores in detail the ways in which doctors can build an effective interpersonal relationship with clients at the same time as addressing clients' medical concerns. It would include strategies for:**
 - » Sharing knowledge and decision-making
 - » Providing information effectively and checking information is understood
 - » Ensuring clients have presented concerns, and asked pressing questions
 - » Checking clients have understood technical terms, diagnosis, treatment, procedures etc
 - » Demonstrating medical expertise together with empathy and rapport
 - » Using communicative time efficiently regarding amount and depth of information, explanation, and discussion
 - » Communicating diagnoses, particularly bad news
 - » Valuing and validating clients' concerns and issues
 - » Integrating 'chat' into more formal talk
 - » Communicating with clients whose dominant language is not English – reducing ellipsis and reducing the number of complex questions and statements.
- 2. A module that would build on the approaches and knowledge developed in the first module to produce video role-plays focussing on effective and less effective communicative situations. The role plays would be used for discussion and reflective activities. This module would contain:**
 - » Design and scripting of scenarios
 - » Technical production
 - » Reflexive activities
 - » Role-playing activities.



8. REFERENCES

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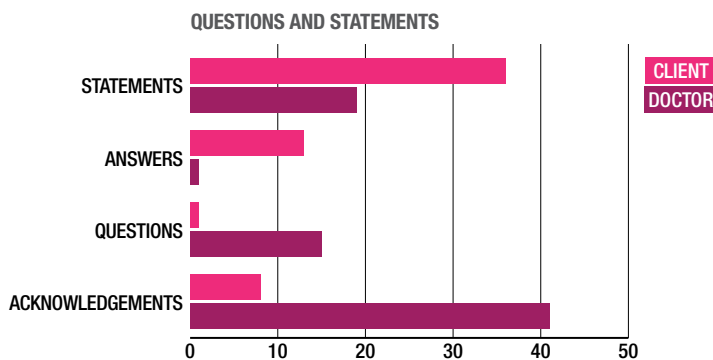
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APPENDIX 1. ANALYSIS OF A CONSULTATION

In this appendix, a summary analysis of the communication between a client and a doctor in one consultation is presented. The transcript of the consultation is available in Appendix 2 in a format that presents the interactions as Moves and Turns.

The transcript and analysis presented here provide the opportunity to see and better understand what goes on in a consultation from the beginning to the end. Further, the commentary makes visible and available the analytic approach to the language and discourses used by clients and doctors. Each of the consultations was analysed in a similar way.

What the bar graph below shows us is that the doctor asked relatively few questions (15 in all), and made considerably fewer statements compared with the client (19 versus 36). Twenty seven percent of the doctor's questions were open and 73 percent were closed. What is significant in this consultation is the large contributory



role played by the client, who made many more statements about her health/emotional state than did the doctor, who encouraged her to develop lengthy turns at talk. This approach reflects the Family Planning ethos of empowering clients, so that they act as co-agents in the problem solving and decision-making processes. Importantly, the doctor did not dominate the talk, but opened it up to allow the client space in which to develop her narrative, to offer opinions and to clearly state her preferences for treatment. The strategies employed by the doctor are discussed in detail below.

QUESTIONS

Open questions give the client discretion in relation to their response, and allow the client to tell their story:

- » *So, how, how've you found it?*
- » *What side effects did you have?*

Yes/No questions are used to probe more explicit information:

- » *So can you say whether overall you feel that it helped==or didn't help?*
- » *So are you on it again at the moment?*
- » *And did you get the same range of side effects you got the first time?*

Assumptive questions close off client response choices.

- » *And you've had a **fairly erratic** life pattern, haven't you?*
- » *You have a **mini manic** period?*

Complex questions ask the listener to provide more than one piece of information in reply.

- » *Are you **happy** to continue taking it like this on for the time that you're premenstrual for a few months to see how you go? Or would you prefer to take it consistently, because (both), **you know, I think** there's evidence that you could do it either way?*

TYPE OF CONSULTATION: MANAGEMENT

QUESTIONS AND STATEMENTS			
Doctor A		Client 1	
Questions Total	15	Questions Total	1
Open	4 (27%)	Open	
Yes/No	11 (73%)	Yes/No	1
Assumptive	6		
Statements Total	19	Statements Total	36

THE CONSULTATION

The doctor gave the client agency in this consultation largely by eliciting and incorporating the stories that the client brought to the medical encounter. One of the key ways the doctor achieved this was by allowing the space for the client to tell her own narratives about her health – both physical and psychological. The consultation contained a series of narratives, which were facilitated by the doctor's questioning strategies: the doctor asked a number of open, discretionary questions (see above) which allowed space for the client to open out, and more probing closed questions (see above) which were used to build up specific information around the client's health. The strategies used by the doctor included actively listening with supportive, collaborative feedback, and not asserting her medical expertise early in the consultation or stating her opinion definitively.

The doctor reduced her professional distance from the client in a number of ways, such as use of the inclusive pronoun *we* to construct solidarity:

Doctor: *I suggested that **we** try the anti-depressants.*

The doctor allowed space for the client to be part of the decision-making process by modalising and modulating recommendations which allowed the client to question or disagree:

Doctor: *I am **actually** wondering...*

Doctor: *I am starting to wonder **whether you might be, you might** find it a benefit to **actually**...*

Doctor: *I **think** we talked about it.*

Health care practitioners need to learn complex rhetorical strategies that enable them to work with clients in building the shared knowledge that is vital for an objective and accurate diagnosis and an effective treatment plan. One way that the doctor began the process of building up the shared knowledge in the consultation was by introducing the idea that the client was suffering from depression. This was the key moment in this interaction:

Doctor: *==Now, I'm **just** wondering. I'm **going to put an idea**, I'm **just** going to talk about an idea...I've been treat, I **suggested** that we try the anti-depressants because of its properties for managing premenstrual symptoms and of course you **just** take it for a short period of time when that's happening. Now, I'm **actually** wondering **whether we've actually uncovered that you've got a bit of real depression**==*

Client: *==Mm.*

Doctor: *that is there all the time.*

Client: *I think I [sighs], well, I suppose post-traumatic stress disorder is something that I had identified by a counsellor.*

Doctor: *Yeah.*

Interestingly, depression was not mentioned again explicitly in the consultation.

Another way to build up the shared knowledge was by eliciting and validating the client's ' own views about what she thought was the appropriate treatment for her own health (This follows the above interaction):

Client: *I think I [sighs], well, I suppose post-traumatic stress disorder is something that I had identified by a counsellor.*

Doctor: *Yeah.*

Client: *I wouldn't begin to know what to do about it apart from trying to manage it by keeping my stress levels down.*

Doctor: ***Yeah, which is good. That's a really important thing to do.***

What follows is the doctor validating the client's way of dealing with the problem:

Client: *And that's what I try and do. But it's really difficult in this sort of day and age, you know, it's like...==you know, there's always something.*

Doctor: ***==I'm starting to wonder whether you might be, you might** find it a benefit to actually take this for a period of time.*

And I'd like to know how you would feel about that.

Client: *Well...I wouldn't necessarily be in agreement with taking a full dose.*

Doctor: *No, I don't think so==*

Client: *==Cause I think it's too strong.*

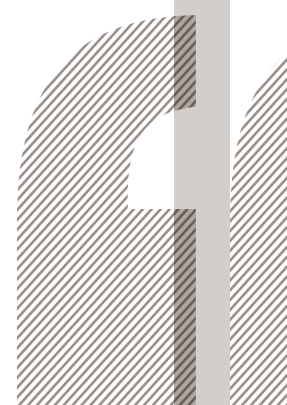
Doctor: ***because you actually had a few side effects, I agree with that.***

The doctor even modulates the recommendation to take the medication for a period of time *I'm starting to wonder whether you might be, you might...*, which allows the space for the client to disagree. The doctor hands over even more control to the client by the comment *And I'd like to know how you would feel about that* which explicitly allows for shared decision making. Another example of shared decision-making from the consultation is as follows:

Doctor: *Alright. Well, look, I think **we'll** agree that you do it the way that you've outlined to me. And maybe do it over another, say, three months. And then let's review it.*

Client: *See how it goes.*

What is also interesting here is the use of the personal pronoun *we* which this doctor uses throughout the consultation creating a feeling of solidarity and joint decision-making.



EMPATHY AND RAPPORT

There are various ways that the doctor showed empathy and rapport in the consultation. One way was by introducing herself and immediately putting the client at ease:

Doctor: *So, nice to see you again, I think I saw you on the 1st February.*

Another way was to offer supportive and reassuring feedback. The doctor used high frequency continuatives and acknowledgements including *Mmm, Yeah, Good, OK, All right* throughout the consultation. These encouraged the client to continue telling her narrative. Yet another way was to mirror the client's point of view by agreeing with many of the client's statements, by repeating or reinstating the client's propositions:

Client: *...But, like, it goes over the top.*

Doctor: **Yeah, ==it's almost like**

Client: *==And goes bang again.*

Doctor: **You have a mini manic period.**

Client: *Yeah. It's like a manic sort of up and down. I mean, I wouldn't be prepared to sort of label myself but it really does seem to coincide with the cyclical==things.*

Doctor: **==Yes, it sounds like it does.'**

Below is a restatement of the client's proposition:

Client: *As I said, I work shift work.*

Doctor: *Yeah. And you've had a fairly erratic life pattern, haven't you?*

Client: *Well, basically, yeah. That whole carer sort of thing.*

Another way that empathy and rapport were established with the client was by the doctor chatting to the client about aspects of her own life which were unrelated to the client's health:

Doctor: *I think that's very true. No, I've been interested to see how my mother's been dealt with in hospital too and==*

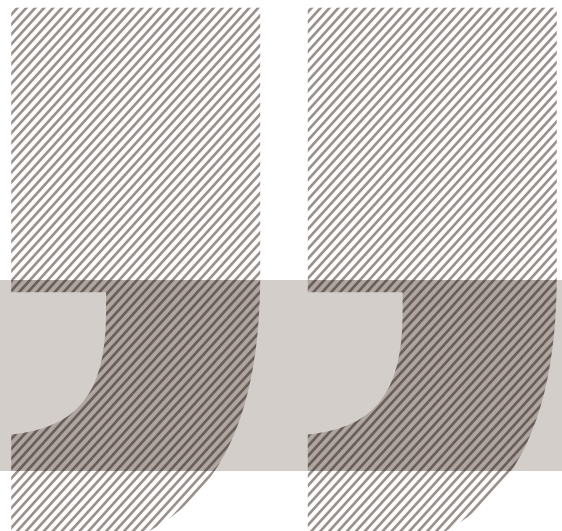
And then a little later, by or by sharing her personal views:

Doctor: *Yeah, we're a bit guilty of doing that in the medical profession, giving that impression.*

POST-CONSULTATION INTERVIEWS

Both client and doctor felt that this had been a successful consultation. The client said that she got what she required from the consultation and that her and the doctor were in agreement about the appropriate treatment for her pre-menstrual symptoms. The client says, *she basically mirrored back ... much of what I thought ... I felt that she was quite ... received my information quite positively, she gave me positive feedback and agreed with me on a number of points.*

During the consultation the client referred to a number of struggles in personal life as well as number of physical and mental medical issues. This is indicative of the doctor's concern with the whole person rather than just one presenting issue. At the end of the consultation the doctor was emotional and explained to the researcher that she is often moved by clients, *I may feel very sympathetic to the patient.* The doctor said that she hoped the client took away a sense of being heard ... *and of being in control herself of what's happening.* The doctor made a further interpersonal comment, *I like her ... I like people who are outside the square.*



APPENDIX 2. TRANSCRIPT OF A MANAGEMENT CONSULTATION

Management consultations are where doctor and client explore options for managing issues such as fertility control or menopause.

The structure of the following management consultation is:

Opening ^ **Statement of concern** ^ **Exploration of condition**ⁿ ^ **Diagnosis**ⁿ ^ **Treatment**ⁿ ^ **Digression** ^ **Closing**

NOTE: ^ = followed by ⁿ = recurring stage

In language analysis, a Move is a speaker's utterance. The analysis below describes the function of each utterance:

FUNCTIONS

MOVES	MOVE CODE	PARTICIPANTS	CODE
Statement	S	Doctor	D
Question	Q	Client	C
Command	C	Nurse	N
Answer	A	Family/Friend	F
Offer	O	Other	Z
Acknowledge	K	Researcher	R
Tracking	t		
Challenge	ch		
Response	r		
Backchannel	B	Question type	
Patient Cue	X	WH, open	w
Appraisal (in bold)	'hit by a bus' 'nice'	Yes/no, closed	y

TRANSCRIPT

Consult:	080307FPC2
Client:	Female ESB
Presenting concern:	Follow up on use of antidepressant for premenstrual tension
Length:	15 mins 20 seconds

Words and phrases in bold in the transcript are examples of expression of attitude and emotion.

GENERIC STRUCTURE	INTERACTIVE STRUCTURE	TURNS/MOVES	SPEAKER	TEXT
Opening	DS		Doctor	So, nice to see you again.
	DS	1	Doctor	I think I saw you on the 1st of February.
	CK	2a	Client	Yeah, yeah.
	CS	2b	Client	You trialled==()
Statement of concern	Dt	3	Doctor	==Trialling the () to see if we could help your premenstrual symptoms.
	Crt	4	Client	Yes.
Exploration of Condition	DQw		Doctor	So, how, how've you found it?
	CA		Client	Well, I took it as suggested and the first half tablet it was like I got hit by a bus . But that's okay because I felt like throwing myself under one anyway==
	DK		Doctor	==Right.
	CS		Client	so I guess, yeah. [laughs] Very apt. [laughter] Very apt.
	DS		Doctor	We'd better get onto Sydney Transport eh?
	CK		Client	Well, side effects actually wear off.
	DQw		Doctor	What side effects did you have?
	CA		Client	Well, initially, headaches.
	Dt		Doctor	Yeah?
			Client	Also sleepiness. And morning fogginess , basically.
	CS		Client	I'm one of those people, I open my peepers and I'm all, I'm there.
	DK		Doctor	Right.
	CK		Client	Ah, [laughs]
DQy		Doctor	So you're a==	
CS		Client	==I might be grumpy but I'm there.	
DK		Doctor	Yeah.	
CS		Client	Whereas, yeah, it took me a while to wake up, which wasn't a bad thing because my biggest problem is actually insomnia, which really impacts quite a lot on my health and which just worsens as the PMT sets in, which is, like I said, very prolonged. Um...the problems I had was actually coming off it and when I actually got my period==	
Dt		Doctor	==And stopping.	

transcript cont.

GENERIC STRUCTURE	INTERACTIVE STRUCTURE	TURNS/MOVES	SPEAKER	TEXT
	CS		Client	Again, I stopped taking it as soon as I got my period but when I have my period I felt like I've been hit by a bus anyway.
	DK		Doctor	Right.
	CS		Client	So there's not a lot of difference between how I feel when I have my period and when I took the first half of the tablet, it was almost identical.
	DK		Doctor	Right.
	CS		Client	And... then I, when, when I stopped taking it after a few days I actually had a bit of a backlash of mood swings.
	DK		Doctor	Right.
	CS		Client	And I actually had a friend point out to me how erratic I was being and... I don't know, maybe it's better either to actually halve the dose again and then come off it really slowly or whether I shouldn't take it as a fulltime thing.
	DK		Doctor	Okay. Just== ()

Video footage starts here. Comments on non-verbal communication in [].

			Doctor	<i>[Doctor and client facing each other across corner of desk and making eye contact] It's like you're a film star. You're Nicole Kidman today. [shared laughter] Can you just push that door? [Client reaches back behind her to close door] Thanks.</i>
		Dt	Doctor	So, you wondered, you actually felt better taking it and you felt worse when you tried to come off it==
			Client	==()
			Doctor	and you had a bit of a rebound from coming off it?
			Client	A bit of a rebound.
		DK	Doctor	Yeah. <i>[nodding head]</i>
		CS	Client	Apart from that, I felt that some days it made me drowsy, other days it didn't.
		DK	Doctor	Yeah.
		CS	Client	And I think that might have something to do with my health status on that particular day, like whether I'm tired and stressed . <i>[doctor nods head continually as client talks]</i>
		DK	Doctor	Yeah.
		CS	Client	As I said, I work shift work.
		DQy	Doctor	Yeah. And you've had a fairly erratic life pattern, haven't you?
		CA	Client	Well, basically , yeah. That whole carer sort of thing .
		DQw	Doctor	Yeah. So can you say whether overall you feel that it helped==or didn't help?
		CA	Client	==Yeah, I feel it helped.
		DK	Doctor	Okay.
			Client	Because certainly one of the things that I felt it did was that when I get... <i>[doctor starts to write notes on file]</i> when I get sort of upset or anxious about something, it's almost like being sucked into a worm hole and I can't get out.
		DK	Doctor	Yep. <i>[doctor continues to write notes]</i>

GENERIC STRUCTURE	INTERACTIVE STRUCTURE	TURNS/MOVES	SPEAKER	TEXT
			Client	And that thought will predominate above everything else. <i>[doctor finishes writing notes and resumes eye contact with client]</i>
		Dt	Doctor	Okay, so you start to==
		Crt	Client	==Start to==visualise <i>[doctor and client mirror each other's hand gestures]</i>
			Doctor	==think negative .
		CS	Client	Well, visualise some trauma or something==
		DK	Doctor	==Okay.
		CS	Client	you know. It can be any time of the day but then everything else just, is like being sucked into a worm hole . And that tended to stop that.
		DK	Doctor	Okay.
			Client	So that I was actually able to stop==
Diagnosis	DS		Doctor	==Now, I'm just wondering. I'm going to put an idea, I'm just going to talk about an idea... I've been treat, I suggested that we try the anti-depressants because of its properties for managing premenstrual symptoms and of course you just take it for a short period of time when that's happening.
		DQ	Doctor	Now, I'm actually wondering whether we've actually uncovered that you've got a bit of real depression==
		CB	Client	==Mm.
			Doctor	that is there all the time.
		CA	Client	I think [sighs], well, I suppose post-traumatic stress disorder is something that I had identified by a counsellor. <i>[doctor and client mirror each other's hand gestures, doctor nodding as client talks]</i>
		DK	Doctor	Yeah.
		CS	Client	I wouldn't begin to know what to do about it apart from trying to manage it by keeping my stress levels down.
		DK	Doctor	Yeah, which is good . That's a really important thing to do.
		CS	Client	And that's what I try and do. But it's really difficult in this sort of day and age, you know, it's like ...==you know, there's always something.
Treatment	DQ		Doctor	==I'm starting to wonder whether you might be , you might find it a benefit to actually take this for a period of time.
		CB	Client	... Mm.
		DQ	Doctor	And I'd like to know how you would feel about that.
		CA	Client	Well... I wouldn't necessarily be in agreement with taking a full dose.
		DK	Doctor	No, I don't think so==
			Client	==Cause I think it's too strong .
			Doctor	because you actually had a few side effects, I agree with that.
		CS	Client	It's quite strong . And I have to say, it's effects are quite interesting . [laughs].
		DQ	Doctor	What are the==
			Client	==To say the least.

GENERIC STRUCTURE	INTERACTIVE STRUCTURE	TURNS/MOVES	SPEAKER	TEXT
	DQ		Doctor	So the effect of being, feel like being hit by a bus ==plus
	CA		Client	==Initially. ==Initially
	DQ		Doctor	==And other, and==
Exploration of Condition	CA		Client	==And then, like, the thing, the thing that it did, when that those sort of side effects settled down was that it allowed me to concentrate more on the here and now rather than sort of, I mean , my mind often just , like, the whole premenstrual thing, when that kicks in, what happens is my mind starts to speed up and up and up . And at the end of that period, it's almost like, it's, I can't sleep, you know, I'm sort of , start pacing, I'm doing several things at once and I seem to achieve quite a lot during those times but then when I get menstrual it's again like being hit by a bus , suddenly I'm so groggy . And that's why, it's like this cycle and riding a wave . And then after about a week, when my period's finished, I level out. <i>[client uses a lot of hand gestures to emphasise what she's saying]</i>
	DK		Doctor	Mm. <i>[doctor listening to client very intently, sitting very still]</i>
			Client	And then very slowly it goes on the up and up and up and up and up and up . Then I get really restless and agitated and, you know, running around doing 101 things at once. But, like, it goes over the top .
	Dt		Doctor	Yeah, ==it's almost like
			Client	==And goes bang again.
	DQ		Doctor	you have a mini manic period.
	CA		Client	Yeah. It's like a manic sort of up and down . I mean , I wouldn't be prepared to sort of label myself [doctor shakes head] but it really does seem to coincide with the cyclical==things.
	DK		Doctor	==Yes, it sounds like it does.
	CS		Client	But it's so extreme . And that's what I wasn't coping with.
	DK		Doctor	Yeah.
Diagnosis	DS		Doctor	Well, there's certainly are, I think we talked about it last time, you can go from having it so severely that it's actually classified as a mental disorder.
	CB		Client	Mm.
			Doctor	That's about 4 to 6% of women. But 96% of women do experience some premenstrual changes. So you're probably not at the extreme end but you're probably closer to that end that you are up to the, you know, ==end that doesn't have symptoms.
	CS		Client	==Well. It was like, when I was younger, it wasn't that extreme .
	DK		Doctor	No.
			Client	It's as I'm getting older.
	DK		Doctor	Yeah, well, it==does worsen .
	CS		Client	==And it's exacerbating .
	DB		Doctor	Mm.
	CS		Client	And the periods where I'm actually level are getting shorter .
	DK		Doctor	Yeah.

GENERIC STRUCTURE	INTERACTIVE STRUCTURE	TURNS/MOVES	SPEAKER	TEXT
			Client	Where it's like this roller coaster ride. And along come the hot flushes as well and everything==
	DB		Doctor	==Mm.
Treatment			Client	associated with that. And I suppose, you know , lifestyle issues do come into it.
	DS		Doctor	Well, specifically in terms of taking this is alcohol and other drugs that can affect the brain so that's important that we don't, you know.
	CS		Client	Well, I'm not taking any other drugs. And the alcohol's been quite minimal.
	DK		Doctor	Excellent . Well, that's fine .
	CS		Client	But that doesn't seem to [laughs] really... you know, I still realise at this point, I started keeping a diary and after, I actually wrote down when I started taking the tablets <i>[doctor nodding head]</i> and when I started feeling off, except I forgot to bring it this morning as I'm actually premenstrual at the moment and I'm quite stupid .
	DQy		Doctor	So are you on it again at the moment?
	CA		Client	Yes, I started um... about four days ago.
	DQy		Doctor	And did you get the same range of side effects you got the first time?
	CA		Client	No, no. No.
	DK		Doctor	Good , okay. So, are==
			Client	==It was just that first one.
	DQy		Doctor	are you happy to continue taking it like this on for the time that you're premenstrual for a few months to see how you go? Or would you prefer to take it consistently. Because (both), you know, I think there's evidence that you could do it either way.
	CA		Client	There is. I think I'd like to... just fine tune it a bit more and instead of this time abruptly ceasing it, what I'd like to do, like, for instance, when I started it again this time, I did still get the drowsiness so I decided not to take one the next day because I wanted to see how long that drowsiness would last. And all into the next day I felt the effects. So that then I took it the following night and then I took it, I didn't have a problem. <i>[doctor nodding head while client talks]</i>
	DK		Doctor	<i>Okay. [doctor nodding]</i>
			Client	And then when I, instead of abruptly ceasing taking it, what I'd like to actually do is either cut it down to a quarter.
	DB		Doctor	Mm hm.
	CS		Client	And then do that over a few days and then stop it, rather than just abruptly stopping it.
	DK		Doctor	Yeah, I'm okay with that. <i>[doctor nodding]</i>
	CS		Client	Cause, like, when I stopped it, I didn't get any rebound right away, it was a few days later and then I got all== a bit wobbly .
	DS		Doctor	== I think your system's obviously quite sensitive to it because you're on a fairly small dose. But I'm happy for you to do that.
	CS		Client	I'm fairly sensitive to actually just about anything.
	DK		Doctor	Yeah.

transcript cont.

GENERIC STRUCTURE	INTERACTIVE STRUCTURE	TURNS/MOVES	SPEAKER	TEXT
	CS		Client	My, I mean , I don't use any other, I use painkillers for the duration of my period but apart from wine and cigarettes and coffee, and I don't drink a lot of coffee, really nothing else.
	DK		Doctor	Alright.
	DS		Doctor	Well, look, I think we'll agree that you do it the way that you've outlined to me. And maybe do it over another, say , three months. And then let's review it.
	CK		Client	See how it goes.
	DK		Doctor	Yeah.
	DQ		Doctor	Have you got enough in your prescription?
	CA		Client	Well, you have given me some repeats.
	DS		Doctor	Yeah, so there should be enough there.
	CK		Client	Yeah, yeah.
	DK		Doctor	Yeah.
	Dt		Doctor	And you're only taking a small amount anyway.
	Crt		Client	Yeah, yeah.
	DK		Doctor	Good. Alright.
	DS		Doctor	Well, I think that, look, I, I think I did explain to you last time that this is all trial and error, there's no absolute answer and there's never one size fits all with this. But I think==
	CS		Client	==I wasn't looking for a magic cure. <i>[doctor leans in more towards client]</i>
	DS		Doctor	I think if we've overall, if you overall think that you've got some improvement and you've got some, you know , something to work with, I hope that we'll get some results in the end. It's about learning to manage it.
Digression	CS		Client	It's about learning to manage it, you're right there, because, you know, there are other factors that come into it as well. And I think we live in a society where we think, you know, some tablet's going to create magic cure alls for everything and they're just really tools.
	DK		Doctor	Yeah, <i>[doctor picks up client file, holds it, looks back at client as she starts to speak]</i>
	DS		Doctor	we're a bit guilty of doing that in the medical profession, giving that impression.
	CS		Client	Well, the rest of the community is too, so it's not just a one way street.
	DK		Doctor	Yeah, mm.
	CS		Client	People expect that.
	DK		Doctor	Mm.
	DS		Doctor	It's about, this sort of thing is very much about you working out what is happening to you and what works for you and then us helping you to kind of fine tune it. But if it gives you a better sense of control over your life, then you can often make some changes in other areas that will allow you to have a more == consistently smooth existence.
	CK		Client	==That's right.
	CS		Client	<i>[doctor starts to write on client file]</i> There is a relationship between lots of different things when talking about stuff like that, so. I think I'm very aware, working in the health services myself.

GENERIC STRUCTURE	INTERACTIVE STRUCTURE	TURNS/MOVES	SPEAKER	TEXT
	DS		Doctor	I think you've got good insight, yeah. <i>[doctor stops writing to look at client]</i>
	CS		Client	I mean , I deal with people every day who... you know , take a, have a pharmacy sitting in their house. And one of the biggest problems now is that there's an expectation there that, you know , even with in services, you know , that we don't deal with things from, you know , like a holistic approach.
	DK		Doctor	I know, I know, that's true.
	Ct		Client	I guess that's the word for it.
	Drt		Doctor	I think that's very true. <i>[doctor leans back and relaxes into her chair]</i>
	DS		Doctor	No, I've been interested to see how my mother's been dealt with in hospital too and==
	CK		Client	==Scary stuff.
			Doctor	you'll get one person saying this and one person saying that and you need to match them up.
	CS		Client	<i>[client leans down to put something in her bag, packing up to go]</i> And being a doctor, you know what goes on. <i>[looks up at doctor and they smile at each other]</i>
	DK		Doctor	Yes.
	DS		Doctor	So then you have to unpack it for your mother [laughter].
	CK		Client	Scary stuff. Scary stuff, yeah.
	DK		Doctor	Alright, ().
	DO		Doctor	I'll give you that to take back to the receptionist. <i>[doctor hands client her file]</i>
	CrO		Client	Alright.
Treatment	DC		Doctor	And say, you know, about four months.
	CrC		Client	About four months, yeah. Okay. Alright.
	DK		Doctor	Good.
	CQ		Client	And if I run out in the meantime, I can I suppose just go to a GP==
	DA		Doctor	==Yes. Yes.
			Client	and have that.
	DS		Doctor	They may not understand quite what I'm doing but you understand.
	CS		Client	I understand what I'm doing.
	DK		Doctor	Yeah.
	CS		Client	And if the quarter doesn't work I'll try it full time. [laughs]
	DK		Doctor	Alright then.
Closing	CS		Client	Okay. See you later.
	DS		Doctor	And thanks very much for doing this.
	CC		Client	Take care.
	DrC		Doctor	You too.
	CS		Client	Bye bye.
	DS		Doctor	Bye. [recordings end]

APPENDIX 3. STAFF INTERVIEW QUESTIONS

- » Can you tell us a little about your professional background?
- » Can you now tell us about what your roles and responsibilities are and what a typical day or week may look like?
- » Regarding communication – can you discuss how communication works operationally at FP and are communication processes and networks effective?
- » Are there problems in communication at FP here at Ashfield? How are grievances dealt with?
- » Can you discuss communication training in your education programs? (either as a participant or as a trainer)
- » Focussing on the consultation, can you outline what you believe are effective communications strategies you use in consultations?
- » What kinds of communication detract from the development of shared understandings?
- » Can you give some examples of where you thought there may have been misunderstandings or breakdowns in communication with a client?
- » Can you give a specific example of where you think there has been a mismatch or misunderstanding that has been taken away from the consultation?
- » How do social and cultural factors influence what occurs for both clients and practitioners in the consultation?
- » How can this research contribute to improving the effectiveness of the consultation?
- » Would you like to add any further comments?

APPENDIX 4. POST- CONSULTATION INTERVIEW QUESTIONS – DOCTORS

1. Describe briefly in your own words what happened in the consultation.
2. What were the main points that you think you communicated to the client?
3. What were the main points that you think the client communicated to you?
4. From your experience was this a successful consultation?
5. Do you think you successfully pinpointed the main issue for the client?
6. Do you think the client left anything unsaid in the consultation?
7. What did you find challenging or difficult about the consultation?
8. What do you think the client took away?
9. Do you have any additional comments?

APPENDIX 5. POST- CONSULTATION INTERVIEW QUESTIONS – CLIENTS

1. Can you briefly describe what happened in the consultation?
2. What were the main points you think you successfully communicated to the doctor?
3. What were the main points you think you think the doctor communicated to you?
4. Was this a successful consultation for you?
5. What did you find challenging or difficult about the consultation?
6. What did you take away from the consultation?
7. Do you have any additional comments?

APPENDIX 6. THE ROLE AND TYPE OF QUESTIONS

The question types identified in the recorded Family Planning consultations are outlined below:

Closed Yes/No questions take the form of interrogative clauses. They are used to seek unknown information:

Doctor: Have you got enough in your prescription?

Client: Well, you have given me some repeats (Consultation C15).

Assumptive questions take the form of statements with rising intonation. They are typically used to check a doctor's understanding of what the client said. They tend to close off the range of possible responses:

Doctor: Last year. So you had it removed in September?

Client: May have been towards the end of the year before, I'm really bad with my timing ==[] (Consultation C01).

Extended assumptive questions take the form of a statement followed by a question. They also check a doctor's understanding of what the client has said:

Doctor: So, it says identify present contraception, so can I write abstinence, is that okay?

Client: Abstinence [LAUGHS], it's right (Consultation C01).

Command questions take the form of a command demanding a verbal service. These questions can open up the opportunity for clients to tell narratives about their symptoms, concerns or lifestyles:

Doctor: *And tell me what symptoms you get.*

Client: *Generally it's always come, the thing is as well, this is the other thing is that I teach group fitness classes so I wear a lot of lycra leggings* (Consultation C02).

Cohesive sequences of questions often occur when the doctor is following through on symptoms and trying to gain a detailed or more accurate description:

Doctor: *Yeah, yeah. So tell me the symptoms, so you get sore?*

Client: *Just sore.*

Doctor: *Sore where?*

Client: *Ah...well, mainly on the outer side not inside.*

Doctor: *So is it on the labia, the lips of your vulva as well?*

Client: *Yeah, I guess so. Yeah, yeah, yeah.*

Doctor: *And the vaginal opening there?*

Client: *Yes* (Consultation C02).

Alternative questions take the form of two or three questions connected through the word *or*. They most often occur when the client is being offered two choices:

Doctor: *So, are you happy to continue taking it like this on for the time that you're premenstrual for a few months to see how you go? Or would you prefer to take it consistently? Because (both), you know, I think there's evidence that you could do it either way.*

Client: *There is. I think I'd like to...just fine-tune it a bit more and instead of this time abruptly ceasing it ...* (Consultation C15).

THE EFFECTIVE USE OF QUESTIONS

Questions can either extend or limit the exchanges between doctors and clients. When wanting to explore the concerns of clients and to pinpoint the medical or psychological issues that are concerning the clients, open-ended questions and command questions allow space for clients to provide detailed responses.

In the following exchange, the command question leads to a full explanation from the client, enabling the doctor to suggest a diagnosis:

Doctor: *Yeah. So can you say whether overall you feel that it helped or didn't help?*

Client: *Yeah, I feel it helped.*

Doctor: *Okay.*

Client: *Because certainly one of the things that I felt it did was that when I get ... when I get sort of upset or anxious about something, it's almost like being sucked into a worm hole and I can't get out.*

Doctor: *Yep.*

Client: *And that thought will predominate above everything else.*

Doctor: *Okay, so you start to*

Client: *Start to visualise.*

Doctor: *Think negative.*

Client: *Well, visualise some trauma or something*

Doctor: *Okay.*

Client: *you know. It can be any time of the day but then everything else just, is like being sucked into a worm hole. And that tended to stop that.*

Doctor: *Okay.*

Client: *So that I was actually able to stop*

Doctor: *Now. I'm just wondering. I'm going to put an idea, I'm just going to talk about an idea ... I've been treat, I suggested that we try the anti-depressants because of its properties for managing premenstrual symptoms and of course you just take it for a short period of time when that's happening. Now, I'm actually wondering whether we've actually uncovered that you've got a bit of real depression* (Consultation C15).



**DEVELOPING EFFECTIVE
COMMUNICATION BETWEEN
DOCTORS AND CLIENTS:
SEXUAL AND REPRODUCTIVE
HEALTH CONSULTATIONS**